

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

ORIGINAL

PRINTED: 10/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435120	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER PIONEER MEMORIAL NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070	
(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 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/22/14 through 9/24/14. Pioneer Memorial Nursing Home was found not in compliance with the following requirements: F325 and F514.	F 000	Addendums noted with an asterisk per 10/20/14 telephone to facility administrator. PE/SDDO4/MF	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and policy review, the provider failed to ensure two of six sampled residents (2 and 8) with weight loss had timely and thorough nutrition assessments by the consulting registered dietitian (RD). Findings include: 1. Observations from 9/22/14 through 9/24/14 of resident 2 revealed she: *Was a very thin and petite woman. *Was very confused related to advanced	F 325		

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

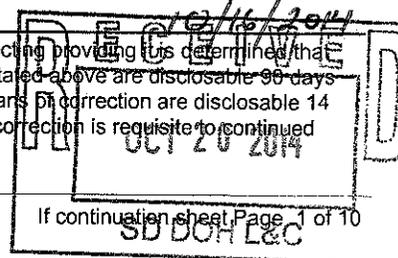
TITLE

(X6) DATE

Thomas V. Riles

CEO

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 325	<p>Continued From page 1 dementia (memory loss). *Was unable to answer questions appropriately. *Ate very slowly but was able to eat after set-up without assistance. -When she took a bite she chewed and chewed, but eventually removed the small bite and laid it on her plate. *Was able to drink fluids, but that was also done slowly.</p> <p>Review of resident 2's weight records revealed her weight on 3/10/14 was 102.5 pounds (lb), and on 9/18/14 her weight was 94.5 lb.</p> <p>Review of resident 2's progress notes revealed: *The consulting registered dietitian (RD) documented on 12/24/13 a nutrition note stated: "Will monitor wt [weight] for changes that would indicate inadequate energy intake. Reviewed notes from previous facility indicating resident decreased wt and was given supplement between meals which resolved the issue. Resident is continuing supplement in this facility. Resident is currently in acceptable range." -The note had not addressed her current weight. -It had not reviewed any laboratory values. -It had not addressed medications that could have affected her appetite. *The dietary services manager (DSM) had documented on the following: -3/13/14: "She averages 50-100% of meals served. She is a nutrition risk related to her cognition (poor memory). Her current weigh is at 103# [pound]". *3/26/14: "Observed the resident while eating her breakfast. She chews her food and continue to spit any food with texture out. I notified ST [speech therapy] and she will be observing her. Staff believes it is a behavior and dementia."</p>	F 325	<p>Nutritional Assessment Policy D1Y1401 updated to reflect the process; an audit was completed of all nursing home residents (including residents 2 and 8) to identify any insidious weight loss. All residents identified were reviewed by the interdisciplinary nutritional risk team on 10/15/2014. Interventions identified were implemented and care planned as needed. Dietary Manager will review resident's weights weekly. If significant weight change or other areas of concern are noted Dietary Manager will refer them to Dietitian for review. Dietitian will review any areas of concern and bring them to the monthly interdisciplinary nutrition risk team meeting. Interventions will be implemented, care planned, and noted by Dietitian or designee. Dietitian or designee will complete an audit in three months, of all residents to ensure significant weight loss and weight loss trends are addressed and documented. Results of audit will be reported to Performance Improvement Committee. The Dietary Manager will be responsible for implementation of the Plan of Correction.</p>	11/13/14

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F 325	<p>Continued From page 2</p> <p>-6/14/14: "Resident has varied meal intake. She averages 1-25% of meals served. She receives a supplement for extra caloric support. Her current weight is at 100#. No changes noted. Will review care plan and make appropriate revisions [changes] if needed."</p> <p>-8/29/14: "Resident was observed while she was eating lunch. She did not verbally respond to me as I tried visiting with her. She did take a few bites, chew and spit out the chewed food on her fork. This is a continuous behavior of hers. She does receive supplementation for nutrition support. She consumes 1-25 to 26-50% of meals served. Her current weight is at #96. In 90 days her weight is down #2 and in 180 days down #7 (7.3%). She does exhibit restlessness. She continues on a NDDII (National dysphasia diet/difficulty swallowing) diet. She is a nutrition risk and weight loss relating to poor intake, cognition and behaviors." *There were no further assessments completed by the consulting RD.</p> <p>Review of resident 2's 4/14/14 speech evaluation revealed: *When the resident chewed and then spit the food out that was not a swallowing issue. *It was a behavior related to the dementia.</p> <p>Review of resident 2's 1/7/14 care plan revealed: *Problem: "Risk for weight loss related to small eater, diagnosis, history of weight loss and spits food out." *Goal: "Will maintain weight without significant weight loss." *Approaches: "Offer snacks off snack cart. Offer supplements bid [twice a day]. Provide diet as ordered with small portions." *The plan had not been updated to offer food</p>	F 325		

