

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

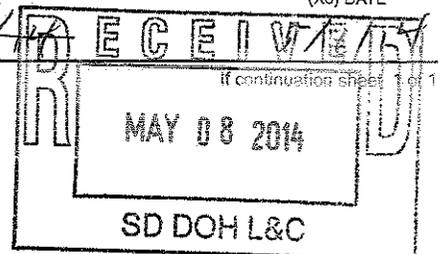
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10636	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
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NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY STREET IRENE, SD 57037
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S 000	<p>Initial Comments</p> <p>Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/07/14 through 4/09/14. Sunset Manor Avera Health was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i> 5/6/14	(X6) DATE 5/6/14
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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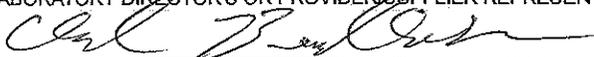
PRINTED: 04/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
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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 4/07/14 through 4/09/14. Sunset Manor Avera Health was found not in compliance with the following requirements: F221, F281, F309, F371, F431, and F441.	F 000	Addendums noted with an asterisk per 5/14/14 telephone to facility DON. MUH/SDDOH/MF	
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, record review, interview, and policy review, the provider failed to follow their physical restraint policy for five of ten sampled residents (4, 5, 6, 7, and 8) for: *Obtaining prior consent from the resident or family for: -Three of three sampled residents (4, 5, and 7) with side rails. -Three of three sampled residents (6, 7, and 8) with seat belts. *Obtaining a physician's order for: -Two of two sampled residents (5 and 7) with side rails. -Two of three sampled residents (7 and 8) with seat belts. *Completing periodic assessments for:	F 221		

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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 dischargeable 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 dischargeable 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.

MAY 08 2014

SD DOH L&C

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F 221	<p>Continued From page 1</p> <p>-Three of three sampled residents (4, 5, and 7) with side rails.</p> <p>-Two of three sampled residents (7 and 8) with seat belts.</p> <p>Findings include:</p> <p>1. Random observations on 4/7/14 through 4/9/14 of resident 4's bed revealed four half side rails, one half rail to each side of the head and foot of the bed.</p> <p>Review of resident 4's medical record revealed:</p> <p>*A 2/2/14 Minimum Data Set (MDS) assessment indicated side rails had not been used.</p> <p>*A 2/27/14 care conference note stated his last fall had been on 10/31/13, and side rails were used.</p> <p>*There had been no assessment to indicate the need for side rails.</p> <p>*There had been no consent for the use of side rails.</p> <p>*A 2/28/14 faxed physician's order requested approval "to have all four side rails up on his bed (split rails) for safety and his ability to assist with repositioning, boundary identification also."</p> <p>*A care plan dated 7/2/07 stated:</p> <p>-"____ [resident 4] has an electric bed, controls are locked when he is in bed for safety."</p> <p>-"____ [resident 4] is to have side rails up when laying in bed to aid in repositioning and for safety. He uses side rails for boundary identification also."</p> <p>-"Resident to use trapeze bar above bed to assist in mobility."</p> <p>Interview on 4/8/14 at 11:40 a.m. with registered nurse (RN) E revealed:</p> <p>*She had requested the order for the side rails.</p> <p>*The resident would become restless at times,</p>	F 221		

