

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

ORIGINAL

PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221
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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 2/25/14 through 2/26/14. Bryant Parkview Care Center was found not in compliance with the following requirements: F221, F226, F280, and F431.	F 000	Addendums noted with an asterisk per 4/3/14 telephone to facility administrator. NUH/SDDH/ME	
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: 32332 Based on observation, interview, record review, and policy review, the provider failed to assess the need for a restraint prior to its application for two of two residents (3 and 5) with a restraint. Findings include: 1. Random observation from 2/25/14 through 2/26/14 of resident 5 revealed a lap buddy (a vinyl-covered foam cushion) had been applied above and over his lap between the arms of his wheelchair. The lap buddy had been used when he was in his wheelchair except during mealtimes. Review of resident 5's medical record revealed: *On 2/4/14 at 2:30 p.m. a staff member had faxed resident 5's physician for an order "regarding lap	F 221	1. Resident #3 and #5 have been updated to facility policy to include a post application assessment of least restrictive physical restraint and notification/ consent from resident's family. All residents with physical restraints will be audited for compliance of facility policy. 2. All staff was in-serviced on 3-10-14 on facility policy for restraint usage including assessment and notification/ consent from family. 3. Restraint audits for policy compliance will be completed by the DON/designee on all residents currently using restraints and on any new orders *weekly x 4 and monthly X 3 and reported to QA Committee by the DON and monitored by the Administrator until advised to discontinue reporting by the QA Committee.	4-17-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lynalle Rust</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-21-14</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 requisite to continued program participation.

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F 221	<p>Continued From page 1 buddy for safety." *There had been no documentation regarding safety concerns in the ten days preceding the request. *No documentation the resident had been assessed for the need of a restraint. *On 2/5/14 at 2:30 p.m. resident 5 had been leaning out a recliner. At that time a staff member placed him in a wheelchair with a lap buddy on him for safety. *An order had been received on 2/6/14 for a lap buddy as needed (PRN) for poor trunk control and leaning forward in the wheelchair. *No documentation of having contacted resident 5's family to obtain consent for the use of the lap buddy. *No documentation of having notified the family of the restraint order.</p> <p>Interview on 2/26/14 at 10:55 a.m. with the MDS coordinator revealed: *There was no formal restraint assessment used prior to application of restraints. *She looked through the nurses' charting to determine if there had been a need for a restraint. *The staff would obtain a physician's order before using the restraint. *The nursing staff was expected to call the family prior to using a restraint. *The nurse was expected to review the risks and benefits of restraints with the family, but no formal consent was used to document the review. *She did not feel the lap buddy had been a restraint for resident 5. *She stated she thought he could remove the lap buddy by himself.</p> <p>Interview on 2/26/14 at 2:20 p.m. with certified nursing assistant C revealed she had not seen</p>	F 221			

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F 221	<p>Continued From page 2 resident 5 attempt to remove the lap buddy.</p> <p>Observation and interview on 2/26/14 at 3:00 p.m. with resident 5 revealed when asked to remove the lap buddy, he had been unable to remove it from between the wheelchair arms.</p> <p>Interview on 2/26/14 at 2:40 p.m. with the director of nursing (DON) revealed: *She would expect staff to perform an assessment prior to applying a restraint or obtaining a physician's order for a restraint. *The lap buddy was a restraint. *The family should have been contacted for approval prior to applying a restraint. *The family should have been instructed regarding the risks and benefits of restraints. *The staff had not followed their policy.</p> <p>Surveyor: 12218 2. Random observation during the survey on 2/25/14 through 2/26/14 of resident 3 revealed she had a lap buddy (a vinyl-covered cushion) applied above and over her lap between the arms of her wheelchair. It was on whenever she was in the wheelchair. It had been removed at mealtime at 5:00 p.m. on 2/25/14, and for breakfast and for lunch on 2/26/14.</p> <p>Review of resident 3's medical record revealed: *She had fallen and fractured her right hip prior to her admission on 7/24/13. *She had fallen several times since her admission. *On 9/2/13 she had fallen and fractured her right arm.</p>	F 221		