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F 325	<p>Continued From page 3</p> <p>items that were not of the texture the resident was likely to spit out.</p> <p>Telephone interview on 9/24/14 at 3:00 p.m. with the consulting RD revealed:</p> <p>*She ran a monthly variance report of weights during her first visit every month.</p> <p>*That report highlighted residents who had lost weight defined as 'significant', which was a 5% weight loss in 30 days, 7.5% weight loss in 90 days, and a 10% weight loss in 180 days.</p> <p>*After she had reviewed that report she met with the interdisciplinary team to discuss the residents who had a significant weight loss or gain.</p> <p>*Resident 2 had not had a weight loss that fell into the significant weight loss definition, but she agreed the resident had lost weight.</p> <p>*When you only weighed about 90 lb a 4 lb weight loss was significant.</p> <p>*She was not aware if resident 2 had drank the supplement they offered her. The DSM should have evaluated that.</p> <p>*She was unsure why the DSM had said she was at nutritional risk. "She must have copied that from something I wrote."</p> <p>-When the surveyor asked her where that had been written she did not respond.</p> <p>Surveyor: 32332</p> <p>2. Observation from 9/22/14 through 9/24/14 of resident 8 revealed he:</p> <p>*Required assistance with eating his meals.</p> <p>*Displayed confusion related to a diagnosis of dementia (a disease that caused a decline in mental functioning).</p> <p>Review of resident 8's weight records revealed on</p>	F 325			

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F 325	<p>Continued From page 4</p> <p>the following:</p> <ul style="list-style-type: none"> *6/30/14 (on admission): 251 lb. *7/20/14: 251 lb. *7/29/14: 240.5 lb. *8/5/14: 242 lb. *8/17/14: 238 lb. *9/16/14: 236 lb. <p>Review of resident 8's 7/1/14 through 9/23/14 progress notes revealed:</p> <ul style="list-style-type: none"> *The consulting RD had documented on 7/2/14: <ul style="list-style-type: none"> -He had good intake since admission. -He had been evaluated by occupational therapy for the use of adaptive silverware. The silverware was recommended to assist with getting food to his mouth without spilling it. -The provider would monitor weights and intake. *The consulting RD had documented on 9/17/14: <ul style="list-style-type: none"> -The resident had been reviewed related to a weight loss of 5.2 percent (%) in thirty days. -He had recently moved from the dementia unit, and staff felt he would have an improved intake due to improved stimulation (more activity around him to keep him awake). -He was sleeping during meals on the secured unit. -He had not lost any further weight since his move out of the dementia unit to the main nursing home on 9/11/14. -The provider would monitor weight and intake for further changes. -It had not addressed any laboratory values. -It had not addressed medications that could have affected his appetite or caused him to sleep through his meals. -There were no recommendations from the RD other than to monitor the weight and intake. *The DSM had documented on 9/19/14: <ul style="list-style-type: none"> -Resident 8 sat at the assisted dining table. 	F 325			

