

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
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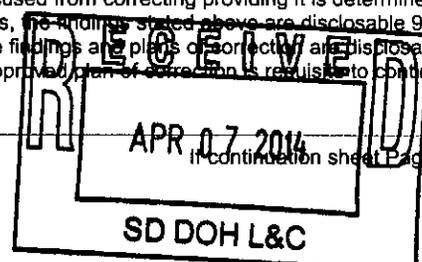
NAME OF PROVIDER OR SUPPLIER  <b>THE NEIGHBORHOODS AT BROOKVIEW</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR BROOKINGS, SD 57006</b>
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F 000	INITIAL COMMENTS	F 000		
F 221 SS=E	<p>Surveyor: 30170 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/18/14 through 2/20/14. The Neighborhoods at Brookview were found not in compliance with the following requirements: F221, F272, and F314.</p> <p><b>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to ensure side rail assessments for restrictive versus enabling use had been completed for four of four sampled residents (2, 4, 11, and 12) who had been observed with side rails on their beds. Findings include:</p> <p>1. Observation on 2/18/14 at 3:07 p.m. of resident 2 revealed she had been in her bed with a half side rail up at the top of her bed.</p> <p>Review of resident 2's 2/6/14 Minimum Data Set (MDS) assessment revealed for bed mobility she required total assistance from one staff person.</p> <p>Observation and interview on 2/18/14 at 4:00 p.m. with the director of nursing (DON) and the</p>	F-221	<ol style="list-style-type: none"> <li>Side rails by the footboard of the beds have been removed on residents 2, 4, 11 and 12.</li> <li>All residents have the potential to be effected if they have not been screened for proper side rail usage. <i>4-3-14 OR</i></li> <li>Care Plans for residents 2, 4, 11 and 12 were revised. Temporary care plan was revised to include transfer/mobility devices. Admission checklist was revised to include the need to complete the screening tool for assistive devices. All staff will be re-educated on proper usage of side rails for bed mobility/transfers at an in-service on March 18 by the Nursing Director. <i>4-3-14 OR</i></li> <li>The Nursing Director or her designee will audit all admissions and 3 residents weekly x 4 and monthly x 3 to ensure screening is completed and if side rails are used as an enabler they are care planned. Results of audits will be provided by Nursing Director to the QAA monthly committee with follow as recommended by the committee. <i>4-3-14 OR</i></li> </ol>	<i>4-11-14</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>4-3-14</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 required to continue program participation.



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F 221	<p>Continued From page 1 administrator revealed: *Bottom and top half side rails were on the beds in residents rooms Oak 3 and Elm 3. *They had not considered the side rails restraints and had not completed assessments. *Most of the residents had used the side rails for positioning while in bed.</p> <p>Surveyor: 30170 2. Observation on 2/19/14 at 2:00 p.m. in resident 4's room revealed: *She had three side rails on her bed. *Two of those side rails were placed on each side on the top of the bed and there was one side rail on the left side at the foot of the bed.</p> <p>Review of resident 4's complete medical record revealed no assessment for the side rails.</p> <p>Surveyor: 18560 3. Observation on 2/20/14 at 9:20 a.m. revealed resident 12 in her bed with side rails up at the top of her bed.</p> <p>Interview on 2/20/14 at 9:25 a.m. with RN E confirmed resident 12 had two side rails on her bed and had used them for repositioning. She stated the side rails had not been assessed for the appropriate use by resident 12.</p> <p>Surveyor: 32332 4. Random observations on 2/19/14 and 2/20/14 of resident 11's bed revealed one raised half side rail attached to the upper half of her bed.</p> <p>Review of resident 11's medical record revealed:</p>	F 221		
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F 221	<p>Continued From page 2</p> <p>*There had been no assessment indicating a need for a side rail.</p> <p>*There had been no physician's order for a side rail.</p> <p>*Her 2/3/14 care plan: -Had not indicated how she moved in bed. -Had not indicated she required a side rail.</p> <p>*Her 1/24/14 MDS indicated bed rails (side rails) had not been used.</p> <p>Interview on 2/20/14 at 10:30 a.m. with RN C revealed: *She had not considered the side rails to be restraints. *The rails were used to assist with bed mobility. *They had not needed to be written on the care plan.</p> <p>5. Interview on 2/20/14 at 11:20 a.m. with the DON revealed: *She had not considered the rails to be restraints, and therefore: -The residents had not been assessed for the medical necessity of a restraint prior to using the side rails. -The physicians had not been contacted for an order to use the rails. -The side rails had not been care planned. -They had not been coded on the MDSs.</p> <p>Review of the provider's August 2012 Restraint Use policy revealed: *Physical restraints had included using side rails that would have kept a resident from voluntarily getting out of bed. *The need for a restraint was to have been assessed on admission and with each care plan review. *The provider and staff were ultimately</p>	F 221			