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F 221	<p>Continued From page 3</p> <p>*There was no documented assessment of the need for the use of a lap buddy as the least restrictive physical restraint for her medical symptoms.</p> <p>Review of resident 3's physician's orders revealed:</p> <p>*9/3/13: A faxed request to the physician that stated: "Due to numerous falls and injury, may we do lap buddy with "TABs x(times) 2 weeks then re-evaluate?" The physician had signed it on 9/3/13.</p> <p>*9/17/13: A faxed request to the physician that stated: "Per orders we have used a lap buddy on resident while in wheelchair unsupervised x 2 weeks. May we continue order for lap buddy PRN (as needed), remove every 2 hours and when having one to one interactions with staff?" The physician had checked it yes and had signed on 9/17/13.</p> <p>Interview on 2/26/14 at 11:15 a.m. with the Minimum Data Set (MDS) coordinator regarding resident 3 revealed:</p> <p>*She had been tracking and trending what went on with the resident when she completed the MDSs by looking at the physician's orders, nursing notes, and the interdisciplinary progress notes.</p> <p>*She had coded the resident for the physical restraint as "other, used daily."</p> <p>*She confirmed there was no documented assessment initially and quarterly for the use of the lap buddy.</p> <p>Interview on 2/26/14 at 2:20 p.m. with the DON revealed:</p> <p>*There was no formal assessment form used to determine if a resident needed a physical</p>	F 221		

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F 221	<p>Continued From page 4</p> <p>restraint and what was the least restrictive for the symptoms.</p> <p>*The MDS coordinator used a form quarterly that included physical restraints when she coded the MDS, but it had not included an assessment of the resident's medical symptoms.</p> <p>*She confirmed resident 3 had a fractured right hip when she was admitted, and then had several falls after admission.</p> <p>*She confirmed the lap buddy was used and applied after she had fell on 9/2/14 and had fractured her right arm.</p> <p>*They had received an order from the physician on 9/3/13 to try it for two weeks, and another order on 9/17/13 to continue the use of the lap buddy.</p> <p>*There was no quarterly assessment completed for the continued use of the lap buddy for resident 3.</p> <p>Surveyor: 32332</p> <p>Review of the provider's 2008 Use of Restraints Policy revealed:</p> <p>*The provider was to have done a pre-restraining assessment and review to determine the need for a restraint.</p> <p>*The assessment would have been used to determine possible underlying causes of a medical symptom and to determine if less restrictive interventions could have been used.</p> <p>*Restraints should only have been used:</p> <ul style="list-style-type: none"> -With the written order of a physician. -After obtaining consent from the resident and/or representative. <p>*The order was to have included:</p> <ul style="list-style-type: none"> -A specific reason for the restraint. -How it would have been used to benefit the resident. -The type of restraint and period of time for the 	F 221			

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F 221	Continued From page 5 use of the restraint. *The resident/family was to have been informed about the potential risks and benefits of restraints, not using restraints, and alternatives to restraints. *Documentation of the restraints was to have included: -Full documentation of the episode leading to the use of the physical restraint. -A description of the resident's symptoms. -The type of restraint used. -The length of effectiveness of the restraint time. -Observation, range of motion, and repositioning sheets.	F 221			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to appropriately educate one of one social services designee (SSD) on her role and responsibility of investigating and conclusionary reporting of resident incidents. Findings include: 1. Interview and record review on 2/25/14 at 1:00 p.m. with the SSD revealed: *She had been employed as the SSD since June 2013.	F 226	1. The event report policy with investigation and reporting process was reviewed with SSD by the Administrator and DON on 3-19-14. 2. All staff was in-serviced on 3-10-14 on event reporting including the 24 hour notification and 5 day investigation. 3. 24 hour and 5 day investigation/ reporting has been added to our weekly leadership agenda. Audits will be done weekly X 4, monthly X 2 by the SSD and monitored by the DON/Administrator reported to QA Committee by the SSD until advised by to discontinue by the QA Committee. <i>*Event reporting mjhs/dh/mf</i>	<i>*quarterly mjhs/dh/mf</i> 4-17-14	

