

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH PATRICK AVENUE WHITE, SD 57276
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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
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F 000	<p><i>Addendums noted with an asterisk per 9/11/14 telephone to facility administrator. DK/SDDOH/IME</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/23/14 through 6/25/14. White Senior Living was found not in compliance with the following requirements: F221, F281, F329, and F441.</p>	F 000	F221 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	*7/31/14 DK/SDDOH/IME
F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Side rail assessments had been completed for two of three sampled residents (6 and 8) who had side rails on their beds for positioning. *Seat belt assessments had been completed for two of two sampled residents (6 and 8) who had seat belts in their wheelchairs for positioning. *Residents and/or residents' families had been provided notification of risks of using a side rail for positioning for three of three sampled residents (6, 8, and 9) and two of two sampled residents (6 and 8) using a seat belt for positioning. Findings include: 1. Observation on 6/25/14 at 7:30 a.m. revealed resident 8 lying on her bed with two half side rails</p>	F 221	<p>1. Resident #6, #8 and #9 have been re-evaluated for use of least restrictive device. Therapy will be evaluating for wheelchair positioning without use of device. Resident and/or their guardian have been notified of risks of use of devices and consent has been obtained. All residents with assistive devices will be re-evaluated to assure least restrictive device is used and systems of notification of risks have been given and consents obtained by 7/31/14.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angie Miller</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>7-21-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUL 23 2014

SD DOH L&C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 221	<p>Continued From page 1 up on the top half of her bed.</p> <p>Review of resident 8's 4/1/14 care plan revealed: *"At times resident will use side rail to assist in repositioning/turning." *"Seatbelt to be on when up in w/c (wheelchair) to maintain body alignment."</p> <p>Review of resident 8's medical record revealed: *No assessment had been completed for the use of the side rails. *No assessment had been completed for the use of the seat belt for positioning while in her wheelchair.</p> <p>Interview on 6/25/14 at 11:30 a.m. with the director of nursing (DON) regarding resident 8 confirmed no physical device evaluation had been completed for the side rails or the seat belt. She also confirmed a notification of risks had not been completed for use of the side rails on the bed or the seat belt in the wheelchair.</p> <p>Surveyor: 32332 2. Random observations from 6/23/14 through 6/25/14 of resident 6 revealed: *He had one half side rail attached to his upper bed in the up position when he had been in bed. *He wore a seat belt when he was sitting in his wheel chair.</p> <p>Review of resident 6's medical record revealed: *A 5/6/14 physician's order for "Side rails on bed to aid in bed mobility/repositioning." *The 6/13/14 physician's recertification orders had not included the side rail order nor an order for the use of the seat belt. *His 5/6/14 care plan indicated:</p>	F 221	<p>2. Re-education to MDS Coordinator and IDT has been completed including, definition of restraint, device used for positioning, assessment for use with safety considerations and least restrictive device, physician involvement and resident/guardian informed consent, reassessment and care plan for use. All staff were re-educated to the system and the above components on 7/15/14.</p> <p>3. The DNS and/or her designee will audit all new admissions and three residents weekly for four weeks and then one resident weekly for two months for completion of the physical device evaluation, notification of risks to resident/guardian, informed consent is obtained and the care plan reflects usage and individual resident needs.</p> <p>4. The DNS and/or her designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.</p>	

**MURPHY
6/25/14*

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F 221	<p>Continued From page 2</p> <p>-On 2/13/14, the care plan was updated to include the use of a seat belt while sitting in his wheel chair for proper positioning.</p> <p>*On 3/10/14, the care plan was updated to include:</p> <p>-A side rail to aide with bed mobility.</p> <p>-He was able to remove the seat belt independently.</p> <p>*A 4/18/14 Physical Device Evaluation indicated the resident used side rails to aid in bed mobility and repositioning, turning side-to-side for weakness and Parkinson's disease.</p> <p>*Quarterly Minimum Data Set assessments on 2/5/14 and 5/5/14:</p> <p>-Indicated he used the seat belt when he sat in the wheel chair.</p> <p>-Had not indicated the use of the side rail.</p> <p>*There were no consents from the resident or family for the use of the side rail or the seat belt.</p> <p>Interview on 6/25/14 at 11:15 a.m. with the DON revealed:</p> <p>*She had not considered the side rails or the safety belt to have been restraints.</p> <p>*Resident 6 had not been assessed for the use of the seat belt.</p> <p>*The side rails and seat belts had not been reassessed quarterly to determine appropriateness of continued use.</p> <p>*Consents had not been obtained for the use of the side rail or the seat belt.</p> <p>*There had not been a discussion with the resident or family members regarding possible risks of the side rail or seat belt use.</p> <p>4. Review of the provider's November 2002 Restraint - Physical Restraint Reduction policy revealed:</p> <p>*Prior to physical restraint application a restraint</p>	F 221		