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F 221	<p>Continued From page 2</p> <p>and then would slide his body to the bottom of the bed.</p> <p>*He would hang his feet over the edge of the bed.</p> <p>*He had not been assessed prior to obtaining a physician's order for the side rails.</p> <p>*There had been no written consent for the use of the side rails.</p> <p>2. Observation on 4/9/14 at 10:00 a.m. of resident 7's bed revealed two half side rails to the head of her bed.</p> <p>Review of her medical record revealed:</p> <p>*A care plan dated 9/18/08 that stated:</p> <p>- "Side rails to resident's left side to aid in repositioning in bed."</p> <p>- "Operate seat belt to prevent falls due to balancing problems."</p> <p>- "Bed will be in its lowest position at bedtime and call light will be in reach."</p> <p>*No consent for a seat belt.</p> <p>*No physician's orders for side rails or a seat belt.</p> <p>*A 3/26/14 MDS indicated she had used the side rails daily. No other restraints had been indicated.</p> <p>*A physical restraint elimination assessment dated 2/8/14 indicated:</p> <p>- She used a seat belt.</p> <p>- She had been able to unbuckle the belt herself.</p> <p>- She had a signed restraint consent. (No consent had been located.)</p> <p>- A score of 28. A score of 21 - 35 would have indicated she had been a good candidate for restraint elimination.</p> <p>*Nothing about whether the least restrictive measures had been utilized.</p> <p>*She had not been assessed for the use of the side rails.</p> <p>Interview on 4/9/14 at 10:20 a.m. with the MDS coordinator revealed:</p>	F 221		

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F 221	<p>Continued From page 3</p> <p>*Resident 7 had used two half side rails at the head of her bed for repositioning.</p> <p>*She had been assessed quarterly for the use of the seat belt.</p> <p>*She had not been assessed for the use of the side rails.</p> <p>3. Interview on 4/9/14 at 5:15 p.m. with the director of nursing (DON) revealed:</p> <p>*She had obtained orders for resident 4's side rails when she found out there had not been orders.</p> <p>*She had not obtained side rail orders for resident 7.</p> <p>*She had not thought resident 7's seat belt had been a restraint, since it had been part of the wheelchair when the resident had been admitted.</p> <p>*She agreed the provider had not followed their physical restraint policy.</p> <p>Review of the provider's undated Physical Restraint policy revealed:</p> <p>***Restraints will only be used after other alternatives have been tried unsuccessfully, and only with informed consent from the resident, physician, and/or representative."</p> <p>***Orders indicate the specific reason, type, and period of time for the use of restraints. Restraints must be used only as a last resort, and the medical record must indicate the events leading up to the necessity of the restraint."</p> <p>***A resident placed in a restraint will be observed at least every thirty minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record."</p> <p>***The need for restraints will be reevaluated at least quarterly to determine their continued need. Every effort will be made to eliminate their use."</p> <p>***The resident's care plan must indicate that the</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>continued use of a restraint had been reevaluated and that a reorder from the physician is so noted."</p> <p>Surveyor: 12218</p> <p>4. Observation from 4/7/14 through 4/9/14 of resident 5's bed revealed it had an assist bar attached to the upper outer side of her bed. Review of resident 5's medical record revealed: *Her 3/31/14 quarterly MDS assessment had the following functional abilities in activities of daily living (ADL): -Needed only supervision for her independent bed mobility without any physical help. -Was independent in ability to transfer. -Was independent in her balance in transitions but was not able to walk. -Had no limitation in her range of motion for upper and lower extremities. *Her 1/18/14 care plan revealed under the ADL functional deficit: -She was to use the assist bar on the side of her bed for positioning. -She was to be assisted with transfers as needed.</p> <p>Interview with the MDS coordinator at 2:30 p.m. on 4/9/14 regarding resident 5's side rail revealed: *She confirmed there was no consent form signed by the resident or the family. *There was no physician's order for the use of a side rail or assist bar. *There had been no periodic assessments completed on resident 5's use of the side rail or assist bar.</p> <p>5. Review of resident 6's medical record</p>	F 221			