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F 226	<p>Continued From page 6</p> <p>*A licensed social worker oversaw her work. *When she received a report of an incident she completed an internal form titled "Investigative Data Sheet." *The forms had been created before she had taken the job as the SSD.</p> <p>Review of resident 2's medical record revealed notification had been sent to the physician regarding bruises of unknown origin on 8/28/13, 12/6/13, 1/18/14, and 2/16/14.</p> <p>Continued interview on 2/25/14 at 1:00 p.m. with the SSD revealed: *She had found the investigative data sheets regarding resident 2's bruises of unknown origin. *The reports had not included: -Time of the incident. -Interviews of staff. -Patterns or trends. -What had been occurring prior to the incident. -When the last time the resident had been assisted. *Review of eight random residents investigative data sheets revealed none of the reports included the above information. *She had no other documentation that could provide that information. *She had been trained by the consulting social worker on how to complete the investigative data sheets. *She had never sent any reports to the state agency. *Nursing would send twenty-four hour reports to the state agency, but she was not sure if they had sent any five day reports. *She had not been trained on sending reports to the state agency.</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>Interview on 2/25/14 at 1:20 p.m. with the SSD and registered nurse (RN) B revealed: *RN B had sent twenty-four hour reports to the state agency if there had been a cut or injury to a resident. *RN B had never sent a five day report to the state agency.</p> <p>Interview on 2/25/14 at 1:35 p.m. with the SSD and the director of nursing (DON) revealed: *The DON stated the SSD sent in the five day reports to the state agency. *The SSD informed the DON she had never received training on reporting to the state agency. *The DON had thought she had received the training from the past SSD and the licensed social worker who consulted for them. *The DON had not followed up with the SSD since she had been hired for the social service position to review what she had been trained on.</p> <p>Review of the provider's August 2008 Policy and Procedure for Resident Abuse revealed: *The investigative team included social services, the quality improvement director, the DON, and the administrator. *The investigative team would have reviewed all incident reports regarding residents including those that indicated: -An injury of unknown origin. -Abuse. -Neglect. -Misappropriation of property. -Involuntary seclusion. *The review would have occurred "no later than the next working day following the incident." *An investigation would have begun immediately. **Written statements will be received from all staff working the area/unit at the time of the alleged</p>	F 226		

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F 226	Continued From page 8 incident." *The investigative team would have determined if further investigation was needed. **"Social services personnel or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the Falls/Skin Issues/Occurrence Report." ***Social Services or designated person will also complete and submit any reports required by the state.	F 226			
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. This REQUIREMENT is not met as evidenced by: Surveyor: 12218	F 280			

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F 280	<p>Continued From page 9</p> <p>Based on record review and interview, the provider failed to revise and update the care plan for one of two sampled residents (3) with physical restraints. Findings include:</p> <p>1. Review of resident 3's 1/21/14 care plan had not revealed the resident was at high risk for falls or that she had a lap buddy. The following focus areas and interventions related to falls were: *Focus: "Resident has delirium or an acute confusional episode related to change in condition, change in environment, pain in right hip. Date initiated 8/8/13." *Interventions: -"Monitor resident's safety maximum of every two hours." -"Resident's symptoms which increase safety risks are falls, anxiety, crying, hollering out. Date initiated 8/8/13." *Focus: "Actual fall with serious injury prior to admission, right hip ORIF (surgery procedure for fracture) done. Date initiated 8/8/13." -Update on 9/3/13: "Pain to right arm, fall with fracture." -"Resolved 10/22/13." *Interventions for focus area of fall prior to admission: -"Continue interventions on the at-risk plan." -"For no apparent acute injury determine and address causative factors of the fall. Date initiated 8/8/13." -Updated intervention on 9/3/13: "Sling to arm, unable to repair, transferred with two and gait belt. Pt (physical therapy) still on board." -Completed date: 1/21/14.</p> <p>Review of resident 3's medical record revealed she:</p>	F 280	<p>1. Resident #3 care plan has been updated to reflect use of a lap buddy, interventions on prevention/directions for use and focus area for high risk for falls, and history of falls with injury. All other residents with restraint usage will be reviewed for compliance.</p> <p>2. All staff was in-serviced on 3-10-14 on updating the resident's care plan for restraint usage.</p> <p><i>*All MDS/ADDMF involving physical restraints MSH/DOH/MF</i></p> <p>3. Care plans will be audited with the MDS Assessment schedule or change of condition by DON/Designee. And monitored by the Administrator. Audits will be reported to QA Committee by the DON/designee until advised to discontinue by the QA Committee.</p> <p><i>*quarterly MSH/DOH/MF</i></p>	4-17-14

