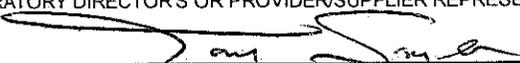


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401
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F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/14/14 through 1/15/14. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirements: F221, F281, F309, F323, F325, and F387.	F 000	Addendums noted with an asterisk per 2/24/14 telephone to facility administrator and DON. PE/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: 18560 Based on observation, record review, interview, and policy review, the provider failed to: *Remove the lap buddy (a flat cushion that fits over a person's lap and under the arm rests of a wheelchair) restraint during meal observations for one of one sampled resident (10) with a lap buddy. *Assess the use of side rails for three of three sampled residents (1, 3, and 6) observed with side rails. Findings include: 1. Observation on 1/14/14 at 12:06 p.m., on 1/14/14 at 5:54 p.m., and on 1/15/14 at 7:59 a.m. revealed resident 10 was seated at the dining room table with her lap buddy on. Her lap buddy remained on throughout all of the meal services	F 221	Physical Restraints (Policy L-19) was reviewed and revised to include quarterly review of each resident with restraints by the resident care supervisor and documentation for continued use of restraint. Accidents, Falls, and Safety (Policy N-559) was reviewed and revised to remove bedrail procedure. A new bed rail policy (Policy L-18) was developed to include one-half bed rail use. Resident #10 cardex care plan was updated on 1/15/14 to include removal of lap buddy at mealtime. Care plans were reviewed for each resident with a restraint to assure	3/6/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 2/11/14
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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.

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F 221	Continued From page 1 listed. Review of the provider's Physical Restraint Consent form signed on 8/23/13 by resident 10's power of attorney revealed the duration of use of the lap buddy restraint was for when she was in her wheelchair. It was to have been removed at meals. Review of resident 10's care plan dated 12/23/13 revealed no documentation to remove her lap buddy during meals. Interview on 1/14/14 at 5:20 p.m. with resident care coordinator A revealed resident 10's lap buddy should have been removed at meal times while she was being fed by a staff member. Interview on 1/15/14 at 3:30 p.m. with the director of nursing (DON) confirmed resident 10's lap buddy should have been removed at meal times while she was being fed by a staff member. 2. Observation on 1/15/14 at 8:40 a.m. revealed resident 3 was in bed with half side rails up on both sides of her bed. She appeared asleep. Review of resident 3's medical record revealed no quarterly assessments had been done for the appropriate use of side rails. Surveyor: 32332 3. Observation on 1/14/14 at 9:45 a.m. of resident 1's room revealed she had two half side rails on her bed. Review of resident 1's 10/31/13 care plan revealed "1/2 side rail for bed mobility."	F 221 <i>including residents 1, 3 and 6 per 5000H JJ</i>	appropriate documentation in place. Reviewed all resident's medical records with 1/2 side rails for appropriate assessment and documentation of need for side rails for bed mobility/ positioning. Need for side rails to meet the resident's needs will be assessed on admission, quarterly, and with change of condition by Resident Care Supervisor. Documentation will be noted in the mobility assessment in resident's EMR. Education will be provided to all nursing staff by DON and ADON on restraints and bed rail policies prior to 2-13-14. Monthly audits of care plans for residents with restraints will be completed by ADON or designee to assure documentation is on the care plan for physical restraints (bed mobility). Monthly audits of Mobility Assessment will be completed by ADON or designee for restraint	

