

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

ORIGINAL

PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/23/2014
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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000} INITIAL COMMENTS

Surveyor: 27473
A revisit recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/21/14 through 10/23/14. Southridge Health Care Center was found not in compliance with the following requirements recited: F278, F281, F314, F323, F333, F441, and F514.

{F 278} 483.20(g) - U) ASSESSMENT
SS=E ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

{F 000}

Addendums noted with an asterisk per 11/19/14 email from facility administrator. DWIS000HMF

{F 278}

Resident #2 and #3, when completing the monthly nursing summary section and skin, the nurse will compare to the documentation forms in the skin assessment book to verify accuracy, treatments and follow ups. Resident # 3 skin treatment is documented on care plan, pocket plan and in the shower book.

This same process will be utilized for all residents in the facility.

11/16/14

Education will be provided to nursing staff.

Auditing of monthly nursing summaries. Audits will be completed by MDS/coordinators weekly for 12 weeks. Results will be shared with QAPI for future recommendations.

**Auditing of monthly nursing summaries will be for all residents as they become due. (cont. on pg 2) DWIS000HMF*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Jeffrey Bugala

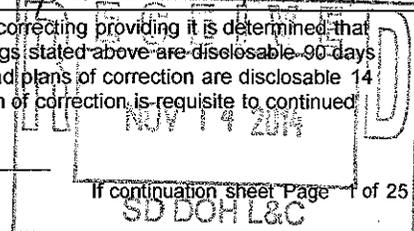
TITLE

Emergency Permit Holder / Administrator

(X6) DATE

11-13-14

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.



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{F 278} Continued From page 1

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Surveyor: 30170

Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (2 and 3) had a thorough and accurate monthly nursing assessment following the 9/11/14 survey.

Findings include:

1. Observation on 10/21/14 at 3:00 p.m. of resident 2 revealed he was lying in his bed on his right side.

Review of resident 2's Weekly Pressure Ulcer Record for September 2014 revealed:

*On 9/2/14 he had a stage 2 (partial thickness loss of dermis [skin] presenting as a shallow open ulcer with a red or pink wound bed) pressure ulcer to his left hip.

*The area was 1.7 centimeters (cm) by 1.0 cm.

*The treatment was DuoDerm (type of dressing) to his left hip every five days and as needed.

Review of resident 2's 9/4/14 Minimum Data Set (MOS) assessment revealed he:

*Was at risk for pressure ulcers.

*Currently had a stage 2 pressure ulcer.

*Had a pressure reducing device for his bed and his wheelchair.

*Was not on a turning and positioning program.

Review of resident 2's 9/2/14 comprehensive care plan revealed he had a pressure ulcer to his left hip.

{F 278}

For resident # 3, the physician prescribed shampoo and creams will be kept in medication cart. Will be administered by nurse or med tech as ordered. Shampoo will be provided to C.N.A when doing bathing to assure given as ordered per physician.

For all residents, any prescribed shampoos, creams, ointments, etc. will be kept in medication cart to administer as according to ordered. Prescribed shampoos will be written on care plan, pocket care plan and shower book to notify staff that they need to check with the nurse for the shampoo.

**(continued from pg. 1) Results will be shared with QAD on a monthly basis by DON for future recommendations. DWISODHMF*

DWISODHMF

Officer [Signature]

Emergency Permit Holder/Administrator

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{F 278}	Continued From page 2 Review of resident 2's 9/10/14 Monthly Nursing Summary revealed there was no documentation regarding his current pressure ulcer to his left hip. There was no current treatment listed. Interview on 10/21/14 at 11:40 a.m. with licensed practical nurse AA regarding documentation on the monthly nursing summary form for resident 2 revealed there should have been documentation of his current pressure ulcer to his left hip and his current treatment. 2. Observation on 10/21/14 at 1:00 p.m. of resident 3 revealed: *He had a very dry and scaly scalp. *There were visible layers of dry scaling skin on the back of his scalp. *His eyelids were scaly and reddened. *His neck was reddened and scaly. Review of his October 2014 Treatment Administration Record (TAR) revealed: *He had a physician's order for the following: *On 9/4/14 Ketoconazole 2% (percent) shampoo apply topically as directed two times weekly on Tuesday and Friday. -On 9/17/14 Clobetasol 0.5 % cream apply topically (skin) two times daily to the affected area of his scalp and neck. -On 9/17/14 Triamcinolone 0.025% cream apply topically two times daily as directed to his eyebrows, eyelids, mustaches, chin, and abdomen. Review of resident 3's 9/30/14 Monthly Summary revealed: *There was no documentation regarding his current skin issues.	{F 278}	* [REDACTED] [REDACTED]