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F 221	Continued From page 3 assessment was to have been completed. *The resident or responsible party was to review the Restraint Consent Form to provide education regarding restraint use. *If the assessment had determined the equipment had been appropriate it would have been added to the care plan. *The equipment was to have been reassessed at least quarterly to determine the need for continued use, alternative or least restrictive device, or elimination of the device. Surveyor: 33488 5. Observation and interview on 6/24/14 at 3:00 p.m. with resident 9 revealed: *She had two half side rails attached to the top of her bed on both sides. *She would use the side rails to hold herself in position when staff would turn her to the side. Review of resident 9's medical record revealed no consent or explanation to the resident of risks associated with the use of side rails had been documented in the medical record. Interview and record review on 6/25/14 at 10:20 a.m. with the administrator regarding resident 9's side rail usage revealed she: *Was unaware a consent or explanation of risks involved with the use of side rails *Was unaware risks needed to have been explained to the resident and documented in the medical record.	F 221		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281	F281 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law. The	

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F 281	Continued From page 4 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure professional standards were followed for: *Crushing an extended release medication by one of one unlicensed assistive personal (UAP) (F) for one of one random resident (5) observed receiving extended release medications *Accuracy of dosage on an insulin bottle for one of one sampled resident (7) observed receiving an insulin administration by one of one registered nurse (E). *Obtaining a prescription refill in a timely manner for one of one sampled resident (7) with an expired prescription. *Updating physicians' orders to reflect: -The current medication regimen for two of nine sampled residents (3 and 6). -The current treatment regimen for one of nine sampled residents (3). Findings include: 1. Observation on 6/24/14 at 8:15 a.m. of UAP F during a medication pass revealed she: *Removed resident 5's medications from her blister seals. *Placed four of the five medications into a plastic bag and crushed them with a pill crusher. *Placed the crushed medications into a medication cup. *Placed the uncrushed pill in with the crushed medications. *Added applesauce to the medications and spooned them into resident 5's mouth.	F 281	preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: <i>*F D/K/S/D/D/H/M/F</i> 1. The identified UAP for Resident #5 was re-educated to medications on "Do Not Crush" list and also to five rights of medication administration by DNS on 6/24/14. The identified RN (E) for resident #7 was re-educated to use of warning stickers on multi-use medications with order changes. Warning sticker placed on insulin bottle on 6/23/14. Order was clarified for Vit D2 medication on 6/23/14. Resident #3 Consolidated orders reflect correct Glipizide order and Betadine treatment which was signed by physician on 7/1/14. Resident #6- Consolidated orders reflect correct Ranitidine HCl- which was signed by physician on 7/1/14.	<i>*7/15/14 D/K/S/D/D/H/M/F</i>	

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F 281	<p>Continued From page 5</p> <p>Interview with UAP F at that time revealed: *She crushed all of the medications except Namenda XR (for dementia), including bupropion (for depression) XL (extra long). *She had not crushed the Namenda XR (extended release), because it was a 'do not crush' medication. *She would look on the residents' chart for standing orders to see if she could crush their medications.</p> <p>Review of resident 5's physician's standing orders revealed medications could have been crushed if the resident was unable to take it whole as long as it "was not contraindicated (extended or delayed release, enteric coated, etc...)." </p> <p>Review of the provider's consultant pharmacy 'do not crush' list revealed both the Namenda XR and the bupropion XL were not to have been crushed.</p> <p>Interview on 6/25/14 at 11:15 a.m. with the director of nursing (DON) revealed her expectation would have been all extended release medications were not to have been crushed.</p> <p>Review of the provider's 2009 General Medication Administration Guidance policy revealed the staff should have checked a "Do Not Crush Chart" to determine if medications could have been crushed.</p> <p>2. Observation on 6/23/14 at 5:50 p.m. of registered nurse (RN) E during an insulin administration to resident 7 revealed: *The insulin label instructed to give Novalog (for</p>	F 281	<p>2. Licensed staff and UAP were re-educated to five right of medication administration, updating orders prior to physician signature, clarification of orders when a discrepancy of label/MAR do not match and expected timeframe for physician response on 7/15/14.</p> <p>3. DNS and/or her designee will audit three staff per week for four weeks and then two staff for eight weeks for five rights of medication administration including use of warning labels and clarification of orders. DNS and/or her designee will audit three MARS and physician orders per week for four weeks and then two per week for eight weeks for accuracy of orders and consolidated orders.</p> <p>4. The DNS and/or her designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.</p>	