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F 221	<p>Continued From page 2</p> <p>Interview on 1/15/14 at 8:55 a.m. with resident care coordinator B regarding resident 1 revealed: *There were two half side rails on her bed. *She used them for repositioning. *She would have been assessed upon admission to see if she would need them for repositioning. *They had not completed any written assessments on side rails as they were not considered a restraint.</p> <p>Interview on 1/15/14 at 3:15 p.m. with the DON revealed: *All residents had been assessed upon admission to determine if they needed the side rails for repositioning. *Resident 1's side rail use had not been reassessed periodically, because the provider had not considered half side rails a restraint.</p> <p>Surveyor: 32335 4. Observation on 1/14/14 at 7:45 a.m. of resident 6's room revealed she had two half side rails on her bed.</p> <p>Review of resident 6's 12/24/13 care plan revealed no mention of half side rails on her bed.</p> <p>Review of resident 6's undated cardex care plan revealed she had two half side rails on her bed that she used. There was no mention of why she had needed them.</p> <p>Interview on 1/15/14 at 8:15 a.m. with resident care coordinator B regarding resident 6 revealed: *There were two half side rails on her bed. *She used them for repositioning. *She would have been assessed upon admission to see if she would need them for repositioning. *They would have requested a physician's order</p>	F 221	<p>necessity documentation in resident's EMR.</p> <p>Monthly audits will be completed by ADON or designee of staff compliance with appropriate use of bed rails (bed mobility) and any physical restraints currently in use.</p> <p>Audits will be reported quarterly to the QA Committee by ADON until advised to discontinue reporting by the QA Committee.</p>	

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F 221	Continued From page 3 at that time. *They had not completed any assessments on side rails as they did not think they were a restraint. 5. Interview on 1/15/14 at 3:00 p.m. with the DON and resident care coordinator A regarding bed side rails revealed: *They had residents that had half side rails on their beds for repositioning. *Residents would have been assessed upon admission to determine if they needed the side rails for repositioning while in bed. *Resident 6 had been admitted in 2008 but had been discharged to the hospital a few times. *Resident 6 would have been reassessed for bed side rails at those times of readmission but not on a quarterly basis. *No residents had been assessed on a quarterly basis as they did not think side rails were a restraint. *They agreed half side rails could prevent residents from getting out of bed if they had reduced mobility. Review of the provider's May 2013 Accidents, Falls, and Safety policy revealed bedrails would be used only if necessary to meet resident's needs. Full and three-fourths side rails on both sides of the bed were considered restraints and required a physician order. There had been no mention of assessing residents for any type of side rails.	F 221		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	Physician's Orders (Policy# 1514) was reviewed and revised to include	3/6/14

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F 281	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Preceptor: 32332 Based on observation, interview, record review, and policy review, the provider failed to ensure professional standards were followed for: *Transcription (copying of information) of physician's medication orders for 4 of 16 sampled residents (7, 18, 19, and 20). *Updating medication administration records (MAR) to reflect current orders for 1 of 16 sampled residents (1). *Clarification of physician's orders for 1 of 16 sampled residents (6). Findings included: 1. Review of resident 7's physician's order forms and MARs revealed an order for an antibiotic. There had been no date identified when the antibiotic medication order had been copied onto the MAR. 2. Review of resident 18's physician's order forms and MARs for December 2013 revealed: *A sliding scale insulin order for 6:00 a.m. had been written by the physician. The computer generated physician order printed on the MAR had been dated 8/26/10. *Handwritten changes to the physician's order appeared on the November 2013 and the December 2013 physician's order forms changing the dose from six to twenty-three units. *No date or initials were included on the MAR to identify who changed the order or when the order had been changed.	F 281	initialing and dating transcribed orders. Resident 1, 6, ^{* 18 and 20's PE/SCDH/JJ} orders were clarified with primary care physician and clarified orders correctly written on MAR. Resident ^{* 7 and PE/SCDH/JJ} 19's February MAR was reviewed to assure physician's order entries were complete and accurate. New physician orders will be transcribed, dated, initialed and verified on ^{medical plan of care PE/SCDH/JJ} (MPOC) & MAR per policy and procedure and updated in computer prior to next printing. Person responsible for printing MPOC & MAR will verify transcribed orders are on computer printout and any discontinued orders from previous month have been removed. Education will be provided to nurses and consultant pharmacist by 3/6/14 regarding Physician's Order (Policy# 1514) correct transcription of orders, date of order, order initialed and verified by another nurse or med aide will be reviewed during education.	