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F 221	<p>Continued From page 5 revealed:</p> <p>*Under the problem of fall risk: -She had a traumatic brain injury (TBI) with balance problems and lower extremity weakness. -She was able to operate a seatbelt (in her wheelchair) to prevent falls due to balancing problems and sliding down in her chair. *Under alteration in ADL performance related to TBI she required limited to extensive assistance of one staff person with transfers.</p> <p>Interview on 4/9/14 at 3:00 p.m. with the TBI unit program director revealed there had been no prior consent form signed by either the resident or her family.</p> <p>6. Observation from 4/7/14 through 4/9/14 of resident 8 revealed she was wearing a seatbelt. Review of her medical record revealed: *She had a tramatic brain injury. *She was in a wheelchair. *No consent form for the use of a seatbelt signed by the resident or her family was found. *No physician's order for the seatbelt was found. *A pre-restraining assessment had been done. *No periodic assessments had been done since 6/1/11.</p> <p>Interview on 4/9/14 at 3:15 p.m. with the DON confirmed there was no consent form or physician's order, but periodic assessments had been done but none recently.</p>	F 221	<p>Consent forms have been obtained for residents #4, 5, 6, 7 and 8. Physician orders have been obtained for residents 5, 7, and 8. Assessments have been completed for residents #4, 5, 7 and 8.</p> <p>Nursing staff has reviewed all current nursing home resident charts for the presence of restraints. The residents who were identified as having restraints have an assessment completed, physician order obtained and a consent form has been signed.</p> <p>The Policy and Procedure for physical restraints has been reviewed by the Director of Nursing. The policy and procedure will be reviewed by the QAPI Committee on 5.13.14 for approval. Nursing education was held in reference to restraints and the current policy on 4.11.14.</p> <p>The facility MDS Coordinator will audit compliance with the policy monthly x6 months then quarterly for one year thereafter and report her findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p>Completion Date: 5.22.14</p>	5.22.14
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281		

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F 281	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, and interview the provider failed to adequately identify and document necessary medical information on admission for one of nine sampled residents (9). Findings include:</p> <p>1. Review of the entire medical record revealed: *The physician's orders summary dated April 2014 and the medication administration record (MAR) dated April 2014 had not identified: - If there were any allergies or no known allergies (NKA) for the resident. -Code status (whether to treat or not to treat if heart or lungs quit functioning). -All diagnoses (medical or psychiatric problems). Missing were: epilepsy, seizure disorder, paraplegia (inability to use legs), history of alcohol dependency, organic affective syndrome, and mood disorder. *The undated care plan had not identified the existence of a metal plate that had been placed in his head. *There was a physician's order on admission dated 9/12/13 ordering "pneumovax on admission, if not previously given." No notation had been made on the face sheet concerning that vaccine. -No documentation of whether he had received or had been offered a pneumovax vaccine.</p> <p>Interview with the director of nursing on 4/9/14 at 5:00 p.m. revealed: *She expected information concerning allergies, code status, and a list of all diagnoses to have</p>	F 281		

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F 281	Continued From page 7 been available on the face sheet, the physician order summary, and the MAR. After review of those documents she agreed the information was not on the physician's order summary or the MAR. *She had heard that resident 9 had a metal plate in his head. She stated it should have been noted on the face sheet and care plan, so all staff could have accessed the information if needed. After review of those documents she agreed the information was not noted on the care plan. *She agreed documentation clarifying whether pneumovax vaccine had been given, offered, or refused had been missing from the medical record. A request had been made on 4/9/14 at 1:30 p.m. for a policy on required physician orders. The DON informed this surveyor on 4/9/14 at 3:45 p.m. that no policy regarding required physician orders had been located.	F 281	The information said to have been missing from the chart of resident #9 has been identified and placed in the resident's chart which includes physician orders and Medication Administration Record noted with allergies, code status, all diagnosis and pneumovax. Nursing education was completed 4.11.14 regarding the required information to be included in the resident chart upon admission. [REDACTED] will be completed monthly x3 then quarterly for one year by the facility Medical Records Coordinator. Findings of the audit will be reported at the QAPI Meeting monthly for review and appropriate recommendations. Completion Date: 5.22.14 <i>* Five random resident chart audits MHHKDDHME</i>	5.22.14
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: 33265 Based on observation, interview, and record review, the provider failed to provide necessary	F 309		