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F 281	<p>Continued From page 6 diabetes) 15 units three times daily. *The medication administration record order read Novalog 18 units three times daily.</p> <p>Interview with RN E at that time revealed: *He had received the order for 18 units, so he knew that amount was correct. *He had notified the pharmacy of the order change, but the pharmacy had sent an incorrect label with the next bottle ordered. *He would go to the chart to find the correct order if he had not known which order had been correct. *They had not used order change warning stickers on multi-use bottles to warn staff of order inconsistencies.</p> <p>Interview on 6/25/14 at 11:15 a.m. with the DON revealed her expectation had been staff would place warning stickers on multi-use medications with order changes.</p> <p>Review of the provider's 2009 General Medication Administration Guidance policy revealed: "If there is a discrepancy between the card, label and MAR, hold the medication until the medication pass is completed and verify with the physician's order sheet."</p> <p>3. Review of resident 7's June 2014 MAR revealed: *An order for Vitamin D2 50,000 units to have been given once weekly on Thursday. *Review of the MAR revealed on 6/5, 6/12, and 6/19 the nurses had circled their signatures and added NA (not applicable) below the signatures. *Attached to that MAR was an undated, unsigned, hand-written note stating "Script was not refillable. Have faxed MD [medical doctor]."</p>	F 281			

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F 281	<p>Continued From page 7 Awaiting response on Vit [vitamin] D2."</p> <p>Interview on 6/25/14 at 11:15 a.m. with the DON revealed her expectation had been the nursing staff would have contacted the physician no more than three days after no returned response to obtain the refill order.</p> <p>Review of the provider's 2009 General Medication Administration Guidance policy revealed "At all times, the facility staff should communicate any questions or concerns to their pharmacy/consultant pharmacist and/or prescriber."</p> <p>4a. Review of resident 3's most current 6/13/14 physician's orders revealed a 5/23/14 order for glipizide (to treat diabetes) 10 milligrams (mg) once daily.</p> <p>Review of resident 3's June 2014 MAR revealed a 5/27/14 order for glipizide 5 mg, one tablet twice daily.</p> <p>Interview on 6/25/14 at 11:15 a.m. with the DON revealed: *The glipizide order had changed on 5/27/14. *The nurse had made the correct changes on the MAR. *The nurse had not updated the physician's order sheet with the correct order. *The physician had signed orders for the wrong dose on his last visit on 6/13/14. *Her expectation was the Mimumum Data Set (MDS) nurse (responsible for updating the physician's orders) would update all orders before each physician's visit.</p> <p>b. Review of resident 6's most current 6/13/14</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>physician's orders revealed: *A 4/30/14 order for omeprazole (for stomach acid) 20 mg daily. *A 1/29/14 order for ranitadine Hcl (for stomach acid) 150 mg daily.</p> <p>Review of resident 6's June 2014 MAR revealed: *The omeprazole had been discontinued on 5/29/14. *An undated order change for ranitadine HCl 150 mg twice daily.</p> <p>Interview on 6/25/14 at 11:15 a.m. with the DON revealed: *The omeprazole order and the ranitadine order on the MAR were correct. *The physician's orders had not been transcribed onto the MAR prior to the physician's visit. *The physician had signed orders for the wrong doses on his last visit on 6/13/14. *Her expectation was the MDS nurse would have updated all orders before each physician's visit.</p> <p>c. Review of resident 3's June 2014 treatment administration record (TAR) revealed a 5/1/14 order for Betadine (antiseptic) to her foot ulcers daily.</p> <p>Review of her most current 6/13/14 physician's orders revealed: *No order for Betadine to the foot ulcers. *The physician had not signed for the use of Betadine.</p> <p>Interview on 6/25/14 at 11:15 a.m. with the DON revealed: *Resident 6 had orders from 5/1/14 for the Betadine treatment. *The orders had not been transcribed onto the</p>	F 281			