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F 281	<p>Continued From page 5</p> <p>3. Review of resident 19's physician's order forms and MARs for November 2013 revealed: Seven vitamin D entries had been written on the MAR. None of those seven entries included the initials of the person copying the orders or the dates the orders had been written.</p> <p>4. Review of resident 20's physician's order forms and MARs for November 2013 and December 2013 revealed: *The same computer generated physician's order dated 5/31/11 for differing amounts of Novolin insulin to be given in the a.m. and p.m. had been present on the MARs for both months. *The p.m. dose was crossed off both months by hand. The order for the p.m. dose was then rewritten on the MAR without the date the order was written or the initials of the person who copied the order. *Two physician's orders for Ativan (muscle relaxant medication) were handwritten on the November 2013 physician's orders sheet and dated 11/12/13. The two orders were then copied onto the November 2013 MAR without identifying who had copied the information onto the MAR.</p> <p>5. Interview on 1/15/14 at 3:30 p.m. with the director of nursing (DON) revealed: *She agreed without initials or dates included on handwritten entries there was no way to track who had written the entry or when. *She agreed repeated changing of the same orders month after month should not be continued, but should be entered into the computer system for clarity and to prevent errors. *She stated there was no policy on transcription (copying) of physician's medication orders when orders had been changed or added.</p>	F 281	<p>Monthly audits of 50 physician orders to ensure new orders are dated initialed and transcription verified by another nurse or med aide will be conducted by ADON or designee.</p> <p>Audits will be reported quarterly to the QA Committee meeting by ADON until advised to discontinue reporting by QA Committee.</p>	

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F 281	<p>Continued From page 6</p> <p>Interview on 1/15/14 at 2:25 p.m. with the pharmacist revealed:</p> <ul style="list-style-type: none"> *He could not identify when the handwritten twenty-three units of insulin order for resident 18 had started. *He could not identify who had made the handwritten changes to the physician's order forms and MARs each month. <p>Surveyor: 32332</p> <p>6. Review of resident 1's January 2014 MAR and the updated (11/22/13) physician's orders sheet revealed several discrepancies:</p> <ul style="list-style-type: none"> *Phenaseptic liquid (for sore throat) with a prescription (Rx) number: <ul style="list-style-type: none"> -Had been discontinued 10/21/13 on the physician's order sheet. -Remained on the MAR as an active order. *Guaifenesin DM Syrup (for coughing) with a Rx number: <ul style="list-style-type: none"> -Had been discontinued 10/21/13 on the physician's order sheet. -Remained on the MAR as an active order. *Herbal supplements at bedside without a Rx number: <ul style="list-style-type: none"> -Remained on the physician's order sheet as an active order. -Had been crossed off the MAR as discontinued with no date. *Optifoam dressing (for pressure ulcers) to right heel without a Rx number: <ul style="list-style-type: none"> -Remained on the physician's order sheet as an active order. -Had been crossed off the MAR as discontinued with no date. *Betadine (antiseptic) swab to right heel without a Rx number: <ul style="list-style-type: none"> -Remained on the physician's order sheet as an active order. 	F 281		

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F 281	<p>Continued From page 7</p> <p>-Had been crossed off the MAR as discontinued with no date.</p> <p>Interview on 1/15/14 at 2:15 p.m. with the pharmacist and the DON revealed: *The computer generated physicians' orders sheets and the monthly MARs had not been updated to reflect the current orders. *If the order had an Rx number the pharmacist had been responsible for updating the MAR. *If the order had no Rx number registered nurse (RN) I had been responsible for updating the MAR. *RN I was new to updating the MARs and the pharmacist and DON were unsure if she knew how to make changes on the computer. *There had been no policy to indicate whose job it had been to update the MARs.</p> <p>Surveyor: 32335</p> <p>7. Review of resident 6's physician's order dated 1/11/14 revealed the physician had written "Moved to palliative care [treatment that specialized in relieving pain, symptoms, and stress of serious illness] meds [medications] stopped. Sugars stopped along with insulin." The physician had signed the order, and it had been acknowledged on 1/11/14 by staff.</p> <p>Review of resident 6's January 2014 MAR revealed: *The MAR had not been changed to reflect the 1/11/14 physician's order to stop her medications. *On 1/12/14 she had been given one antidepressant medication and one sedative medication. *On 1/13/14 she had been given one antidepressant medication and one sedative</p>	F 281			