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F 309	<p>Continued From page 8 care and services for: *Care plan assessment and interventions for one of nine sampled residents (2) . *Timely individualized feeding assistance for one of four residents (2) who required assistance with eating. Findings include:</p> <p>1. Observation on 4/7/14 during the evening meal revealed resident 2: *Had been seated at the table nearest the doorway to the dining room, in the chair immediately next to the doorway. *Had fluids available to drink. *Would loudly yell out at random times. -Other residents displayed displeasure at the noise through head shaking and grimaced faces. -One resident (9) yelled back and then laughed. *Repeatedly stood up from the chair and attempted to walk away and was redirected to sit down by staff. *Was the last to be served food in the dining room.</p> <p>Observation on 4/8/14 during the noon meal revealed resident 2: *Was assisted into dining room in a wheelchair at 11:11 a.m. There had been glasses of fluids and a bowl of fruit at his place setting. *Was assisted in eating a few pieces of fruit and then left unattended. *Started to disrobe at 11:45 a.m. Staff stopped the disrobing, redressed, and resealed him. *Started making loud nasal snuffling noises at 11:55 a.m. *Repeatedly stood up and was resealed by staff. *Was served last. The plate of food was delivered to the place setting in front of the resident at noon.</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>*Resident 9 wheeled towards doorway and directly by resident 2. He stopped next to resident 2 and started randomly listing items of food (hot dogs, hamburgers, ice cream, french fries). Resident 9 then laughed and left the dining room. Resident 2 immediately yelled out after hearing food items listed.</p> <p>*An unidentified staff member then sat down and had begun assisting residents at the table with the meal at 12:07 p.m.</p> <p>Review of resident 2's undated care plan revealed:</p> <p>*The resident had an attention span of 10 to 15 minutes.</p> <p>*The resident was not to be left unattended in the dining room at any time.</p> <p>*The approach or intervention for inappropriate behavior had been listed as "appropriately addressing resident" without any specific actions identified.</p> <p>*Identified the resident yelling out as a problem.</p> <p>-There was no identification of when the yelling occurred, or what might have caused the yelling.</p> <p>-No specific interventions for that behavior had been identified.</p> <p>*Identified the resident's disrobing as a problem.</p> <p>-There was no identification of when disrobing occurred, or what might have caused the disrobing.</p> <p>-No specific interventions for that behavior had been identified.</p> <p>2. Observation on 4/7/14 at the evening meal and on 4/8/14 at the noon meal revealed resident 2:</p> <p>*Had been seated at the table nearest the doorway to the dining room with three other residents (13, 14, 15) who each required assistance with eating.</p>	F 309			