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F 281	Continued From page 9 current physician's orders prior to the physician's visit. *Her expectation was the MDS nurse would update all orders before each physician's visit.	F 281		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure	F 329	F329 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Resident #6 and #7 MARs have been updated to include Behavior monitoring and monitoring for adverse side effects on 7/17/14. All residents have been reviewed to ensure those identified with antipsychotic use are being monitored for behaviors and adverse side effects.	*7/17/14 DK/SDDH/ME

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F 329	<p>Continued From page 10</p> <p>appropriate documentation was maintained to monitor for behavior symptoms and side effects in response to antipsychotic medication (used to treat mental disorders) used for two of seven (6 and 7) sampled residents receiving antipsychotic medications, with potential for unnecessary use of drugs or physical harm related to adverse side effects.</p> <p>Findings include:</p> <p>1. Review of resident 6's medical record revealed: *He had been admitted on 1/29/14. *Diagnoses of dementia (a loss of brain functioning that could affect judgement and behaviors) with behavioral disturbance and depressive disorder. *A physician's order for the medication quetiapine fumerate (antipsychotic) used to treat schizophrenia (a mental disorder that makes it hard to tell the difference between what is real and what is not real) and depressive disorder. *His 5/8/14 care plan indicated: -He had hallucinations (seeing or hearing things that were not real) of seeing bugs on his skin. -He had behavioral symptoms of picking at his skin. -Staff were to have monitored for side effects of quetiapine fumerate. -Staff were to have informed the charge nurse of hallucinations or behavior symptoms. *No documentation areas for monitoring the side effects or behaviors on a daily basis.</p> <p>2. Review of resident 7's medical record revealed: *He had been admitted on 1/30/14. *A diagnosis of schizophrenia. A physician's order for the medication clozapine</p>	F 329	<p>2. DNS and IDT will review and revise as needed the policy and procedure for appropriate monitoring and documentation for use of antipsychotic medications. The review will include monitoring for potential side effects of ordered medication, effectiveness of the medications and other interventions per individual, who will monitor, what is to be monitored and how it will be documented, review for change in maintaining the plan or making alterations in interventions. All staff was educated on 7/15/2014 about resident behavior and expectations for observations and responses.</p> <p>3. The DNS and/or her designee will audit three residents MAR/TAR for behavior monitoring and adverse side effect monitoring for those receiving antipsychotic medications for four weeks and then two records per week for eight weeks.</p> <p>4. The DNS and/or her designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.</p>	

*x m m h h y
12/10/2014*

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2014
NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH PATRICK AVENUE WHITE, SD 57276		
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F 329	<p>Continued From page 11 (antipsychotic medication used to treat schizophrenia). *His 5/6/14 care plan indicated: -He had a history of delusions (abnormal thoughts) and hallucinations. -Staff were to have documented behaviors. -Staff were to have monitored for side effects of Clozapine. *No documentation areas for monitoring the side effects or behaviors on a daily basis.</p> <p>3. Interview on 6/25/14 at 8:30 a.m. with registered nurse E revealed: *Nurses monitored behaviors and side effects for certain residents each shift and documented them on the medication administration record. *Nurses had not documented behaviors or side effects for residents 6 or 7. *He was unsure why they were not documenting on those residents.</p> <p>Interview on 6/25/14 at 11:15 a.m. with the director of nursing revealed her expectation had been the nurses monitored for side effects and behaviors of all residents receiving antipsychotic medications every shift. The nurses were to have documented those behaviors and side effects on the medication administration record.</p> <p>Review of the provider's undated Guidelines for Behavior Monitoring and Psychoactive (affect brain functioning) Medication Monitoring policy revealed: *Daily behavior monitoring was required for those residents on antipsychotic and antianxiety (for nervousness) medications. *Behaviors were to have been documented on the treatment administration record. *Behavior monitoring would have allowed the staff</p>	F 329		