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F 281	<p>Continued From page 8 medication. *On 1/14/14 she had been given one antidepressant medication and one pain medication.</p> <p>Interview on 1/15/14 at 8:15 a.m. with resident care coordinator B regarding resident 6 revealed: *Prior to 1/11/14 the physician had discontinued all of her medications except an antidepressant, a sedative medication, and a pain medication. *She had not known the physician had come in on 1/11/14. *Staff should have clarified with the physician regarding his note on 1/11/14 to verify if he wanted the antidepressant, sedative, and pain medications stopped.</p> <p>Interview on 1/15/14 at 2:50 p.m. with the DON regarding resident 6 revealed staff should have clarified the 1/11/14 physician's order regarding the antidepressant, sedative, and pain medications.</p> <p>8. Review of the provider's September 2012 Physician's Orders policy revealed: *All new orders would be written on the physician's order form and on the MAR. *Correct transcription of all new orders should have been verified and initialed on the physician's order form and the MAR by another nurse or certified medication aide.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, p. 419, revealed: *The physician was responsible for directing medical treatment. *Nurses were obligated to follow the physician's orders unless they believed the orders were in</p>	F 281		

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F 281	Continued From page 9 error or would harm the resident. *All orders were to have been assessed. *If one had been found to be erroneous or harmful, further clarification from the physician was necessary.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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: 32335 Based on record review, interview, and policy review, the provider failed to have a coordinated plan of care for one of one sampled resident (11) receiving hospice services. Findings include: 1. Review of resident 11's 12/6/13 care plan revealed one problem area that was addressed had been "end of life concern." The interventions for that area had been "hospice consult - LTC [long term care] seen by hospice staff." The care plan had several problem areas identified but had not addressed who was responsible for the interventions she had received. The care plan had not included pain management. Interview on 1/15/14 at 11:15 a.m. with registered nurse C regarding resident 11 revealed: *She worked for the hospice provider who was	F 309	Hospice Services (Policy N-255) was reviewed. Resident #11's care plan was revised on 2/10/14 by Resident Care Supervisor to identify responsible parties for listed interventions. <i>*Resident 11 is the only hospice resident at this time. PEISODAH/JJ</i> Pain management was addressed and documented by Resident Care Supervisors per Hospice recommendation. Resident Care Supervisors will be responsible for initiating and updating and educating staff on integrated hospice care plan. Care plan will be developed with collaboration with Hospice nurse. Audits will be completed on Hospice care plans by ADON or designee to assure Hospice care plan integrated and identifies responsible parties for listed interventions. Audit will be reported quarterly to the QA Committee by ADON until advised to discontinue reporting by	3/6/14

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F 309	Continued From page 10 caring for the resident. *They had completed a care plan and had given it to the provider. *The provider should have used it to complete a coordinated care plan of their own. Interview and record review on 1/15/14 at 3:00 p.m. with the director of nursing and resident care coordinator A regarding resident 11 revealed: *The plan of care should have identified the responsible parties for the interventions listed. *The 12/6/13 care plan was not a coordinated plan of care. Review of the provider's July 2013 Hospice Services policy revealed: *Hospice and the provider would integrate the current plan of care at their first meeting. *The integrated plan of care would be updated and revised as necessary to reflect the resident's current status. *The plan of care would have included directives for managing pain and other uncomfortable symptoms.	F 309	the QA Committee.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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:	F 323	Disinfectant wipes have been removed from resident care areas and were placed in locked closets by 2-11-14. Accidents, Falls and Safety (Policy N-559) was reviewed and revised to include locking disinfectant wipes in cupboard or closet.	3/6/14