Jeffrey Brizak

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{F 278}	Continued From page 3 *The section for skin conditions was hand marked as "None." Interview on 10/21/14 at 4:00 p.m. with the director of nursing II regarding the above findings revealed: *Her expectation would have been that the nurses document any skin concerns the resident was experiencing at the time of the assessment and the monthly summary. *She was unsure why the nurses had not documented resident 2 and 3's skin conditions. Review of the provider's August 2008 Charting and Documentation policy revealed: *All services provided to the resident, or any changes in the resident's medical or mental condition should have been documented in the resident's medical record. *All observations, medications administered, services performed, should have been documented in the resident's clinical record.	{F 278}	* [REDACTED] DW/SDDCH/MF
{F 281} SS=H	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (3) who had a significant dermatitis to his scalp, neck, and face had the prescribed physician's orders followed and monitored his skin twice weekly as indicated	{F 281}	Resident #3, by assuring that prescribed creams, ointments, and shampoo are kept on the med cart, the nurse will need to sign off administration of treatment appropriately. Audits of prescribed medicated ointments, shampoo, creams will be done daily on the night shift by the nurse on duty. Data to be shared at QAPI for review and recommendations. *MONTHLY BY DON DW/SDDCH/MF 11/16/14

Jeffrey Buzick

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{F 281}	<p>Continued From page 4 on his current Treatment Administration Record (TAR). Findings include:</p> <p>1. Observation on 10/21/14 at 1:00 p.m. of resident 3 revealed: *He had a very dry and scaly scalp. *There were visible layers of dry scaling skin on the back of his scalp. *His eyelids were scaly and reddened. *His neck was reddened and scaly.</p> <p>Review of his October 2014 Physician's Medication and Treatment Order sheet revealed: *He had a physician's order for the following: -On 9/4/14 Ketoconazole 2% (percent) shampoo apply topically as directed two times weekly on Tuesday and Friday. -On 9/16/14 Clobetasol 0.5% cream apply topically (skin) two times daily to the affected area of his scalp and neck. -On 9/17/14 Triamcinolone 0.025% cream apply topically two times daily as directed to his eyebrows, eyelids, mustaches, chin, and abdomen.</p> <p>Review of resident 3's September 2014 TAR revealed: *The Clobetasol 0.05% cream apply twice daily had been started on 9/16/14. There was no documentation the cream had been administered three times during 9/16/14 through 9/30/14. *The Triamcinolone 0.025% cream apply twice daily had be started on 9/16/14. There was no documentation the cream had been administered four times during 9/16/14 through 9/30/14. *The Ketoconazole 2% shampoo apply twice weekly with bath had been started on 9/4/14 three days after the physician had ordered the shampoo. The was no documentation the</p>	{F 281}	<p>For all residents, staff will be educated on the ethical and legal responsibility for documenting all procedures and administration of prescribed medications.</p> <p><i>[Handwritten signature: DW/SDH/MF]</i></p>

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Emergency Room Holder / Administrator

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{F 281}	<p>Continued From page 5</p> <p>medicated shampoo had been administered on 9/26/14 and 9/30/14.</p> <p>Review of resident 3's October 2014 TAR on 10/21/14 at 8:58 a.m. revealed:</p> <ul style="list-style-type: none"> *There had been no documentation the Ketoconazole 2% shampoo had been administered on including 10/3/14. *The skin assessments that were to be done on Tuesday had no documentation that they had been completed. *There was an unsigned handwritten note taped to the TAR that read "Needs Bath STAT (needs immediately) et (and) skin assessment." <p>Interview on 10/21/14 at 9:20 a.m. with certified nursing assistant (CNA) DOD regarding bathing of resident 3 revealed:</p> <ul style="list-style-type: none"> *She had just started her position on 10/5/14. *She was a CNA and had been giving baths to assigned residents for the day. *She felt as though she had not been given sufficient training in the bathing of residents. *She was given a pocket care plan to follow for her assigned care of the residents. She would refer to that pocket care plan as she was not familiar with the residents. *She was going to give resident 3 a whirlpool bath today. She was unaware that resident 3 had special medicated shampoo. She had referred to her pocket care plan, and there had been no information on that care plan regarding his medicated shampoo. <p>Interview on 10/21/14 immediately following the above observation, interview, and record review of resident 3 with director of nursing II revealed:</p> <ul style="list-style-type: none"> *She was sure the nurses had administered the medicated shampoo as order but had forgotten to 	{F 281}		<p>* [Redacted]</p> <p>DW/SDD/MTF</p>

[Handwritten Signature]