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F 221	Continued From page 3 responsible for determining if the restraint had been appropriate. *A physician's order was required prior to the restraint application. *The resident and family were to have been informed and educated about the restraint use. *Documentation regarding restraints was to be included in the clinical nursing notes and in the care plan.	F 221		4-11-14	
F 272 SS=D	<b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b>  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F-272	<ol style="list-style-type: none"> <li>Note completed, stating the reason as to why the staff interview versus resident <sup>4-3-14</sup> interview was completed for resident 2. The Household Coordinator and Nursing Supervisor staff were re-educated on section B of the MDS and interview sections by the MDS coordinator.</li> <li>All residents with cognitive impairment are at risk.</li> <li>The Household Coordinator and Nursing Supervisor staff were re-educated on section B of the MDS and interview sections by the MDS coordinator.</li> <li>The Nursing Director or her designee will audit section B of the MDS weekly x 4 and monthly x 3 to ensure the MDS reflects the resident's current status. Results of audits will be provided by Nursing Director to the QAA monthly committee with follow as recommended by the committee.</li> </ol>	4-3-14 08	

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F 272	<p>Continued From page 4</p> <p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on Minimum Data Set (MDS) assessment record review and interview, the provider failed to accurately complete the resident interview versus staff interview for 1 of 13 sampled residents (2). Findings include:</p> <p>1. Review of resident 2's 8/13/13 and 2/6/14 MDS assessments revealed: *Under section B question B0700 they had assessed that she usually made her self understood. *Under section B question B0800 they had assessed that she could usually understand others. *On 8/13/13 under section C question C0100 they had stated the resident interview should have been completed. *The brief interview for mental status section C (C0200 through C0500) had not been completed even though she usually understood. *The staff assessment had been done instead. *On 2/6/14 under section C question C0100 they had stated the resident interview should not have been done because the resident was rarely/never</p>	F 272			

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F 272	<p>Continued From page 5 understood. *The staff assessment was then completed even though she usually understood according to section B.</p> <p>Interview on 2/20/14 at 8:30 a.m. with household coordinator F regarding resident 2 revealed: *She had attempted to complete the resident interview on the 2/6/14 MDS. *The resident had not responded to her. *She then completed the staff assessment instead. *She was not aware the resident interview should have been completed based on section B and her ability to understand and make herself understood.</p> <p>Interview on 2/20/14 at the above time with household coordinator G revealed the nurses completed the MDS section B. The household coordinators completed section C. She had not been aware Section C was completed based on responses in section B.</p> <p>Interview on 2/20/14 at 12:25 p.m. with registered nurse H revealed staff had been instructed on when to complete resident interviews on the MDS. She confirmed the nurses completed section B regarding the resident's ability to have been understood and to understand. The nurses and household coordinators should have been communicating regarding sections B and C. Then they would have known when to complete the resident interviews and when to have completed the staff assessments.</p> <p>Review of the October 2013 Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 revealed the staff</p>	F 272		