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F 329	Continued From page 12 to evaluate the interventions and effectiveness of the medication used. *Medication side effect monitoring was to have been documented on the medication administration record.	F 329			
F 441 SS=F	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	F441 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and State law. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: (*) (NA A & RN E) DK/SD/HH/ME 1. Identified staff was educated to proper sanitation of the whirlpool tub, change of gloves during personal cares and disinfecting the glucose meter between uses. Beauty shop staff was educated to cleaning of rollers between resident uses. 2. The ED, DNS and IDT team reviewed and revised as needed the policy and procedure regarding	* 7/10/14 DK/SD/HH/ME	

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F 441	<p>Continued From page 13</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: 33488 Based on observation, interview, guideline review, and policy review, the provider failed to: *Appropriately follow the Whirlpool Tub Sanitizing and Disinfecting guidelines according to policy resulting in the potential to spread infection for unidentified residents who used the whirlpool. *Follow the glove use guideline policy by certified nursing assistant (CNA) A during a dressing change for one of one resident (2) resulting in potential for cross-contamination. *Clean and disinfect multiple use curlers after use on unidentified residents in one of one beauty shop resulting in the potential for cross-contamination. *Clean and disinfect a multiple-use glucose meter (to check blood sugars) between resident use for two of two residents (7 and 11) observed glucose meter checks resulting in the potential for cross-contamination. Findings include:</p> <p>1. Observation and interview on 6/24/14 at 9:38 a.m. with certified nursing assistant (CNA) A in the whirlpool tub room revealed she: *Demonstrated spritzing the tub with Classic Whirlpool Disinfectant Cleaner that had been stored in a spray bottle. *Would then "fill the whirlpool to just above the lower jets, turn them on for about a minute, then</p>	F 441	<p>infection prevention and control. The review included appropriate hand hygiene and glove use for each assigned task, appropriate care and maintenance of resident use items, multi-use glucose meters, care and sanitization and disinfection of whirlpool tubs. All staff was provided education to the above identified areas on 7/15/14. Beauty Shop Personnel were educated on 7/18/14 on the importance of cleaning/disinfecting multiple use curlers after use on each resident per facility policy and SD cosmetology commission.</p> <p>3. The DNS and/or her designee will observe three opportunities each of whirlpool sanitation, gloving and hand washing for personal cares, glucose meter sanitation and Beauty shop sanitation of curlers and equipment between resident use per week for four weeks and then two opportunities each for eight weeks.</p> <p>4. The DNS and/or her designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.</p>	

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NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH PATRICK AVENUE WHITE, SD 57276
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F 441	<p>Continued From page 14 shut them off." *Was unaware the whirlpool cleaning instructions had been posted on the cabinet beside the tub. *Agreed the instructions said to use twelve ounces of the Classic Whirlpool Disinfectant Cleaner to disinfect the whirlpool tub. *Agreed not following the posted cleaning instructions would pose a risk of infection for all residents who used the tub.</p> <p>Observation and interview on 6/24/14 at 9:45 a.m. with CNA B in the whirlpool tub room revealed she: *Demonstrated spritzing the tub with Classic Whirlpool Disinfectant Cleaner that had been stored in a spray bottle. *Would then "fill the whirlpool to just above the upper jets, turn them on and let them run for a while, then shut them off." *Was aware the whirlpool cleaning instructions had been posted on the cabinet beside the tub but had not remembered the instructions. *Agreed she should have used twelve ounces of cleaner versus the light coating that had been applied from the spray bottle. *Opened the cupboard that the instructions had been posted on, pulled out a measuring cup, and agreed that was what staff were supposed to have used to put the cleaner in. *Agreed not following the posted cleaning instructions would pose a risk of infection for all residents who used the tub.</p> <p>Review of the undated manufacture's guidelines for the Classic Whirlpool Disinfectant Cleaner revealed two ounces of cleaner would be used per gallon of water.</p> <p>Review of the provider's revised 6/14/13</p>	F 441		
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F 441	<p>Continued From page 15</p> <p>Whirlpool Tub Sanitizing and Disinfecting Guidelines revealed water should be filled to above the whirlpool jets and twelve ounces of cleaning solution should have been added.</p> <p>Interview on 6/24/14 at 9:55 a.m. with the director of nursing (DON) regarding the whirlpool tub revealed: *She agreed staff had not followed instructions regarding the cleaning and disinfecting of the whirlpool tub. *It had been her expectation instructions for cleaning were to have been followed.</p> <p>2. Observation on 6/25/14 at 9:45 a.m. of CNA A while she provided personal care and assisted the nurse during a dressing change for resident 2 revealed she: *Had put on clean gloves. *Used a washcloth to cleanse between his buttocks and dried the area with a towel. *Assisted the nurse in holding the resident's buttocks apart. *Used her soiled gloves to grab the bed control and raise the bed. *Placed her soiled gloved hands on the resident's back as she spoke with him. *Returned to assist the nurse by holding the resident's buttocks apart again. *Continued to redress the resident with her soiled gloves. *Touched the resident's shoulder with her soiled gloves and assisted him to roll over.</p> <p>Interview on 6/25/14 at 10:20 a.m. with the administrator regarding the above glove use revealed she agreed staff had not used proper glove technique as outlined in their policy. She also agreed the CNA had contaminated the</p>	F 441		