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F 280	<p>Continued From page 10</p> <p>*Was admitted on 7/24/13 from a hospital stay. *Had fallen at the assisted living center where she lived. *Was admitted to the nursing home with a fractured right hip. *Had falls after her admission to the nursing home on 7/26/13, 8/18/13, 8/20/13, 8/28/13, and on 9/02/13. *Fractured her right arm when she had fallen on 9/2/13.</p> <p>Review of the resident 3's physician's orders revealed: *9/3/13: A faxed request to the physician that stated: "Due to numerous falls and injury, may we do lap buddy with "TABs x(times) 2 weeks then re-evaluate?" The physician had signed it on 9/3/13. *9/17/13: A faxed request to the physician that stated: "Per orders we have used a lap buddy on resident while in wheelchair unsupervised x 2 weeks. May we continue order for lap buddy PRN (as needed), remove every 2 hours and when having one to one interactions with staff?" The physician had checked it yes and had signed on 9/17/13.</p> <p>Review of resident 3's interdisciplinary progress notes and the nurses progress notes regarding the lap buddy revealed: *9/3/13 at 1850 (6:50 p.m.) Nurses progress notes: "...appetite 100% (per cent) supper, required assistance with eating, dependent upon staff for ADLs (activities of daily living), used lap buddy while in wheelchair. Tolerated well." *9/9/13 at 1800 (6:00 p.m.) Interdisciplinary progress note: "Resident becoming anxious at this time. Tab alarm sounding 4 times. Resident attempting to stand up or leaning over to touch</p>	F 280			

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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	
F 280	<p>Continued From page 11</p> <p>ground. Redirected to sit down. Lap buddy in place."</p> <p>*9/10/13 Interdisciplinary progress note: "Resident's right hip is doing well. Resident bears weight without complains of pain. Resident remains very weak. Resident fell on 9/2/13. She had her right arm x-rayed on 9/3/13 and found the humerus (upper arm bone) broken lengthwise. Resident's arm had been in a sling since that time. Resident complains of pain when she has to move the arm, but no other time. Resident becomes very confused and agitated at times, is using a lap buddy and tabs arlarm to prevent further falls as she will still try to get up and walk..."</p> <p>Review of resident 3's following Minimum Data Sets (MDS) revealed section P for physical restraints used in chair or out of bed were coded as used daily for the following: *Sixth day after admission (9/24/13). *Quarterly on 10/22/13. *Quarterly on 1/21/14.</p> <p>Interview on 2/26/14 at 11:15 a.m. with the MDS coordinator regarding resident 3 revealed: *She was not the person that completed the care plans. *The director of nursing (DON) and care team had done the care plans. *She had been tracking and trending what went on with the resident when she completed the MDSs. *She had coded the resident for the physical restraint as "other, used daily." *She confirmed there was no documented assessment initially and quarterly for the use of the lap buddy.</p>	F 280			

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: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2014
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F 280	Continued From page 12 Interview with the DON on 2/26/14 at 2:20 p.m. revealed the care plan: *Had not mentioned the lap buddy. *Had no interventions/directions for the use of the lap buddy. *Had no separate focus area for falls since the resident had been at high risk for falls, history of falls, and falls with injury. The interventions could have focused on prevention of fall techniques.	F 280			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431			

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F 431	<p>Continued From page 13</p> <p>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 observation, record review, interview, and policy review, the provider failed to maintain secured storage of schedule II and III (government-controlled) emergency medications for one of two sampled hospice residents (8). Findings include:</p> <p>1. Observation on 2/26/14 at 9:00 a.m. of the medication room refrigerator revealed a bag of medication including: *Ten vials of Morphine (medication for severe pain) 15 milligrams/milliliter (mg/ml), each containing 1 ml. *Ten vials of lorazepam (for anxiety) 2 mg/ml, each containing 10 ml. *Both medications had been dispensed by the pharmacy on 1/17/14 with resident 8's name on the labels.</p> <p>Interview and medication reconciliation at that time with registered nurse (RN) B revealed: *The medication had been delivered by hospice and was to have been used as a hospice emergency kit. *She was unaware the medication had been delivered. *It had not been secured. *It was not being counted each shift to maintain</p>	F 431	<p>1. The DON contacted the Hospice vendor and educated them on the facility's responsibility on the delivery/counting of Scheduled II and III medications and received their policy for Hospice Emergency Comfort Kit. These medications will appear on the Medication Administration Record after the order has been received by the Physician.</p> <p>2. All staff was in-serviced on 3-10-14 on Hospice and facility procedures for delivery storage, and accountability of Scheduled II and II medications, and Physician orders on Medication Administration Record when resident is using the medication. Charge Nurses will count and document delivery of all medications with the Hospice Nurse.</p> <p>3. Audits will be completed with all future Hospice residents for compliance of policy by the DON and monitored by the Administrator. The DON will report audits to QA Committee until advised to discontinue by the QA Committee.</p> <p><i>* policy and procedure</i> <i>* on the above policy and procedure</i></p>	4-17-14