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F 325	<p>Continued From page 5</p> <ul style="list-style-type: none"> -His intake was better since he had moved to the main unit, because there was more stimulation out there than in the dementia unit. -His intake averaged 76-100%. -His current weight was 236 lb, down fifteen pounds in seventy-eight days. -His weights and intake would continue to be monitored. <p>*There had been no further documentation in the progress notes of the weight loss which had begun in July.</p> <p>Review of resident 8's 7/9/14 care plan revealed:</p> <ul style="list-style-type: none"> *He was at risk for decreased meal intake. *Interventions had included: <ul style="list-style-type: none"> -A general, healthful diet. -Offer assistance and tray preparation as needed. -Offer a late morning snack if he slept through breakfast service. -Provide curved, large-handled silverware and a plate guard (device attached to the plate to prevent food from being pushed off by silverware). <p>Observation of resident 8 during meal services from 9/22/14 through 9/24/14 revealed:</p> <ul style="list-style-type: none"> *He sat at an assisted dining table. *He had regular silverware at mealtimes. *No plate guard had been attached to his plate. *He was fed by the staff. <p>Interview on 9/24/14 at 8:45 a.m. with certified nursing assistant A revealed:</p> <ul style="list-style-type: none"> *The large-handled silverware and plate guard had been attempted when resident 8 lived on the dementia unit. *He was not able to understand how to use the special silverware and plate guard. *It had not been used after he had moved off the 	F 325			

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F 325	<p>Continued From page 6 dementia unit.</p> <p>Interview on 9/24/14 at 11:30 a.m. with the director of nursing revealed: *Resident 8 had been reviewed at a nutritionally at-risk meeting on 9/17/14 due to significant weight loss. *She had not attended that meeting. *She stated she had thought he had been started on supplements for his weight loss. *Resident 8 had not been reviewed in July for weight loss, because residents had to be over the five percent weight loss in thirty days to have been reviewed. *The weight loss in July had been below five percent. *The RD was in the facility weekly and would have been notified of weight losses. *She was unable to locate further documentation regarding acknowledgement of weight losses beginning in July. *She would have expected there to have been more documentation.</p> <p>Interview on 9/24/14 at 11:45 a.m. with the Minimum Data Set coordinator revealed: *She had attended the nutritionally at-risk meeting on 9/17/14. *The team had discussed resident 8 eating better in the larger dining room and offering him food if he slept in. *She had not remembered if supplements had been discussed at the meeting. *She was not sure if the physician had been notified of the weight loss.</p> <p>Interview on 9/24/14 at 1:40 p.m. with the consulting RD revealed: *Residents were weighed monthly between day</p>	F 325			

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F 325	<p>Continued From page 7 one and day seven. *She then calculated whether there were significant losses which would have been: -Above 5% in thirty days. -Above 7.5% in ninety days. -Above 10% in 180 days. *She gathered that information on the tenth of the month and emailed results of her calculations on the seventeenth of the month to the DSM. *There were variances in weights in July and August, but they had not been determined as significant losses. *The team would have just monitored for weight changes. **"No one had addressed it (the July and August weight loss) with me." **"I do expect the staff to communicate concerns." *Because resident 8 was a large man she had wanted to treat his weight loss with whole foods rather than supplements. *She had not documented the recommendation. **"I guess I didn't state that clearly, but that was my intention."</p> <p>Review of the provider's April 2014 Nutritional Assessment, Nursing Home policy revealed: *The purpose was: -To identify areas of nutritional risk. -To monitor progress toward meeting nutrition goals. -To maintain and improve the nutritional status of the residents. **"Between care conferences it is often necessary to review the nutritional status of residents. The dietary manager identifies conditions that may interfere with optimal nutrition. These residents are identified for the registered dietitian to review when he or she makes their monthly visit." *Areas of nutritional risk identified had included</p>	F 325			

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F 325	Continued From page 8 significant and severe weight changes. *The RD would review those residents with areas of nutritional risk, assessing nutritional needs, and interventions with review of the nutritional care plan as appropriate. *The RD would communicate any care plan interventions to the dietary manager or other health professionals.	F 325		
F 514 SS=B	483.75(l)(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 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure complete and accurate medical information was documented in the medical record regarding discharge for one of one sampled resident (13). Findings include: 1. Review of resident 13's entire record review revealed:	F 514	Documentation Policy NH700 updated to reflect process; an audit of the last six months of discharges was completed and found to be in compliance. Education with Nursing regarding process will be completed by 11/1/2014. MDS Coordinator or designee will complete (Matrix Observation) Discharge Plan of Care. Completed Observation will be printed off, reviewed with resident or responsible party, and signed by resident or responsible party. A copy will be given to resident or responsible party and the original will be scanned to residents chart. Medications will be counted and documented on Residents List of Destroyed Medications. Medications may be released or destroyed in accordance with Medication Management Policy NH400. DON or designee will monitor discharged residents monthly for three months to ensure all discharge planning is complete and on the chart. Results of the review will be reported to the Performance Improvement Committee. DON will be responsible for completing Plan of Correction.	11/13/14