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F 272	Continued From page 6	F 272			
F 314 SS=D	<p>assessments should only be completed if the resident was rarely or never understood.</p> <p><b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b></p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to assess weekly, document and implement appropriate interventions, and follow their policy on skin integrity to prevent a pressure ulcer that was acquired in the facility from reoccurring for one of three sampled residents (2) with current pressure ulcers. Findings include:</p> <p>1. Interview on 2/18/14 at 1:15 p.m. with registered nurse (RN) L regarding resident 2 revealed she had a pressure ulcer on her coccyx (tailbone).</p> <p>Review of resident 2's 7/19/13 through 1/31/14 wound assessment documentation revealed: *All wound assessments had been completed by RN I. *On 7/19/13 the resident had a new stage two</p>	F-314	<ol style="list-style-type: none"> <li>1. Resident #2 does not currently have a pressure ulcer.</li> <li>2. All residents who are screened as high risk for skin breakdown are at risk.</li> <li>3. Wound Care Nurse was re-educated on 4-3-14<sup>at</sup> timely skin assessments and documentation by the Nursing Director on 2/20/14. All staff will be educated on the skin integrity policy and staging at an in-service on March 18 by the Nursing Director.</li> <li>4. The Nursing Director or her designee will audit weekly wound assessments for those with pressure ulcers to ensure weekly documentation is completed in the EMR, turning/repositioning program is followed and documented appropriately, residents with pressure ulcers have appropriate pressure relieving devices in place and care planned appropriately and audit the treatment plan to make sure it is accurate and appropriate-weekly x 4 and monthly x 3. Results of audits will be provided by Nursing Director to the QAA monthly committee with follow as recommended by the committee.</li> </ol> <p>4-3-14 <i>ao</i></p>	4-11-14	