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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
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F 323	<p>Continued From page 11</p> <p>Surveyor: 32335</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *Disinfectant wipes were stored appropriately in three of four hallways (A, B, and C). *Safety tabs were in place for five of eight EZ lifts (mechanical equipment used to transfer an individual from one surface area to another). <p>Findings include:</p> <ol style="list-style-type: none"> 1. Random observations from 1/14/14 through 1/15/14 revealed: <ul style="list-style-type: none"> *CaviWipes XL containers had been in resident rooms A1, A3, A4, A12, and C4. *Those wipes had also been in over the door isolation caddys in resident rooms AA and A3 and in hallways A, B, and C in the lift alcove areas. *Residents with visual and cognitive (the ability to understand) impairments resided in those hallways. *Those containers had green stickers that stated "disinfectant not for patient use." *The label stated: <ul style="list-style-type: none"> - "Hazards to humans. - Caution: harmful if absorbed through the skin. - Avoid contact with eyes, skin, or clothing. - Wash hands before eating, drinking, chewing gum, using tobacco, or using the toilet. - First aid if on skin: Take off contaminated clothing. Rinse skin immediately with plenty of water for 15-20 minutes. Call a poison control center or doctor for treatment advice." <p>Interview on 1/15/14 at 3:15 p.m. with the assistant director of nursing revealed the CaviWipes XL were a disinfectant. They were used on resident equipment and should not have been left in residents' rooms.</p>	F 323	<p>All Nursing, Activities, Nutrition and Food Service, and Environmental Services staff will be educated on Policy N-559 Accidents, Falls, and Safety by 2-11-14 regarding hazards/supervision/ devices.</p> <p>Monthly audits will be completed by ADON or designee to assure all disinfectant wipes are locked in a closet or cupboard when not in direct use by staff.</p> <p>Audits will be reported quarterly to the QA Committee by ADON until advised to discontinue by the QA Committee.</p> <p>EZ Stand Lift (Policy N-325) was reviewed and revised to include checking that the safety tabs are in place prior to life use. Staff will be educated on verifying safety tabs are in place and replacing safety tabs prior to use. Education will be provided by DON and ADON by 2/11/14. Supply of safety tabs placed in nursing supply closet.</p>	

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F 323	<p>Continued From page 12</p> <p>Review of the provider's May 2013 Accidents, Falls, and Safety policy revealed cleaning supplies and chemicals should have been stored in a locked cupboard when not in direct use or observed by staff.</p> <p>2. Random observations from 1/14/14 through 1/15/14 revealed: *In hallway A: -The first resident lift had no safety tabs. -The second resident lift had one out of two safety tabs. *In hallway B: -The two resident lifts had no safety tabs. *In hallway C: -One of the two lifts had no safety tabs.</p> <p>Safety tabs were used to prevent the harness or sling from slipping out of the hook and causing injury to the residents.</p> <p>Interview on 1/15/14 at 2:00 p.m. with maintenance technician G revealed: *There were two lifts on each hallway for a total of eight. *The safety tabs were an ongoing problem. *The safety tabs either broke off or staff had been taking them off, because they had not liked them. *He had not been notified by anyone recently that the safety tabs had been broken. *The lifts were on a quarterly maintenance schedule.</p> <p>Review of the 2013 resident lift maintenance logs revealed: *Safety tabs were not on the list to be inspected. *The lifts had been checked on a quarterly basis. *Entries had been made for when items were replaced such as batteries.</p>	F 323	<p>Plant operations informed they must use the manufacturer preventative maintenance checklist for the lifts.</p> <p>Monthly audits will be completed by ADON or designee to monitor compliance with safety tabs being present on EZ stand lifts and that quarterly preventative maintenance checklists are completed.</p> <p>Audits will be reported quarterly to the QA Committee by ADON until advised to discontinue reporting by the QA Committee.</p>		

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F 323	Continued From page 13 *There had been no entries that stated the safety tabs had been replaced on any of the lifts.	F 323		
F 325 SS=D	Review of the manufacturer's maintenance checklist revealed safety tabs were to be checked to make sure they were not torn or broken. 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and record review, the provider failed to address the nutrition needs for one of two sampled residents (1) with pressure ulcers. Findings include: 1. Review of resident 1's medical record revealed: *A history of pressure ulcers to her buttocks and right heel. *A low albumin level (to indicate if the body was absorbing protein) of 2.8 (normal level would range from 3.8 - 5) on 10/2/12. *A low total protein level of 5.6 (normal level	F 325	Resident #1: Staff Dietician reviewed EMR (Electronic Medical Record) and visited with resident to educate on nutritional needs to promote healing and obtained her preferences for intervention options. Nutrition-related labs and addition of a multivitamin with iron were requested from physician; approval received and orders carried out. Nutrition assessment and EMR documentation was completed. Resident agreed to additional nutrition interventions to promote healing. Plan of Care was updated. These tasks were completed by Staff Dietician 2/6/14. Reviewed Plans of Care, nutrition interventions in place, and documentation for other residents with pressure ulcers present in	3/6/14