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{F 281}	<p>Continued From page 6</p> <p>initial after the shampoo had been administered.</p> <p>*She was going to call the nurses or medication aides that would have worked that day to have them intimal the October 2014 TAR.</p> <p>*The nurses should have documented on the TAR as soon as the treatment or assessment had been completed.</p> <p>*The nurse or medication aide on duty should have informed the CNA who had been giving a bath to resident 3 about the medicated shampoo.</p> <p>*She confirmed the pocket care plan provided to CNA DOD had not been updated to provide the most current information regarding his medicated shampoo.</p> <p>*She agreed resident 3 had a significant skin dermatitis, and the treatments for that skin condition should have been followed as the physician had ordered.</p> <p>*The skin assessments scheduled for Tuesdays with his bath should have been completed in a timely manner.</p> <p>Review of resident 3's October 2014 TAR on 10/22/14 at 8:40 a.m. revealed:</p> <p>*The initials of staff had been filled in on the TAR where there had been blanks on 10/21/14 at 8:58 a.m.</p> <p>*One staff member had documented "10/3/14 forgot to sign off/late entry made." There was no time and no initial of the staff member that had made that entry. That entry had been made nineteen days after the medicated shampoo should have been administered.</p> <p>*One nurse had circled her initials on 10/7/14 and documented on the back of the TAR the shampoo had not been administered, because she was not aware he had an order for the medicated shampoo. The documentation had not been there on 10/21/14 at 8:58 a.m. when this surveyor had</p>	{F 281}		<p>X [REDACTED]</p> <p>DWSDCH/MTF</p>

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{F 281}	Continued From page 7 first reviewed the October 2014 TAR. Review of the provider's August 2008 Charting and Documentation policy revealed: *All services provided to the resident, or any changes in the resident's medical or mental condition should have been documented in the resident's medical record. *All observations, medications administered, services performed, should have been documented in the resident's clinical record. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8 th Ed., St. Louis Mo., 2013, pp. 305 and 306, revealed: *The health care provider was responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe the orders were in error or would harm patients. *Risk management was an organization's system to ensure appropriate nursing care by identifying potential hazards and eliminating them before harm occurs. *Risk management also required complete documentation. A nurses' documentation was often the evidence of care received by a patient and served as proof the nurse acted reasonably and safely. *Nurses were responsible for performing all procedures correctly and exercising professional judgement as they carried out health care provider's orders.	{F 281}	* [REDACTED] DW/SOCHMF
{F 314}	483.25(c) TREATMENT/SVCS TO SS=G PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	{F 314}	* [REDACTED] DW/SOCHMF

[Handwritten Signature]

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{F 314}	<p>Continued From page 8</p> <p>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: 30170 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (3) who had become increasingly more incontinent of bowel and bladder and who had obtained a pressure area had: *A timely nursing assessment completed. *A thorough description sent to the primary care physician. *Appropriate interventions in place to prevent skin breakdown. Findings include:</p> <p>1. Review of the 10/20/14 Skin Assessment Report for resident 3 revealed: *There was an open reddened area 2 cm X 2 cm on his upper right coccyx. There was no description of the open area. *The contributing factor was increased incontinence (unable to control bowel and bladder). *If pressure related - complete only this form and forward to the Nurse Manager.</p> <p>Observation on 10/21/14 from 10:00 a.m. to 12:00 noon of resident 3 revealed: *No staff had entered his room to assist him to the bathroom. *He arose off his bed and went to the dining room</p>	{F 314}	<p>For resident #3, we did redo skin assessment and Braden Scale. Based upon assessments and Braden Score and the history of pressure ulcer, resident will be cued/assist to reposition every 2 hours. This reposition schedule will be added to Care Plan and Pocket Care Plan.</p> <p><i>* Residents identified with a pressure ulcer in the past 3 months were placed on the reposition schedule. DW/SDD/HMF</i></p> <p>11/16/14</p>

Jeffrey Buzich

Emergency Permit Holder / Admin / Grants

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{F 314}	<p>Continued From page 9 for lunch at 12:00 noon without going to the bathroom.</p> <p>: Observation on 10/21/14 from 1:30 p.m. to 4:00 p.m. of resident 3 revealed: *He spent all the time in his room lying in his bed. *He had not attended any activities. *There had been no staff who had entered his room to prompt him to go to the bathroom or assist him with toileting.</p> <p>Review of resident 3's Licensed Nurses Notes for October 2014 revealed: *On 10/10/14 (no time had been documented) "Skin dry warm [warm?] and intact. Abdominal wound healing well. Heels and coccyx intact-bottom slightly pink. Heels need lotion. No pain. Chronic dry scalp. No other issues with skin at this time. Will continue to monitor." *On 10/20/14 (no time documented) "New skin concern on R (right) upper coccyx [bottom] area 2 cm (centimeters) X (by) 2 cm red open area. DuoDerm [type of dressing] on for now. Dr. orders pending, dietary notified, family notified in the am (morning)." *There had been no narrative documentation between 10/10/14 and 10/20/14.</p> <p>Interview immediately following the above record review on 10/21/14 at 4:00 p.m. with the director of nursing (DON) II revealed: *She was unaware resident 3 had a current skin issue on his coccyx. *She was not sure why there had been no documentation prior to the observation on 10/20/14 of the open area to the right upper coccyx. The nurse must have forgotten to document after her assessment.</p>	{F. 314}	<p>Nursing Education will be provided on responsibility for completing weekly skin assessments, documentation, on wound staging, and on wound assessment so a thorough description of the wound will be provided to the physician to better aid in the treatment course for that wound. *STAFF DWISDDOH/MF</p> <p>MDS will audit according to weekly Bath/Skin assessment schedule, the skin book for nursing progress notes on skin findings, on nursing assessment if appropriate and on the correct form, and that wound follow up is occurring. Data will be shared and QAPI for review and recommendations *MORNING by the MDS staff. DWISDDOH/MF</p> <p>* [Redacted] DWISDDOH/MF</p>