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F 309	Continued From page 10 *Had fluids available to drink when seated. *Was the last person to be served food in the dining room. Interview with the director of nursing on 4/9/14 at 10:11 a.m. revealed: *She was not aware that resident 2 was being served meals last in the dining room. *She agreed the place where resident 2 was located in the dining room was not a suitable place. *She stated it was the worst thing in the world for that resident to have a lot of stimulation. *She was not aware resident 9 responded to resident 2's yelling by yelling back, or that comments made by resident 9 as he left the dining room and went by resident 2 resulted in a yelling response by resident 2. *She agreed there were no specific interventions listed in his care plan as to how to respond to identified behavior issues of yelling and disrobing. Interview with the dietary manager on 4/9/14 at 4:40 p.m. revealed resident 2 was served food last to ensure there was assistance available to help him. A request had been made on 4/9/14 at 1:30 p.m. for a policy on care plans. The DON informed this surveyor on 4/9/14 at 3:45 p.m. that there was a policy and that it was included in the packet handed to surveyor at that time. Upon review of the documents in that packet no policy on care plans was found. The DON was informed of that at 5:00 p.m. and no further information was provided.	F 309	The care plan for resident #2 was revised on 4.9.14 to include specific actions for appropriately addressing the resident. Interventions have been implemented for the behaviors that were identified. The Director of Nursing and Dietary Manager collaborated to ensure that resident #2 was placed in a more appropriate environment with less stimulation, receiving 1:1 attention during meal times. Monitoring was completed on resident #9 during dining x1 week after resident #2 was offered a different dining arrangement. A policy for care plans has been reviewed and will be presented to the QAPI Committee on 5.13.14 for review and appropriate recommendations. Education was presented to the Nursing department by the Director of Nursing and Dietary department by the Dietary Manager on 4.11.14 regarding interventions for resident #2, as well as dignity and respect in the dining experience and appropriate responses to exhibited behaviors. All staff will have been given education regarding dignity and respect during mealtimes by 5.5.14. Resident Council was held 4.29.14 and education was shared at that time with residents regarding Dignity and Respect. A member of the Dietary staff will monitor the dining room for appropriate dignity and respect between residents. All findings of dignity and respect not being practiced by residents toward other residents will be addressed immediately by appropriate staff (Administrator, Director of Nursing, Program Director, or Dietary Manager) The MDS Coordinator will audit care plans monthly x6 months and report findings to the QAPI Committee for review and appropriate recommendations. * DM will report findings to QAPI committee. MUI/SDDH/MF Completion Date: 5.22.14 * three times per week for 2 months. MUI/SDDH/MF	5.22.14
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037		
(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 371	Continued From page 11 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 12218 Based on observation, food temperature testing, and interview, the provider failed to maintain proper serving temperatures for food on the steamtable during two out of four observed meal services. Findings include: 1. Observation and food temperature testing with the surveyor's calibrated thermometer on 4/8/14 at 11:30 a.m. of the food on the steamtable for the lunch meal revealed: *Liver and onions had a temperature of 160 degrees Fahrenheit (F). *Au gratin potatoes were 190 degrees F. *Carrots or peas for the vegetable choices were 160 degrees F. *Ground liver for the mechanical soft diets and residents who were not able to chew well was 120 degrees F. *Pureed liver for those residents that had swallowing and chewing problems was 100 degrees F. Interview with cook A revealed: *She was unaware at the above time the food	F 371			

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F 371	<p>Continued From page 12</p> <p>temperatures for the pureed liver and the ground liver had fallen below the acceptable minimum hot holding temperature of 135 degrees F. *She reheated both food items in the microwave. *When those two items were temperature tested after having been reheated they tested at 140 degrees F for the pureed liver and 160 degrees F for the ground liver.</p> <p>2. Observation and food temperature testing on 4/9/14 at 8:40 a.m. of the open breakfast menu items of scrambled eggs and the hot cereal (oatmeal) revealed: *The scrambled eggs were 120 degrees F. *The hot oatmeal cereal was 120 degrees F.</p> <p>Interview with cook B at that time revealed: *She was unaware the food temperatures on the steamtable had fallen below 135 degrees F for both hot food items. *They offered hot breakfast food items until 9:00 a.m. on the daily open breakfast schedule and served until that time. *The temperature dial for those steamtable wells had been set at a low temperature. *She turned up the temperature dials on the steamtable at that time. *She only had a few more residents to come out to breakfast. *She did confirm they were served hot food until 9:00 a.m. After that time they would be served a cold breakfast (usually cold cereal, milk, juice, and toast)</p> <p>According to the United States Department of Health and Human Services, Food and Drug Administration's Food Code regulation 3-501.16 for "Potentially hazardous food (time/temperature control for food safety), Hot and Cold Holding,"</p>	F 371	<p>Food temperatures are being logged for food when placed in the steam table and immediately before serving. A policy for acceptable hot and cold food temperatures has been reviewed by the Dietary Manager and Registered Dietician. Food preparation equipment was examined by our Maintenance professional and found to be in good working condition.</p> <p>The Dietary Manager is auditing proper execution of food temps weekly x4, monthly x3 and quarterly for one year. The Dietary Manager will report her findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p>Completion Date: 5.22.14</p>	5.22.14	