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F 431	<p>Continued From page 14</p> <p>its security along with the other morphine and lorazepam in the building.</p> <p>*The morphine and lorazepam vials had been reconciled with the medication labels at that time by this surveyor and RN B.</p> <p>Review of resident 8's medical record revealed:</p> <p>*No orders for morphine or lorazepam on the medication administration record.</p> <p>*No standing orders for morphine or lorazepam in her medical record.</p> <p>*No documentation from the hospice provider indicating the morphine or lorazepam had been ordered.</p> <p>Interview on 2/26/14 at 2:40 p.m. with the director of nursing revealed:</p> <p>*She had not known how or when the medication had been placed in the medication room.</p> <p>*There had been no orders for the medications in resident 8's medical record.</p> <p>*The morphine and lorazepam had not been accounted for since they had been delivered to the medication room on 1/17/14.</p> <p>Review of the provider's 5/10/10 Storage and Expiration Dating of Medications policy revealed the "Facility should store Schedule II Controlled Substances and other medications deemed by Facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key or access device."</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221
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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 2/25/14. Bryant Parkview Care 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 *Lynelle Ruot* TITLE *Administrator* (X6) DATE *3-21-14*

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 24 2014
SD DOH LSC

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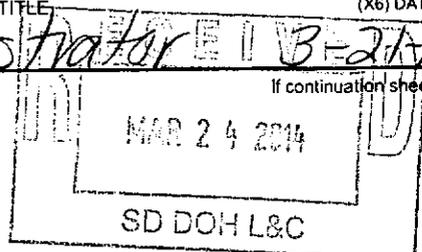
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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S 000	Initial Comments Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/25/14 through 2/26/14. Bryant Parkview Care Center was found not in compliance with the following requirements: S210 and S253.	S 000	<p>Addendums noted with an asterisk per 4/23/2014 telephone to facility administrator. MJH/SDDH/ME</p> <p>1. All new hires will complete a newly revised employee health questionnaire and have it signed by a health professional within 14 days of hire.</p> <p>2. All staff was in-serviced on 3-10-14 of revised policy on health questionnaire for free of communicable disease within 14 days of hire and signed by a health professional. *on all new hires MJH/SDDH/ME</p> <p>3. Audits will be completed weekly X 4, monthly X 2 by the Administrator, with results reported to QA Committee until advised to discontinue by the QA Committee.</p>	
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Rule is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to ensure five of five newly hired employees (D, E, F, G, and H) had the appropriate health evaluation performed by a licensed professional. Findings include:	S 210		4-17-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lynelle Rust</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-27-14</i>
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S 210	Continued From Page 1 1. Review of dietary aide D's employee file revealed: *She had been hired on 9/4/13. *There was no health evaluation in the file. Review of housekeeper E's employee file revealed: *She had been hired on 7/31/13. *There was no health evaluation in the file. Review of certified nursing assistant F's employee file revealed: *She had been hired on 8/13/13. *There was no health evaluation in the file. Review of nurse aide G's employee file revealed: *She had been hired on 9/16/13. *There was no health evaluation in the file. Review of housekeeper H's employee file revealed: *She had been hired on 8/26/13. *There was no health evaluation in the file. Interview on 2/26/14 at 11:30 a.m. with the director of nursing revealed: *They did not have a specific employee health evaluation form. *They had the employee hand write on the tuberculin skin testing form "I am free of communicable diseases to the best of my knowledge." *They had the employee sign that form. *A licensed health professional had not evaluated the employee for communicable diseases.	S 210		
S 253	44:04:04:11.01 SECURED UNITS	S 253		

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S 253	<p>Continued From Page 2</p> <p>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.</p> <p>This Rule is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and policy review, the provider failed to ensure there was a therapeutic activity program for eight of eight residents (1, 2, 11, 12, 13, 14, 15, and 16) for one of one memory support unit (Freedom Path). Findings include:</p> <p>1. Random observations on 2/25/14 from 10:00 a.m. through 11:30 a.m. in the Freedom Path memory support unit revealed: *There were eight residents that lived in the memory support unit.</p>	S 253	<p>1. The facility with our Secured Unit will provide and document in the care plan therapeutic programming* for each resident. A facility policy will be written for the Secured Unit for a therapeutic activity program with a separate calendar addressing those activities.</p> <p>2. All staff was in-serviced on 3-10-14 on the Activity Program for the Secured Unit. *Therapeutic programming</p> <p>3. Audits will be done every 2 weeks X2, then monthly X2 by the Activity Director and DON/designee and *results Monitored by the Administrator. Audits will be reported to the QA Committee by the Activity Director until advised to discontinue by the QA Committee.</p>	<p>for each resident. mjh/kddh/mf</p> <p>*results mjh/kddh/mf</p> <p>4-17-14</p>