Officer Bryant

Emergency Permit Holder/Administrator

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{F 314}	<p>Continued From page 10</p> <ul style="list-style-type: none"> *The staff should have been assisting resident 3 to the bathroom every two hours. *She would have expected the nurses to document their findings after each skin assessment and with each dressing change. *The care plan should have been updated to ensure appropriate interventions had been put in place to prevent skin breakdown. *She would contact the nurse that was suppose to do the weekly skin assessment in between 10/10/14 and 10/20/14 to make a late entry in resident 3's medical record. <p>Interview on 10/22/14 at 10:00 a.m. with Minimum Data Set (MOS) coordinator E regarding resident 3's open area on his coccyx revealed:</p> <ul style="list-style-type: none"> *She usually had done wound/skin rounds on Thursday of each week. *She had not seen the coccyx area on resident 3. -She had received a skin assessment report on 10/20/14 but had not investigated the skin issue. -She would not make an assessment of the skin concern until Thursday, which would have been four days after the open area had been observed. *She stated resident 3 had become increasingly more incontinent of bowel and bladder according to the documentation she had received. She had not assessed the resident. <p>Review of the 10/20/14 physician's notification facsimile (fax) for resident 3's skin concern revealed:</p> <ul style="list-style-type: none"> *The fax had been sent to the physician at 3:00 a.m. *The following had been handwritten: "New skin concerns, open area 2 cm X 2 cm on upper (R) coccyx area. DuoDerm on at this time. Skin sheet included. Any treatment?" *There was no description on the area provided 	{F 314}	<p>For Resident #3, a 3 day voiding diary will be completed to assist in determining his toileting plan, which will be identified on the Care Plan and Pocket Care. Resident's name will be added to the toileting/repositioning schedule.</p> <p>Education will be provided to all nursing staff on repositioning scheduled and toileting program.</p> <p>Auditing of the 3 day voiding records and daily toileting schedule will be done for 12 weeks by the MDS/clinical coordinator. The data will be reported to QAPI for review and recommendations. * Data will be reported monthly to QAPI by MDS staff. DW/SDDH/MP</p>	<p>X [Redacted] DW/SDDH/MP</p>

[Handwritten Signature]

Emergency Permit Holder/Administrator

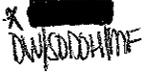
11-13-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/23/2014
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{F 314}	Continued From page 11 to the physician to ensure an appropriate treatment would have been prescribed. Interview on 10/22/14 at 10:30 a.m. with licensed practical nurse (LPN) AAA regarding resident 3's pressure ulcer revealed: *She was unable to stage pressure ulcers. The registered nurse had to assess and stage pressure ulcers. *She agreed the nurse should have had a description of the open area for the physician to make a determination of the kind of treatment that would have been appropriate for that open area. *Open areas on residents were only measured weekly by the MOS nurses. Interview and observation on 10/22/14 at 12:00 noon with LPN AAA and LPN BBB during the dressing change of resident 3's right upper coccyx area revealed: *There was a reddened area on his upper right coccyx area with an open area. The area was not going to be assessed and measured until Thursday. The LPNs stated the measuring of the pressure areas were only done on Thursdays, but they would document in the Licensed Nurses Notes their findings each time the DuoDerm dressing was changed. Interview on 10/22/14 at 1:25 p.m. with certified nursing assistant C regarding resident 3's bowel and bladder incontinence revealed: *He was increasingly more incontinent of bowel and bladder. *She would attempt to remind him every two hours to go to the bathroom. Review of resident 3's Licensed Nurses Notes on	{F 314}	The Bowel and Bladder assessment policy will be instituted for all new admission, re-admissions and annuals effective 11/16/2014. Education of staff will be provided on the new bowel and bladder program. <i>*All new admissions, re-admissions, and annuals will be audited for the 3 day voiding record and daily toileting schedule for 12 weeks by the MDS staff. Data will be reported to QAPI monthly by the MDS staff.</i> DWISDDH/MF	X DWISDDH/MF	