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F 441	<p>Continued From page 16 resident's bed control and clothing.</p> <p>Review of the provider's 12/09/06 Glove Usage policy revealed gloves should have been changed after contact with each resident and at the end of each procedure.</p> <p>3. Random observation on 6/23/14 at 5:00 p.m. and on 6/24/14 at 8:05 a.m. of the beauty shop revealed: *Curlers were found stored in two plastic bins and one Zip-Lock bag in the cupboard. *The curlers were found to be full of hair and debris. *Laminated sanitary instructions posted on the wall of the beauty shop from the South Dakota Cosmetology Commission revealed multi-use items were to be cleaned and sanitized between use.</p> <p>Interview on 6/24/14 at 8:30 a.m. with licensed beautician C by phone revealed: *She had been the main beautician (there were two). *She had been a beautician for thirty years. *One bin of curlers in the beauty shop were hers, the other curlers belonged to licensed beautician D. *Her normal procedure was to take home the curlers that she provided "occasionally" to clean them. *She had not been in the practice of cleaning curlers between resident use and had been unaware multiple use items were to be cleaned between resident use according to her licensing board. *She was aware of the laminated instructions by the South Dakota Cosmetology Commission posted on the wall of the beauty shop.</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 441	<p>Continued From page 17</p> <p>Interview on 6/24/14 at 9:07 a.m. with the DON revealed it had been her expectation that multi-use items such as curlers were being cleaned between resident use.</p> <p>Review of the provider's undated Barber and Beauty Services Policy and Procedure policy revealed reusable tools such as curlers were to have been cleaned after each use.</p> <p>Surveyor: 32332</p> <p>4. Observation on 6/23/14 at 5:30 p.m. of registered nurse E performing a blood glucose (sugar) check for resident 11 revealed he:</p> <ul style="list-style-type: none"> *Removed the glucose meter from the drawer of the medication cart. *Cleansed his hands and applied gloves. *Cleansed the resident's finger and pricked the skin to obtain blood. *Correctly obtained blood glucose results. *Removed his gloves. *Returned the glucose meter to the medication cart drawer without disinfecting it. *Cleansed his hands. <p>RN E then approached resident 7 to obtain a blood glucose check. He:</p> <ul style="list-style-type: none"> *Removed the same glucose meter from the medication cart. *Cleansed his hands and applied gloves. *Cleansed resident 7's finger and pricked the skin to obtain blood. *Correctly obtained blood glucose results. *Removed his gloves. *Returned the glucose meter to the medication cart drawer without disinfecting it. *Cleansed his hands. 	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2014
NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH PATRICK AVENUE WHITE, SD 57276		
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F 441	Continued From page 18 Interview at that time with RN E regarding his procedure for glucose meter disinfection revealed: *The glucose meter was supposed to have been disinfected at the end of each shift. *He usually disinfected it after each mealtime use. *He used disinfectant wipes or alcohol pads to disinfect the glucose meter. Interview on 6/25/14 at 11:15 a.m. with the DON revealed her expectation would have been RN E use a disinfectant wipe to disinfect the glucose meter between each resident. Review of the provider's undated Cleaning and Disinfecting Blood Glucose Meters policy revealed: *Health professionals were to have cleaned or disinfected the meters between each resident to avoid cross-contamination. *Soapy water or alcohol should have been used to clean the meter. *A 1:10 solution of household bleach and water or Sani-cloth germicidal wipes should have been used to disinfect the meter.	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435111	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
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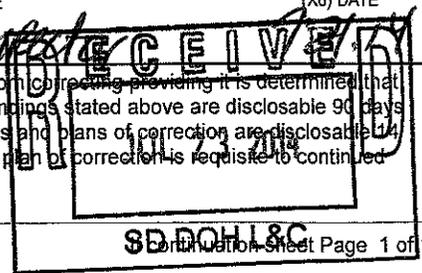
NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 SOUTH PATRICK AVENUE WHITE, SD 57276
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/24/14. White Senior Living 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>Amy McGee</i>	TITLE <i>Executive Director</i>	(X6) DATE
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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.