XALL RESIDENCE

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F 514	<p>Continued From page 9</p> <p>*She had been admitted on 9/5/14. *The admission face sheet said she had been discharged on 9/19/14. *The last entry in the nurses notes was dated 9/18/14 and had been written by a physical therapist. *There was no documentation of: -Her health status at the time of discharge. -Where she was discharged to. -Any discharge teaching. -How her medications were disposed of.</p> <p>Interview with the director of nursing and review of resident 13's medical record on 9/24/14 at 11:00 a.m. revealed: *They had not documented her discharge properly. *They should have documented all the teaching they had done with her, and where she had been discharged to. *She agreed her medical record appeared she was still in the nursing home. *She had been discharged to their adjoining assisted living center (ALC). *Their policy was to destroy the medications when she had been discharged, but the medications had been sent with her to the ALC. *There was not a record of what happened to her medications.</p> <p>Review of the provider's 7/24/13 Documentation policy revealed it had not addressed what should have been documented at the time of discharge.</p>	F 514			

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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 9/23/14. Pioneer Memorial Nursing Home was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Thomas V. Ritten</i>	TITLE <i>CEO</i>	(X6) DATE <i>10/23/2014</i>
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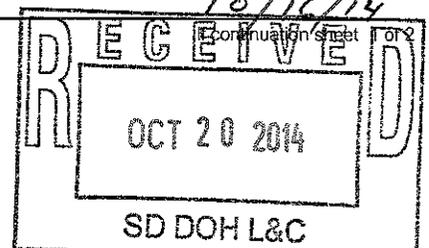
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2014
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NAME OF PROVIDER OR SUPPLIER PIONEER MEMORIAL NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 315 N WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070
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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) COMPLETE DATE
S 000	Initial Comments Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/22/14 through 9/24/14. Pioneer Memorial Nursing Home was found not in compliance with the following requirement: S322.	S 000	Addendums noted with an asterisk per 10/23/14 telephone to facility administrator. PEJSDOHH/MF	
S 322	44:04:08:04.01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS Written authorization by the attending physician must be secured for the release of any medication to a...resident upon discharge or transfer. The release of medication must be documented in the...resident's record, indicating quantity, drug name, and strength. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure physician's orders were obtained for the transfer of medications or the proper destruction of medications had occurred for one of one discharged resident (13). Findings include: 1. Review of resident 13's entire record revealed: *She had been admitted on 9/5/14. *The information sheet said she had been discharged on 9/19/14. *There was no documentation of what had	S 322	Documentation Policy NH700 updated to reflect process; an audit of the last six months of discharges was completed and found to be in compliance. Education with Nursing regarding process will be completed by 11/1/2014. Upon discharge Medications will be counted and documented on Residents List of Destroyed Medications. Medications may be released or destroyed in accordance with Medication Management Policy NH400. *all PEJSDOHH/MF DON or designee will monitor discharged residents monthly for three months to ensure all discharge planning is complete and on the chart. Results of the review will be reported to the Performance Improvement Committee. The Director of Nursing will be responsible for completion of the Plan of Correction.	11/13/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Thomas V. Rube</i>	TITLE CEO	(X6) DATE 10/16/14
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10698	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/24/2014
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S 322	<p>Continued From page 1</p> <p>happened to her medications after she had been discharged.</p> <p>Interview on 9/24/14 at 11:00 a.m. with the director of nursing regarding resident 13 revealed:</p> <ul style="list-style-type: none"> *She had been discharged to the adjoining assisted living center (ALC). *Their policy was to destroy the medications when she had been discharged. *They should not have transferred any medications to the ALC. *When the resident was discharged the medications were sent with her to the ALC. -They did not have a physician's order to do that. -They had not documented they had done that. -They had not recorded what or how many medications had been sent with the resident. *Transferring the medications to the ALC should not have occurred. <p>Review of the provider's 4/23/14 Destroying Medications policy revealed "Medications may be destroyed immediately if the resident expires or is discharged."</p>	S 322		