Officer Buzjak

Emergency Permit Holder/Administrator

11-13-14

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{F 314}	<p>Continued From page 12</p> <p>10/22/14 at 1:30 p.m. revealed:</p> <ul style="list-style-type: none"> *There had been a late entry documented on 10/22/14 for 10/15/14. *The handwritten entry revealed: "Did wkly (weekly) skin assessment. Res. (resident) has dry scaly skin with scalp a particular problem. medicated shampoo used and is improving condition. Heels and coccyx intact. No other concerns." *There had been no mention the reddened area noted on 10/10/14 was heeled or improved. <p>Review of resident 3's September 30, 2014 Monthly Summary completed by a registered nurse revealed:</p> <ul style="list-style-type: none"> *His cognition (memory) was moderately impaired. Required cueing and supervision. *He had little interest or pleasure in doing things. *He was independent with bed mobility and transfers. *He required limited assistance with toileting. *He was on a scheduled toileting program. *He had no skin conditions. <p>Review of resident 3's 10/14/14 MOS assessment revealed he:</p> <ul style="list-style-type: none"> *Was confused with a Brief Interview for Mental Status (BIMS) score of four. A score of fifteen meant the person was orientated to person, place, and time. *Felt tired and had little or no energy. *Required physical assistance of one staff person with bed mobility and transfers. *Required extensive assistance of two or more staff persons with toileting and personal hygiene. *Was frequently incontinent of bowel and bladder. He was not on a toileting program. *Was at risk for pressure ulcers. *Had a pressure reducing mattress for his bed. 	{F 314}		

Jeffrey Buzgal

Emergency Permit Holder / Administrator

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{F 314}

Continued From page 13

*Had not been placed on a turning and repositioning program.

Review of resident 3's 2/14/14 comprehensive care plan revealed:

*"I am at risk for pressure ulcers due to requiring assist with toileting and being incontinent. I also have decreased mobility. I want my skin to remain intact through our next meeting. Please have the nursing staff keep an eye on my skin when they are doing my personal hygiene cleansing and report to the nurses if they see any reddened areas. Have the Licensed Nurses inspect my skin thoroughly each week and document their findings. If concerns arise, please consult my physician and follow his orders. Make sure my incontinence products are changes as soon as possible after they have become wet. Apply barrier creams to protect my skin. Help me to reposition every couple of hours. Keep my pressure reducing mattress on my bed."

Review of the provider's undated Documentation Guidelines for Decubiti (pressure ulcer) revealed:

*location and measurement: Including width, length, and depth in cm of all decubiti upon admission and weekly.

*The treatment provided.

*Healing process, assessed weekly.

*Turning and positioning, how often, daily activity, pressure reduction, and nutritional intake.

Review of the provider's June 2004 Skin Assessments policy revealed the purpose of the policy was to monitor residents with a known history or to be at risk of pressure ulcers or have skin breakdown.

Review of the provider's October 2010 Pressure

{F 314}

* [REDACTED]
DN/SDDH/MF

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Emergency Permit Holder/Administrator

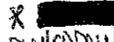
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{F 314}	<p>Continued From page 14</p> <p>Ulcer Risk Assessment revealed:</p> <ul style="list-style-type: none"> *Pressure ulcers were usually formed when a resident remained in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroyed the tissues. *If pressure ulcers were not treated when discovered, they quickly got larger, become very painful for the resident, and often times would become infected. *Routinely assess and document the condition of the resident's skin per facility wound and skin care programs for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor. *Nurses were notified to inspect the skin if skin changes were identified. *Because a resident at risk could develop a pressure ulcer within two to six hours of the onset of pressure, the at-risk resident needed to have been identified and have interventions implemented promptly to attempt to prevent pressure ulcers. *Risk factors for pressure ulcers would include: <ul style="list-style-type: none"> -Immobility. -Altered mental status. -Incontinence. -Poor nutrition. <p>Review of the provider's October 2010 Prevention of Pressure Ulcers policy revealed:</p> <ul style="list-style-type: none"> *The purpose of the procedure was to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors. *Pressure ulcers were often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (such as 	{F 314}	<p>X [REDACTED]</p> <p>DW/SDD/HMF</p>

Jeffrey Buzgala

Emergency Room Holder / Administrator

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{F 314}	Continued From page 15 perspiration, feces (stool), urine, wound discharge, soap residue, etc (and so on), decline in nutrition and hydration status, acute illness : and/or decline in the residents physical and/or mental condition. *The facility should have a system/procedure to ensure assessments were timely and appropriate and changes in condition were recognized, evaluated, reported to the practioner, physician, and family, and addressed. *Address the causes of moisture if possible (bladder training, scheduled toileting). *Check the resident for incontinence at least every two hours and clean skin when soiled. Review of the provider's 11/8/12 Guidelines for Nursing Documentation revealed the following should have been included in the documentation: *Skin surfaces should have been checked regularly. *Changes in the condition of skin. *Specific location of the skin care problem. *Dates of occurrences of skin concerns and dates resolved. *Number, size, degree, and measurement of the pressure ulcer. *Documentation of the cause of the pressure ulcer if known. *Turning and reposition schedules to prevent undue pressure. *Use of specific creams, lotions, medications, or protective devices. *Consultation from other disciplines.	{F 314}	<div style="text-align: right;">  <i>DW/KODD/MF</i> </div>	
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	{F 323}		