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F 371	Continued From page 13 food shall be maintained: *At 57 degrees centigrade (C) or 135 degrees Fahrenheit (F) for hot foods. *At 7 degrees C or 41 degrees F or less for cold foods.	F 371			
F 431 SS=E	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 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	F 431			

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F 431	<p>Continued From page 14 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 an accurate account for schedule III (government controlled) medications in one of three medication carts (the wing 2 and 3 cart) for three of six residents (5, 8, and 11) receiving PRN (as needed) schedule III medications. Findings include:</p> <p>1. Observation on 4/9/14 at 1:15 p.m. of schedule III medications from the wing 2 and 3 medication cart revealed:</p> <p>a. Resident 5 had two blister packs (pre-formed plastic packaging) for PRN lorazepam (for anxiety) 0.5 milligrams (mg). *One blister pack containing thirty tablets had been issued by the pharmacy on 5/22/13. -Four tablets had been removed from the blister seals. *The second blister pack containing thirty tablets had been issued on 1/7/14. -One tablet had been removed from the blister seals. Review of resident 5's May 2013 through March 2014 medication administration records (MAR) revealed four tablets had been documented as given. One tablet had not been accounted for.</p> <p>b. Resident 8 had one blister pack for PRN lorazepam 0.5 mg. *The blister pack containing thirty tablets had</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037
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F 431	<p>Continued From page 15 been dispensed on 9/20/13. *Twenty tablets had been removed from the blister seals. Review of resident 8's September 2013 through March 2014 MARs revealed nine tablets had been documented as given. Eleven tablets had not been accounted for.</p> <p>c. Resident 11 had one blister pack for PRN lorazepam 2 mg. *The blister pack containing ten tablets had been dispensed on 7/16/13. *Seven tablets had been removed from the blister seals. Review of resident 11's July 2013 through March 2014 MARs revealed six tablets had been documented as given. One tablet had not been accounted for.</p> <p>d. Interview at that time with the Minimum Data Set (MDS) coordinator and registered nurse (RN) C revealed they had not known why the above medications had been missing.</p> <p>Interview on 4/9/14 at 5:15 p.m. with the director of nursing revealed there was not a system in place to account for the schedule III medications.</p> <p>Review of the provider's 1/1/13 Inventory Control of Controlled Substances policy revealed the "facility should ensure that Facility staff count all Schedule III-V controlled substances in accordance with Facility policy and Applicable Law."</p> <p>Review of Patricia A. Potter and Ann Griffin Perry, Fundamentals of Nursing, 6th Edition, Mosby, St. Louis, Mo, 2005, revealed on page 907: **All controlled substances are handled according</p>	F 431	<p>The Director of Nursing contacted the pharmacy provider for a policy regarding narcotic counts for Schedule II and III medications. Education regarding the new policy and procedure for Schedule II and III narcotics was shared with all professional nursing staff on 4.11.14.</p> <p>Schedule II and III narcotics, both scheduled and PRN, are now being counted and placed in the narcotic lock box on the correct medication cart for each of those identified residents.</p> <p>The new system was put in place on 4.11.14 and the new count was started on the PM shift of 4-11-14. New policy for controlled substances is now in place from the pharmacy provider and placed in the Narcotic Count Binder. Weekly audits x4 <i>x3 of locked narcotics</i> will be completed x4 weeks, then monthly x3, and then quarterly x3. The audits will be completed by the Director of Nursing. The Director of Nursing will report findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p>Completion Date: 5.22.14</p>	5.22.14
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F 431	Continued From page 16 to strict procedures that account for each medication". **"A special inventory record is used each time a narcotic is dispensed and provides an accurate ongoing count of narcotics used and remaining".	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441			