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F 325	<p>Continued From page 14 would range from 5.9 - 8.4) on 6/19/12. *No further albumin or protein levels had been obtained. *Both ulcer areas had been treated in November 2012 with Juven (a dietary protein supplement for wound healing). *Both areas were documented as healed in January 2013. *Juven had been discontinued on 1/24/13.</p> <p>Review of resident 1's physician's orders indicated treatment on: *9/20/13 for an open ulcer to her right heel. *10/16/13 for a right heel blister. *11/13/13 further treatment for the right heel. *12/4/13 open left buttocks. *12/30/13 reopened left buttocks. *1/13/14 the buttocks were healed.</p> <p>Review of the registered dietitian's (RD) documentation regarding resident 1 revealed: *On 2/5/13 she had talked with her regarding a protein supplement. Resident 1 agreed to try to eat more meat and milk. *No further discussion or education with the resident regarding protein concerns after February 2013. *On 5/7/13 she removed resident 1 from her high-risk charting list, because her pressure ulcers had healed. She had documented the resident's Braden score had been a 13 (indicating she was at risk for pressure ulcers). *On 11/5/13 she had documented the residents albumin level from 10/20/12 had been "severely depleted." The resident's nutritional health had been mildly compromised due to her continued weight loss, chronic edema (fluid retention), and leaving part of her meals uneaten. *Dietary assessments from 1/24/13 through</p>	F 325	<p>facility. Visited with residents to educate on nutritional needs and reviewed their planned interventions of choice which will promote healing of skin concerns. These tasks were completed by ^{* the staff} ₁ dietitian by PE/SDOHL/JS 2/6/14.</p> <p>Steps for improving management of residents at high risk for pressure ulcers:</p> <p>Wound Care Specialist will be included in the monthly Interdisciplinary Team Summary email for "Residents at High Risk for Skin Breakdown" in facility.</p> <p>Staff dietician will continue nutrition interventions, resident education, and EMR documentation until follow-up nutrition-related labs or improved health condition indicates the resident no longer has a risk of skin breakdown.</p> <p>Residents with repeated occurrence of pressure ulcers will be kept on the monthly high risk</p>	

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F 325	<p>Continued From page 15</p> <p>12/12/13 indicated goals to return the resident's laboratory test results to within normal limits and for her to have gradual weight loss.</p> <p>Observation on 1/14/14 and on 1/15/14 during the noon meal revealed resident 1 received only water for a beverage.</p> <p>Interview on 1/14/14 at 5:20 p.m. with the RD regarding resident 1 revealed: *The resident had received a protein supplement last January 2013. *The protein supplement had been stopped, because her pressure ulcer had healed. *The resident had stated she had not wanted to gain weight. *The resident had not received additional protein in her diet. *She had not discussed other protein options with the resident. *She had not been supportive of the resident's weight loss.</p> <p>Interview on 1/15/14 at 11:20 a.m. with occupational therapist/wound nurse H revealed: *She left the dietary recommendations to the dietitian. *She was not aware Juven had been discontinued, and resident 1 was not receiving protein supplements. "That was an oversight." *She agreed the resident's heel and buttocks scarring would be an ongoing issue, and the resident "Would remain hi-risk forever."</p> <p>Review of Patricia A. Potter and Ann Griffin Perry, Fundamentals of Nursing, 6th Edition, Mosby, St. Louis, Mo, 2005, revealed on page 1526: **Clients with potential for or actual decreased serum albumin levels or poor protein intake need</p>	F 325	<p>chart list[*] by the staff dietitian. PE/SODOH/JJ</p> <p>* Audits will be completed monthly by Certified Dietary Manager, or designee, and reported at quarterly</p> <p>Quality Assurance Committee meetings by ADON until advised to discontinue by the Quality Assurance Committee.</p> <p>of the documentation of resident's nutritional education and interventions PE/SODOH/JJ</p>	