Jeffrey Buzgala

Emergency Permit Holder / Administrator

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{F 323}	<p>Continued From page 16</p> <p>as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 27473</p> <p>Based on post fall risk assessment report reviews, interview, and policy review, the provider failed to ensure residents' falls were thoroughly investigated in a timely manner for three of three sampled residents (21, 46, and 65). Findings include:</p> <p>1. Review of the post fall risk assessment reports for October 1 through 21, 2014, revealed there had been thirty-six falls. Of the reported falls, three residents had accounted for fifteen of those falls. Resident 21 had six falls occurring with "cognitive status" and "nurses assessment of cause of fall, interventions added to care plan to prevent further falls for this resident including any education given" as follows: *On 10/6/14 at 4:30 p.m. - "alert, confused. hx [history] of dementia [disorder impairing person's capacity to function normally and safely]" "resident keeps eyes closed most of the time, staff busy answering call lights, more staff." *On 10/7/14 at 9:30 a.m. - "alert, confused, hx dementia" "lay down between meals?" *On 10/7/14 at 8:30 p.m. - "alert et [and] confused" "unable to instruct D/T [due to] dementia." *On 10/8/14 at 7:15 a.m. - "confused" "Frequent VS [vital signs that include temperature, pulse, respirations, and blood pressure]"</p>	{F 323}	<p>For resident #21, #46, and #65, a fall risk assessment will be completed with implementation of safety interventions as appropriate, based upon risk score.</p> <p>A fall team has been organized to take a proactive approach in the prevention of falls and to reduce the incidence of falls. At their first meeting, changes to the fall risk assessment were implemented to initiate interventions based on the risk score.</p> <p>Second agenda item, was to start a "Falling Star" program for any resident risking a 10 or above. Education will be provided to all employees in all departments.</p> <p>The organization will implement a new fall prevention and management program effective 11/16/2014.</p> <p>Staff and education will be provided on policy forms and responsibilities.</p> <p>A fall management audit will be completed for all falls for the next 12 weeks. Data will be taken to QAPI meeting for review and recommendations.</p>	11/16/14

Jeffrey Buzal

Emergency Permit Holder/Administrator

11-17-14

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<p>{F 323} Continued From page 17</p> <ul style="list-style-type: none"> *On 10/9/14 at 7:15 p.m. - "confused" "frequent checks" *On 10/12/14 at 6:15 a.m. - "alert et confused" "unable to instruct resident due to dementia" <p>Resident 46 had six falls as follows:</p> <ul style="list-style-type: none"> *On 10/2/14 at 12:15 p.m. - "confused" "Res [resident] apparently fell in his room or at least fell against something et bumped head" *On 10/2/14 at 9:45 p.m. - "alert and confused" "Res [resident] apparently fell while trying to get from WC (wheel chair) to bed. Res reminded to use call light." *On 10/3/14 at 5:15 p.m. - "no change, confused but no change from baseline" "Resident is a high fall risk" *On 10/5/14 at 4:25 p.m. - "alert - confused R/T [related to] dementia" no nurses assessment. *On 10/9/14 at 3:00 p.m. - "alert, confused" "res attempted to self transfer-does not use call light-educated to use call light for help to avoid injury" *On 10/12/14 at 3:15 p.m. - "no change, resident continues to be alert [sign for with] confusion" "encourage resident to use call light, res has been recently moved to room closer to nurses station" <p>Resident 65 had three falls as follows:</p> <ul style="list-style-type: none"> *On 10/12/14 at 3:45 a.m. - "memory impaired" "possible tangle in bedding" *On 10/13/14 at 2:30 a.m. - "memory impaired" "blankets?" *On 10/13/14 at 9:00 a.m. - "alert to self; confused r/t [related to] dementia" "Lost balance" <p>Interview on 10/23/14 at 8:05 a.m. with RN QQ revealed the provider had recently implemented new forms for responding to falls. She shared</p>	<p>{F 323}</p>	<p>If resident #21, #46, and # 65 has a fall, their fall investigation will occur utilizing the new fall management protocol.</p> <p><i>*Auditing will be done by the MDS staff as the falls occur. Data will be shared with AADI monthly by the MDS staff. DW/SDD/HMF</i></p>		<p>X [REDACTED] DW/SDD/HMF</p>