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F 441	<p>Continued From page 17</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, and interview, the provider failed to ensure aseptic technique was used for one of one sampled resident (3) receiving two dressing changes by one of one nurse (E). Findings include:</p> <p>1. Observation on 4/9/14 at 9:00 a.m. of registered nurse (RN) E performing dressing changes for resident 3's coccyx (tail bone) and right hip revealed she washed her hands and applied gloves. With the gloved hands she: *Opened the package of telfa (non-adhering) dressing and a jar of Silvadene (ointment for wounds and burns). She placed them on top of a trunk located next to the bed. There was no barrier between the clean supplies and the trunk. *With the same gloves on she: -Dipped her gloved finger into the jar of ointment and placed it onto the resident's coccyx. -Covered the coccyx with the telfa dressing. She removed the gloves, washed her hands, and applied clean gloves. With those gloves she: -Opened a package of gauze pads and the new dressing and placed it on the trunk without a barrier underneath it. -Pulled his pants down to reveal the hip wound dressing. -Removed the old dressing and threw it in the trash.</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>*With those same gloves on she: -Picked up the gauze and dabbed the wound to remove excess moisture. *She then removed the soiled gloves, washed her hands, and applied clean gloves. *She left the room to obtain more supplies. *She returned and removed the soiled gloves, washed her hands, and applied clean gloves. *With those gloves she: -Measured the wound. -Picked up the soiled gauze and wound measuring tool and threw it in the trash. -Picked up the clean dressing and applied it to the wound. -Taped the dressing to the skin. -Dropped the tape, picked it up off the floor, and used it to finish taping the dressing onto the skin.</p> <p>Interview on 4/9/14 at 5:15 p.m. with the director of nursing revealed she agreed the nurse had not used aseptic technique during the above dressing changes.</p> <p>The provider had been unable to locate a policy for dressing changes when it was requested.</p>	F 441	<p>Education was shared by the Director of Nursing with professional nursing staff regarding the proper aseptic technique for wound care and dressing changes on 4.11.14.</p> <p>A new Dressing Change policy and new Hand Washing policy are in place and were shared with professional nursing staff on 4.11.14. These policies will be shared 5.13.14 at the QAPI Meeting for review and appropriate recommendations.</p> <p>The Director of Nursing will complete audits to ensure proper aseptic technique for wound care weekly x4, monthly x3 and quarterly for one year. The Director of Nursing will report findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p>Completion Date: 5.22.14</p>	5.22.14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
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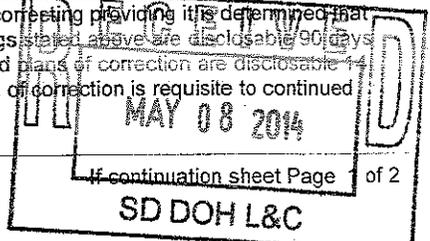
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/9/14. Sunset Manor Avera Health (1966 original and 1997 addition building 01) was found not 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 and the Fire Safety Evaluation System (FSES) dated 4/9/14 upon correction of the deficiencies identified below.</p> <p>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.</p>	K 000		
K 032 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain two conforming exits on each floor or fire section of the building. The east basement mechanical room had only one</p>	K 032		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carl J. [Signature]</i>	TITLE <i>Assistant Director</i>	(X6) DATE <i>5/6/14</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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K 032	<p>Continued From page 1 conforming exit. Findings include:</p> <p>1. Observation at 11:30 a.m. on 4/9/14 revealed the exit stairway from the basement mechanical room discharged into the corridor system on the main level. The second exit from the basement mechanical room was through a window to an area well equipped with a fixed ladder. Review of the previous survey data indicated that condition had existed since the original construction.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiency identified in K000.</p>	K 032		

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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 new health care occupancy) was conducted on 4/9/14. Sunset Manor Avera Health (2008 remodel 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 new 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 *Carl Brubaker* TITLE *Administrator* (X6) DATE *5/6/14*

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 discipable 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 discipable 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.

MAY 08 2014
SD DOH L&C