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F 325	Continued From page 16 a nutritional evaluation to ensure proper caloric intake." **A client can lose as much as fifty g [grams] of protein per day from an open, weeping pressure ulcer." **Increased protein intake helps rebuild epidermal tissue. Increased caloric intake helps replace subcutaneous tissue."	F 325		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Preceptor: 32332 Based on record review, interview, and policy review, the provider failed to ensure a physician's visit had been completed on residents every sixty days for 2 of 13 sampled residents (7 and 10) reviewed. Findings include: 1. Review of resident 7's complete medical record revealed: *Physician assessments had been completed on 7/20/13, 10/3/13, and 12/30/13. *There had been seventy-five days between the 7/20/13 and 10/13/13 assessments. -This assessment had been fifteen days late.	F 387	Physician Visits (Policy# 1511) reviewed. Residents' #7 and #10 physician visits are current. The Medical Director will complete the required visits if the attending physician has not made the visits within the required timeframe. A letter will be sent to all physicians who regularly admit to the facility reminding them of the requirements and of the Medical Director's obligation to see residents when the attending physician fails to meet required visit timeframes. <i>* of all resident physician visits</i> Audits will be completed by the <i>PE/S000H/JJ</i> ADON or designee to track <i>monthly</i> physician visit compliance. <i>PE/S000H/JJ</i> Audits will be reported quarterly to the QA Committee by the ADON	3/6/14

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F 387	<p>Continued From page 17</p> <p>*There had been eighty-eight days between the 10/13/13 and 12/30/13 assessments. -This assessment had been twenty-eight days late.</p> <p>Interview on 1/15/14 at 3:30 p.m. with the director of nursing revealed: *The physician should have seen the resident at least every sixty days. *She had not been aware there were periods of time longer than sixty days during which the resident had not had a physician visit.</p> <p>Review of the provider's revised September 2012 Physician's Orders policy revealed "physician's orders must be reviewed every sixty days with physician visit."</p> <p>Surveyor: 18560 2. Review of resident 10's medical record revealed her physician had visited her on 8/11/13 and 11/12/13.</p> <p>Interview on 1/14/14 at 5:30 p.m. with resident care coordinator A confirmed resident 10's physician had not visited her within the sixty day required time frame.</p>	F 387	until advised to discontinue by the QA Committee.		

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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/15/14. Avera Mother Joseph Manor Retirement Community (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/15/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		F
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation, measurement, and record review, the provider failed to maintain at least 32 inches of clear width for one set of randomly observed smoke barrier doors (between the 1961	K 028		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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[Signature] *[Title]* 2-28-14

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.

MAR 04 2014 FEB 12 2014

Facility ID: 0059

SD DOH L&C SD DOH L&C

If continuation sheet Page 1 of 3

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K 028	Continued From page 1 original building and the 1980 addition) opening. Findings include: 1. Observation at 9:00 a.m. on 1/15/14 revealed the cross-corridor doors from the 1961 original building and the 1980 addition measured 30 inches in clear width. Review of the previous survey report revealed those doors were part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain at least two exits from the second level. Findings include: 1. Observation at 10:30 a.m. on 1/15/14 revealed the second level was not equipped with a conforming exit. The east and west stair enclosures discharged into the main level corridor system. Review of previous life safety code surveys confirmed those findings.	K 032		F

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K 032 K 033 SS=C	<p>Continued From page 2</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain a one-hour fire-resistive path of egress from the second level to the exterior of the building. Two randomly observed stair enclosures discharged into the main level corridor system. Findings include:</p> <p>1. Observation at 11:00 a.m. on 1/15/14 revealed the east and west second level stair enclosures discharged into the main level corridor system. A one-hour fire-resistive path of egress was not provided to the exterior of the building. Review of the previous life safety code survey confirmed that finding.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p>	K 032 K 033		F

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - SOUTHWEST WING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401	
(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
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 1/15/14. Avera Mother Joseph Manor Retirement Community (building 02) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (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.