Jeffrey Buzick

Emergency Permit Holder/Administrator 11-13-14

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<p>{F 323} Continued From page 18 that an Accident/Incident Report and Fall Investigation Worksheet were the new documents that were to be completed. As the Minimum Data Set (MOS) coordinator for her unit she was responsible for completing the investigation for falls. She could not recall when the revised and new policy and forms became effective. She had not used either form yet.</p> <p>Interview on 10/23/14 at 8:18 a.m. with RN J revealed she was responsible for logging all the provider's fall summaries into the computer. She usually received the first page of the Post Fall Risk Assessment forms. Each MOS coordinator was responsible for completing the investigations for their residents after the falls had been reported.</p> <p>Interview on 10/23/14 at 9:05 a.m. with RN CCC revealed she had received education about the use of the new Accident/Incident Report form stating "Yes, I'm sure I got training, I used it. We've had a lot of education lately."</p> <p>Interview on 10/23/14 at 9:15 a.m. with RN E confirmed and revealed as an MOS coordinator she was responsible for completing the investigation for her residents after a fall had been reported. She was asked if she would or any of the other coordinators would investigate on Monday those falls occurring on the weekend or investigate today any falls that might have occurred yesterday. She stated, "It may be a few days for finishing, it just depends on how busy we are with our other work and all the meetings."</p> <p>Review of the undated Procedure for Incident Reporting revealed: 1. "Complete Med-Pass Accident/Incident Report.</p>	{F 323}			<p>* [REDACTED] DN/SDDH/MF</p>

[Handwritten Signature]

Emergency Room Holder / Administrator 11-13-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/23/2014
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{F 323}	Continued From page 19 a. Indicate type of incident b. Physician/family notification c. Route completed report to (name of RN J) 2. Call Fall Line to report falls 3. Make a note in the nurses' notes regarding the incident. Include physician/family notification. 4. Initiate neuro/vitals (neurological and blood pressure, temperature, pulse, and respirations assessment) form as prior 5. Continue 72 hr (hour) charting as prior Report will be given to Case Manager associated with the area to which the resident resides. That case manager will complete the Med-Pass Falls Investigation Worksheet. Completed forms will be routed to the DON (director of nurses) and Administrator for signatures. Once signatures are obtained, the forms will be returned to the case manager for filing in a separate binder, NOT in the resident chart. Falls will be discussed in clinical stand up and in Risk Management Committee meetings." No where in the document was there mention of a specific time frame to have the Fall Investigation Worksheet completed by the MOS coordinators. Review of the undated for facility implementation revised April 2013 Med-Pass, Inc. Accidents and Incidents - Investigating and Reporting document revealed: *Policy Statement - "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator." *In the Policy and Interpretation and Implementation numbers 1. and 2. referenced the Report of Incident/Accident form and the application for use by the Nurse Supervisor/Charge Nurse and/or the department	{F 323}	X [Redacted] DNIS/DHMF

Jeffrey Bryant

Emergency Permit Holder/ Administrator

11-13-14

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

PRINTED: 11/05/2014
FORM APPROVED
OMB NO 0938-0391

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{F 323}	<p>Continued From page 20</p> <p>director or supervisor.</p> <p>*In numbers 4. and 5. the report was again referenced for completion and submitting the original to the DON within 24 hours of the incident or accident. The DON would ensure the Administrator received a copy of the form for each occurrence.</p> <p>*No where in the document was there mention of inclusion of the Falls Investigation Worksheet in the process nor a specific time frame to have the investigation completed by the MOS coordinators.</p> <p>Review of an undated or unsigned document attached to multiple plans of correction documents apparently created by the DON revealed:</p> <p>"Since the 2014 survey has been completed, the DON has had several informal meetings with the MOS Coordinators regarding assessments, care plans, roles and responsibilities and timeliness of their duties. Specific topics discussed include: role in clinical stand up, restraint assessments, incident reports (falls), wound/weight committee joining with current nutrition meeting, lab log, and procedure for receiving all new orders transcribed by the nursing staff. All of this information has been given with verbal understanding communicated to the DON by 10/10/14." The document creator was unavailable for interview.</p>	{F 323}		i * [Redacted] [Signature]
{F 333}	<p>483.25(m)(2) RESIDENTS FREE OF SS=E SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced</p>	{F 333}		* [Redacted] [Signature]

[Handwritten Signature]