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F 314	<p>Continued From page 7</p> <p>pressure ulcer (loss of skin presenting as a shallow open ulcer with a red-pink wound bed) to her coccyx.</p> <p>*Twelve days had gone by before the next assessment was completed.</p> <p>*The next assessment on 7/31/13 stated "the skin had been intact without redness" which meant it was healed.</p> <p>*On 8/14/13 she had a deep tissue injury (an injury to a resident's underlying tissue below the skin's surface that resulted from prolonged pressure in an area of the body) to her coccyx.</p> <p>*Fifteen days had gone by before the next assessment was completed on 8/30/13.</p> <p>*On 8/30/13 and 9/6/13 it was a stage two pressure ulcer again.</p> <p>*On 9/12/13 it was unstageable (the wound was covered by dead tissue).</p> <p>*On 9/18/13 the area was not staged, but nursing continued to measure the wound.</p> <p>*On 9/25/13 and 10/3/13 it had returned to a stage two pressure ulcer.</p> <p>*On 10/3/13 the pressure ulcer had measured 1.5 centimeters (cm) in length and 0.5 cm in width.</p> <p>*On 10/7/13 it was unstageable with measurements of 4.0 cm in length and 2.0 cm in width.</p> <p>*On 10/16/13 and 10/23/13 it was unstageable with measurements of 2.0 cm in length and 1.0 cm in width.</p> <p>*On 10/30/13 it was unstageable with measurements of 1.5 cm in length and 0.8 cm in width.</p> <p>*On 11/5/13 the area was not staged, but nursing continued to measure the wound.</p> <p>*From 11/13/13 through 12/5/13 it was a stage two pressure ulcer.</p> <p>*Fourteen days had gone by before the next assessment was completed.</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>*On 12/19/13 and 12/27/13 it had been a stage two pressure ulcer.</p> <p>*Thirteen days had gone by before the next assessment was completed.</p> <p>*On 1/9/14 and 1/16/14 it was a stage two pressure ulcer.</p> <p>*On 1/23/14 the area had healed.</p> <p>*On the days they had completed the documentation for the dressing type used it was an Allevyn dressing (a range of moist wound environment dressings designed specifically for the management of chronic and oozing wounds) throughout the above time frame except for on 10/3/13.</p> <p>*On 10/3/13 they had used an Hydrocolloid dressing type (a non breathable dressing which adheres to the skin).</p> <p>Observation and interview on 2/19/14 at 9:45 a.m. completed by surveyor 30170 of licensed practical nurse (LPN) M changing a dressing for resident 2 revealed:</p> <p>*The resident had been incontinent of stool.</p> <p>*LPN M had cleaned her up and changed the incontinent product.</p> <p>*There was a slit in the crease of the buttock.</p> <p>*She agreed the wound was open.</p> <p>*The inside of the wound appeared yellow.</p> <p>*She would not have staged the wound or measured it when she changed the dressing.</p> <p>*The wound nurse measured the wound weekly.</p> <p>*LPN M had not used a protective skin barrier cream after cleaning the resident and changing the incontinent product.</p> <p>Review of resident 2's 5/15/13, 8/13/13, and 11/7/13 Minimum Data Set (MDS) assessments revealed:</p> <p>*She was at risk for developing pressure ulcers.</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>*The interventions put in place for the skin and ulcer treatment section had been: - "Pressure reducing device in chair. - Pressure reducing device for bed. - Turning/repositioning program." *No other interventions had been selected.</p> <p>Review of resident 2's 2/6/14 MDS assessment revealed: *She was at risk for developing pressure ulcers. *The same three skin and ulcer treatment interventions listed above had been put in place. *One additional intervention of "application of nonsurgical dressings (with or without topical medications) other than to feet."</p> <p>Review of resident 2's 2/18/14 care plan revealed: *An outcome where the stage two pressure ulcer would not reopen in the next ninety days. *The interventions to reach that outcome included: - "Skin assessments completed weekly related to weight loss, high risk, skin breakdown on coccyx." - "Pressure reducing mattress with bolsters applied to bed." - "Turn/position schedule." - "Encourage to use pillow between ankles while in bed to prevent pressure." - "Pressure reducing chair cushion." - "Reposition/shift weight one to two times between breakfast and noon meal. Two to three times between noon meal and supper. At hs [bedtime]. Then two to three times during the night with rounds. And prn [as needed]." - "Braden skin risk assessment scale." - "ALS [activities of daily living] extensive/total help of 1-2 for all cares."</p>	F 314			