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING 3A - NORTHWEST WING B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
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NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401
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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 1/15/14. Avera Mother Joseph Manor Retirement Community (Building 03) 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 _____

W. L... 2-28-14

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 15 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.

MAR 04 2014

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SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10590	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014	
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT C		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(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 236	<p>Continued From Page 1</p> <p>two-step Mantoux tuberculin (TB) skin test or TB screening within fourteen days of employment. Findings include:</p> <ol style="list-style-type: none"> Review of staff member E's complete employment record revealed: *The date of hire was 8/15/13. *The TB skin test done had been completed twenty-nine days after being hired. Review of staff member F's complete employment record revealed: *The date of hire was 8/2/13. *The TB skin test done had been completed twenty-seven days after being hired. Interview on 1/15/14 at 11:05 a.m. with registered nurse D revealed: *The date of employment was the same date as the date of hire for the above employees. *The TB skin tests were to have been given for those employees: -On the first day of employment for the one-step TB skin test. -Within fourteen days of employment for the two-step TB skin test. *She did not know why those employees had not been given their TB skin tests in a timely manner. <p>Interview on 1/15/14 at 4:05 p.m. with the director of nursing revealed she expected the policy for the TB screenings for the new employees to have been followed.</p> <p>Review of the provider's revised March 2010 Exposure Control Plan Tuberculosis Control Program for Employees and Residents policy revealed each new healthcare worker should have received the two-step method of Mantoux skin testing within fourteen days of employment.</p>	S 236	<p>documented as to why and steps taken to give second step within reasonable time frame of 14 days.</p> <p>Following initial 6 new hires, we will audit one new employee per month.</p> <p>Audits will be reported by the ADON to the quarterly QA Committee until advised to discontinue by the QA Committee.</p>	

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10590	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT C		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(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 236	Continued From Page 2	S 236		
S 314	<p>44:04:08:03.01 Drug Therapy Reviewed Monthly</p> <p>The pharmaceutical service must be under the supervision of a licensed pharmacist who is responsible to the administrator for developing, coordinating, and supervising medication control. The pharmacist must review the drug regimen of each nursing facility resident...at least monthly. The pharmacist must review, at a minimum, the...resident's diagnosis, the drug regimen, and any pertinent laboratory findings and dietary considerations. The pharmacist must report potential drug therapy irregularities and make recommendations for improving the drug therapy of the residents...to the attending physician and the administrator. The pharmacist must document the review by preparing a monthly report of the potential irregularities and recommendations. The administrator must retain the report in the nursing facility...</p> <p>This Rule is not met as evidenced by: Surveyor: 32332</p> <p>Surveyor: 33265 Preceptor: 32332 Based on interview, the provider failed to ensure the pharmacist completed and documented the results of monthly reviews for all residents. Findings include:</p> <p>1. Interview on 1/15/14 at 2:25 p.m. with the pharmacist and the director of nursing revealed the pharmacist: *Signed the physician's order sheet under the space titled "Complete Entries Checked" monthly</p>	<p>S 314</p> <p>of all ← physician's order sheets PE/500H/JS</p>	<p>Pharmacist Consultant – Consultation and Education (Policy# 1903) was reviewed and revised to include pharmacist writing recommendation or no recommendation next to pharmacist signature on the Physician's Order sheet. * Revised policy was reviewed with the consultant pharmacist. PE/500H/JS</p> <p>Monthly audits will be completed by ADON or designee of compliance with Consultant Pharmacist documentation on Physician Order sheet.</p> <p>Audits will be reported quarterly to the QA Committee by ADON until advised to discontinue by the Committee.</p>	3/6/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10590	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT C			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(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 314	Continued From Page 3 to indicate he had completed his monthly review. *Had no policy that stated his signature in the space titled "Complete Entries Checked" on the physician's order sheet signified he had completed a monthly review. *Had not documented in the resident's chart when there were no concerns found during his monthly review. *Had not thought he needed to document in the resident's chart when there were no concerns found during his monthly review.	S 314			