Emergency Permit Holder / Administrator

11-13-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/23/2014
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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
<p>{F 333} Continued From page 21</p> <p>i by: Surveyor: 14477</p> <p>Based on policy review and record review, the provider failed to ensure medications were available and administered according to physicians' orders for two of two sampled residents' (10 and 13) medication administration records (MAR) reviewed. Findings include:</p> <p>1. Review of resident 13's October 2014 MAR revealed on 10/1/14 and 10/2/14 clonazepam (for anxiety/agitation) 0.5 milligram (mg) tablets were not available for administration. The medication notes page of the MAR stated "medication not found and no med ordered." The MAR revealed that medication had been noted as being an "anniversary medication" (a 14 day Short Cycle).</p> <p>2. Review of Resident 10's October 2014 MAR notes revealed on 10/13/14 "no Docusate Sodium (for constipation) no med ordered."</p> <p>Review of the provider's medication administration policy revealed "Anniversary Cards (14-Day Short Cycle Cards) WILL NOT receive spare doses. Facility should notify pharmacy that a new Anniversary Card is needed a day early."</p> <p>{F 441} , 483.65 INFECTION CONTROL, PREVENT SS=G : SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control</p>	<p>{F 333}</p> <p>{F 441}</p>	<p>For resident #13 and #10 and all residents, it will be the expectation and responsibility of the nurse to contact pharmacy immediately when a med is not available.</p> <p>Education will be provided to nursing staff on their role and responsibility on medication procurement, on what is available for staff in the E-kit, and if med not available they will need to be notify the MD.</p> <p>MAR/TAR audit will be done on daily basis by night nurse/wing. Data shared with the DON for follow up and all findings will be taken to QAPI for review and recommendations.</p> <p><i>*MAR/TAR audits are shared with the DON daily. Audits are taken to QAPI monthly by the DON. DW/SD/DOH/MF</i></p>		<p>11/16/14</p> <p><i>DW/SD/DOH/MF</i></p>

Jeffrey Buzala

Emergency Permit Holder/Administrator

11-13-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/23/2014
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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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{F 441}	<p>Continued From page 22</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>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: 14477 Based on observation, interview, and policy review, the provider failed to ensure appropriate handwashing had been completed during one of one observed dressing change by one of one nurse registered nurse (RN) EEE . Findings include:</p>	{F 441}	<p>IFC Practices, ISP hand-washing and use of gloves and MDRO's will be provided to RN EEE.</p> <p>Education will be provided to all nursing staff on IFC practices with dressing changes.</p> <p>Handwashing audits will be completed weekly for the next 12 weeks by DON. Data will be reviewed by the QAPI committee for recommendations</p> <p><i>* Data is taken monthly to QAPI by the DON. DWK/DDO/HMF</i></p>	11/16/14
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Jeffrey Biegel

Emergency Permit Holder/Administrator

11-13-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/23/2014
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 23 1. Observation on 10/21/14 at 9:30 a.m. revealed RN EEE performing a wound dressing change on an unidentified resident. During that time she did not perform any handwashing or hand hygiene. After the dressing change task was completed, she exited the room and went down the hall with soiled hands to the public restroom and completed handwashing there. Interview at that time with RN EEE revealed that resident had tested positive for Methicillin Resistant Staphylococcus Aureus (MRSA) a highly contagious infection in both the wound and blood. Review of the provider's revised October 2010 Dressings, Dry/Clean policy revealed numerous times handwashing or hand hygiene should have been done: * Prior to putting on clean gloves. * After removal of the soiled dressing and soiled gloves. * Prior to re-packing the wound. * Removal of the soiled gloves.	{F 441}		X [REDACTED] DWCDD/ME
{F 514} SS=E	483.75(1)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	{F 514}	Resident #10 and # 13, the MAR's will be monitored for incomplete documentation on a daily basis. The night charge nurse on each wing, will be responsible to review the MAR for documentation gaps on a daily basis. The responsible person will be contracted to complete documentation and progressive	11/16/14

[Handwritten Signature]

Emergency Room # Holder/Administrator 11-13-14

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<p>{F 514} j Continued From page 24</p> <p>preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 14477</p> <p>Based on record review and policy review, the provider failed to ensure complete and accurate medication administration records (MAR) for two of two sampled residents (10 and 13). Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 10's October 2014 MAR revealed lorazepam Intensol 2 milligrams (mg)/milliliter(ml) to be given three times daily. On 10/16/14 revealed a circle with no initials on the 1200 (noon) dose. On 10/17 for the 1200 dose there was a blank space. 2. Review of resident 13's October 2014 MAR revealed acetaminophen 325 mg tablet give two tablets by mouth two times daily. On 10/19/14 the 1800 (6 p.m.) dose had a blank space. Also noted on the same MAR was clonazepam 0.5 mg give one tablet by mouth every evening. On 10/19/14 for the 1800 dose there was a blank space. 3. Review of the provider's August 2008 Charting and Documentation policy revealed: *All observations, medications administered, services performed should have been documented in the resident's clinical record. 	{F 514}	<p>disciplinary action may be initiated if necessary. Data will be shared with the DON for follow-up and compliance. Data will be shared at the QAPI committee for review and recommendations.</p> <p>* MAR/MAR audits will be done for all residents and shared with the DON daily. The audit reports will be reported to QAPI monthly by the DON. DN/SSDDH/MF</p>	<p>* [REDACTED] DN/SSDDH/MF</p>	

Officer Buzgala

Emergency Permit Holder/Administrator

11-13-14