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S 253	<p>Continued From Page 3</p> <ul style="list-style-type: none"> *There was one certified nursing assistant (CNA) working in the unit. *Residents 1, 2, 13, 14, and 16 had been in the living room/kitchen area. *Residents 2 and 13 had been looking at magazines. *Residents 11, 12, and 15 had been in their rooms. *There had been music playing in the kitchen. *CNA A had been making beds in the residents' rooms. *At 10:30 a.m. CNA A had turned off the music and turned on the television (TV) for resident 1 who had been the only one sitting in one of the recliners. *At 10:30 a.m. the activities coordinator took residents 2 and 11 to devotions out in the main area. *At 11:00 a.m. residents 2 and 11 had returned to Freedom Path. *At 11:10 a.m. lunch was served. *No other activities other than music and TV had occurred during that time. <p>Observation on 2/25/14 from 1:55 p.m. through 2:30 p.m. in Freedom Path revealed:</p> <ul style="list-style-type: none"> *Resident 14 had been in the kitchen looking through a drawer. *Residents 15 and 16 had been in the kitchen eating a snack. *Resident 1 had been sitting in the recliner in the living room with the TV on. *Resident 12 had been in his room sleeping. *Resident 2 had been in her room. *At 2:00 p.m. residents 11 and 13 had returned from the main area after playing bingo. *At 2:30 p.m. residents 11, 13, 15, and 16 were still sitting at the kitchen table with no activities occurring. *Resident 14 was still looking through a drawer. *Resident 1 was still in the living room. 	S 253		

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S 253	<p>Continued From Page 4</p> <p>*CNA A had been in the kitchen.</p> <p>Observation on 2/25/14 at 4:10 p.m. in Freedom Path revealed residents 1, 2, 11, 13, 14, 15, and 16 were sitting at the kitchen tables. Resident 12 had been in bed. No activities were occurring.</p> <p>Observation on 2/26/14 at 9:00 a.m. revealed: *Residents 11 and 12 had been in their rooms. *Residents 2, 13, 14, 15, and 16 had been sitting at the kitchen tables. *Resident 14 had been looking at a magazine. *Resident 1 had been sitting in the recliner. *Music playing was the only activity that was occurring.</p> <p>Interview on 2/26/14 at 9:00 a.m. with resident 13 who had been sitting at the kitchen table not doing anything stated she was bored.</p> <p>Confidential interview on 2/26/14 at 9:20 a.m. with a family member to one of the residents in Freedom Path revealed: *She visited her mother about two times per week. *Her mother was usually sitting at the kitchen table or in her room when she arrived. *She felt her mother had done more crafts and projects when she was out in the main area. *She wanted her mother to be doing more activities.</p> <p>Interview on 2/26/14 at 1:25 p.m. with CNA A revealed: *Activities were done by the activity department. *Some of the residents went out into the main area to participate in activities. *She played music and turned on the TV for the Freedom Path unit. *She documented such things as "TV, music, napping, walking, wandering, movies, cookies,</p>	S 253		

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S 253	<p>Continued From Page 5</p> <p>and visiting" on a monthly Freedom Path activity calendar for each resident. *The activities staff had one to two things on the Freedom Path activities calendar. *She had not documented on the individual calendars if the residents had participated in those activities. *Some of those activities had been out in the main area. *The activities on the January 2014 calendar were repeated each week. *The activities staff had not scheduled any activities on the unit that they led.</p> <p>Interview on 2/26/14 at 2:00 p.m. with the director of nursing regarding the activities program on the unit revealed her activity coordinator was in charge of the activities on the Freedom Path unit. She directed me to speak with her.</p> <p>Interview on 2/26/14 at 2:20 p.m. with the activities coordinator revealed: *The unit staff were to have done activities with the residents. *She had provided all kinds of different activities to the staff on the unit. *She had taken some of the residents out to the main area for activities. *Not all the residents came out to the main area for activities. *She stated "I am not sure if the unit staff have been using any of the resources I have provided." *She had an activities policies but not a policy specific to the Freedom Path memory support unit.</p>	S 253		