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F 314	<p>Continued From page 10</p> <p>- "Mobility - high back w/c [wheelchair], total assist with use."</p> <p>- "Toilet - completely incontinent, does not use toilet or commode, briefs changed with cares and prn."</p> <p>- "Transfers - Hoyer lift [mechanical equipment used to transfer an individual from one surface area to another] and 2 staff."</p> <p>- "Skin care - pressure ulcer to coccyx, protective skin barrier cream with changes."</p> <p>*A significant weight loss had been noted on 9/5/13 and 10/7/13.</p> <p>*She was to get a 4 ounce (oz) ensure with meals to assist with the weight loss.</p> <p>*A note on 12/8/13 that stated "discussion with dietician - weight stable."</p> <p>Observation on 2/18/14 at 4:45 p.m. of resident 2 revealed:</p> <p>*Certified nursing assistant (CNA) K and nurse aide J had gone into her room to get her out of bed.</p> <p>*They had used the Hoyer lift to go from her bed to the wheelchair.</p> <p>*Once in the wheelchair they lifted her up as she had been leaning.</p> <p>*They had lifted her to where her feet were not touching the foot pedals.</p> <p>*They wheeled her to the dining room in that position.</p> <p>Interview and record review on 2/20/14 at 10:30 a.m. with the director of nursing (DON), RN I, and occupational therapist N regarding resident 2 revealed:</p> <p>*RN I completed all the wound assessments.</p> <p>*On 7/19/13 the resident had developed a pressure ulcer on her coccyx.</p> <p>*On 7/31/13 it was healed.</p>	F 314			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE NEIGHBORHOODS AT BROOKVIEW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR BROOKINGS, SD 57006</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 314	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>*On 8/14/13 she had a deep tissue injury.</li> <li>*Since that time the pressure ulcer had been ongoing. It would improve, and then it would worsen.</li> <li>*The wound assessment documentation had not been done weekly.</li> <li>*On 7/19/13 she had been referred to occupational therapy (OT) to have a pressure mapping evaluation done of her wheelchair cushion.</li> <li>*They recommended and obtained a gel cushion for her wheelchair.</li> <li>*The 7/23/13 OT note stated the gel cushion had provided good pressure relief, and there were no areas of high pressure.</li> <li>*The 8/9/13 OT note stated "Pt [patient] has gel cushion that provides adequate pressure relief, as pressure ulcer is now resolved."</li> <li>*On 8/19/13 they had requested approval from the administrator to purchase a different wheelchair cushion.</li> <li>*The administrator had approved the purchase of a new wheelchair cushion.</li> <li>*That was the current cushion in resident 2's wheelchair.</li> <li>*No documentation had been completed regarding why a new wheelchair cushion had been ordered.</li> <li>*RN I stated "I think it was because the gel cushion went missing."</li> <li>*On 10/3/13 RN I had staged the pressure ulcer as a stage two and the measurements were 1.5 cm in length and 0.5 cm in width.</li> <li>*On 10/7/13 it was unstageable with measurements of 4.0 cm in length and 2.0 cm in width.</li> <li>*RN I stated she had staged the pressure ulcer unstageable when it had been covered and she could not see the depth.</li> </ul>	F 314			

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NAME OF PROVIDER OR SUPPLIER  <b>THE NEIGHBORHOODS AT BROOKVIEW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR BROOKINGS, SD 57006</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 314	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>*She wouldn't have left it as a stage two pressure ulcer if it had been covered even though it had started as a stage two pressure ulcer.</li> <li>*The measurements on 10/7/13 had been larger because she had measured the pink skin around the wound.</li> <li>*On 2/4/14 the interdisciplinary team decided OT should have re-evaluated the wheelchair cushion.</li> <li>*OT had not yet re-evaluated the cushion as of 2/20/14.</li> <li>*There was no reason why a referral to OT had not been made sooner then five months since she continued to have the pressure ulcer problems.</li> <li>*On 8/15/13 the physician's order had been to apply therahoney to the wound bed and to cover with an Allevyn dressing.</li> <li>*In November 2013 the physician had discontinued the therahoney treatment.</li> <li>*Since then they had been only applying the Allevyn dressing.</li> <li>*The turn and reposition documentation was completed at the end of each shift by the CNAs.</li> <li>*They had not completed any monitoring to have made sure staff had been following the turn and reposition program.</li> <li>*The registered dietitian (RD) had not been available at the time we were meeting.</li> <li>*The RD was aware of the pressure ulcer as it was discussed at their weekly meetings.</li> <li>*The DON was not sure if the RD had made any dietary recommendations to help heal the pressure ulcer.</li> <li>*The 4 oz ensure had been added on 9/5/13 for her weight lose.</li> <li>*On 12/8/13 the DON had instructed the staff not to track her acceptance of the Ensure with meals due to her weight being stable.</li> </ul>	F 314			

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NAME OF PROVIDER OR SUPPLIER  <b>THE NEIGHBORHOODS AT BROOKVIEW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR BROOKINGS, SD 57006</b>		
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F 314	<p>Continued From page 13</p> <p>Interview on 2/20/14 at 1:00 p.m. with the DON revealed she had spoken to the RD. She had made no dietary recommendations since the Ensure in September 2013.</p> <p>Review of the provider's October 2012 Skin Integrity policy revealed:</p> <ul style="list-style-type: none"> <li>*Wound assessments were to be "completed at least weekly by licensed nurse."</li> <li>*The interdisciplinary team would communicate regarding skin issues, appropriate lab follow up, and optimal prevention and treatment options.</li> <li>*The medical director would review quality improvement issues related to pressure ulcers and other skin issue trends, and would serve as a liaison to promote optimal skin integrity.</li> <li>*Staff would assess and treat incontinence.</li> <li>*Staff would have used proper positioning, transferring, and turning techniques.</li> <li>*Staff would identify and correct factors compromising protein and/or calorie intake and consider nutritional supplements.</li> <li>*Dietary consult would be obtained as appropriate.</li> <li>*Staff would assist at risk residents to reposition at least every two to three hours and as needed.</li> <li>*If no improvement had been noted in two to four weeks, the physician should have been notified for change in treatment plan.</li> <li>*The record should have reflected risk factors present that were causing deterioration or lack of progress in healing.</li> <li>**Documentation to include pressure ulcer stage as outlined in NPUAP (National Pressure Ulcer Advisory Panel) standards.</li> </ul> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2013, p. 1179, revealed:</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER  <b>THE NEIGHBORHOODS AT BROOKVIEW</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR BROOKINGS, SD 57006</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 314	Continued From page 14 **"Once you have staged the pressure ulcer, this stage endures even as it heals." **"Pressure ulcers do not progress from a stage III [three] to a stage I [one]; rather, a stage III ulcer demonstrating signs of healing is described as a healing stage III pressure ulcer." *The EPUAP (European Pressure Ulcer Advisory Panel) and the NPUAP had developed the following definition for an unstageable pressure ulcer: -"A full-thickness tissue loss in which actual depth of the ulcer is completely obscured by slough [white or yellow tissue that clings to the wound bed in strings or clumps] and/or eschar (tan, brown, or black [tissue that adheres to]) the wound bed." -"Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it is either a stage III or IV [four]."	F 314			

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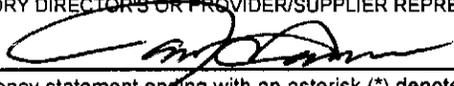
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435083</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2014</b>
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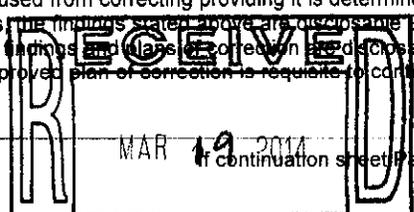
NAME OF PROVIDER OR SUPPLIER  <b>THE NEIGHBORHOODS AT BROOKVIEW</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR BROOKINGS, SD 57006</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 02/19/14. The Neighborhoods at Brookview was found in compliance with 42 CFR 483.70(a)(1) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for New Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		<p>CA</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>3-18-14</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 due within 30 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 due within 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required for continued program participation.



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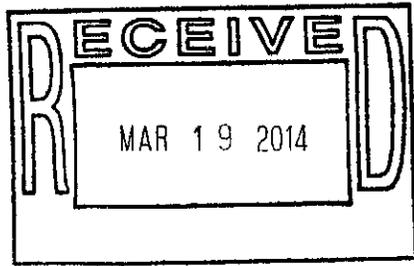
SOUTH DAKOTA DEPARTMENT OF HEALTH

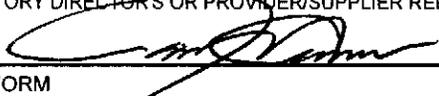
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10600</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>THE NEIGHBORHOODS AT BROOKVIEW</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2421 YORKSHIRE DR BROOKINGS, SD 57006</b>
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S 000	<p>Initial Comments</p> <p>Surveyor: 30170 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/18/14 through 2/20/14. The Neighborhoods at Brookview were found in compliance.</p>	S 000		<p>CPA</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>3-18-14</i>
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