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10708	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
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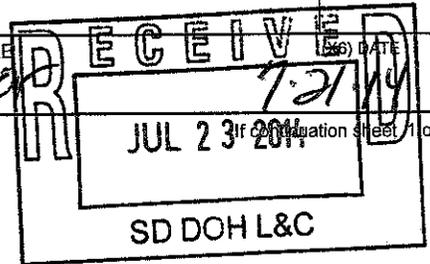
NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 S PATRICK AVE WHITE, SD 57276
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S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/23/14 through 6/25/14. White Senior Living was found not in compliance with the following requirements: S210 and S235.	S 000	Addendums noted with an asterisk per 6/25/14 telephone to facility administrator. DK/SDDCH/ME	
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Rule is not met as evidenced by: Surveyor: 33488 Based on record review and interview, the provider failed to ensure a health assessment had been done for one of five newly hired employees certified nursing assistant (CNA) (G), resulting in the potential spread of communicable	S 210	S210 1. All new employees will complete all required paperwork- including a "health assessment" within 14 days of employment. C.N.A "G" completed her "health assessment" on 6/25/14. 2. New DON educated on 6/25/14 by ED of the requirement that new employees complete all required paperwork- including a "health assessment" within 14 days of employment. 3. ED/Designee will review all new hired employee files to ensure that all paperwork including the "health assessment" is present in the file and signed/dated within 14 days of employment over the next 2 Quarters. 4. The ED and/or her designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.	* 6/25/14 DK/SDDCH/ME

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Amy McGee* TITLE: *Executive Director*

STATE FORM 021199 991811



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10708	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 200 S PATRICK AVE WHITE, SD 57276
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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
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S 210	<p>Continued From Page 1</p> <p>disease. Findings include:</p> <p>1. Record review of CNA G revealed no documentation a health assessment had been done prior to employment or within fourteen days after employment.</p> <p>Interview with the administrator on 6/25/14 at 10:20 a.m. revealed she: *Was unaware CNA G had not received her health assessment by a licensed health professional until that day. *Agreed her expectation would be that state requirements were to be followed and stated "we are out of compliance."</p>	S 210	<p>S235</p> <p>1. All new employees will receive the 2-step Tuberculin test within 14 days of hire. C.N.A "G" received her 2nd step on 6/25/14 which was negative when read on 6/28/14.</p>	<p>6/28/14 DKSDDH/MT</p>
S 235	<p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Each facility shall develop criteria to screen healthcare workers...or residents for Mycobacterium tuberculosis based on the guidelines issued by Centers for Disease Control and Prevention. Policies and procedures for conducting Mycobacterium tuberculosis risk assessment shall be established and should include the key components of responsibility, surveillance, containment, and education. The frequency of repeat screening shall depend upon annual risk assessments conducted by the facility.</p> <p>This Rule is not met as evidenced by: Surveyor: 33488 Based on interview and record review, the provider failed to ensure one of five sampled new</p>	S 235	<p>2. New DON was educated on 6/25/14 by ED on following regulation for Tuberculin testing for new employees and use of facility documentation record to aid with monitoring compliance.</p> <p>3. ED and/or her designee will audit all new employee files to ensure TB testing meets 14day requirement x 2 Quarters.</p> <p>4. The ED and/or her designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.</p>	<p>6/28/14 DKSDDH/MT</p>

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10708	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
NAME OF PROVIDER OR SUPPLIER WHITE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 200 S PATRICK AVE WHITE, SD 57276		
(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 235	Continued From Page 2 employees certified nursing assistant (CNA) (G) completed her tuberculin (TB) screening requirement within fourteen days of being hired. Findings include: 1. Review of the provider's employee personnel files on 6/25/14 revealed: *CNA G had begun her employment on 6/12/14. *Documentation showed only one half of the required two-step TB screening had been done within fourteen days of employment. *No previous immunizations had been documented. Interview with the administrator on 6/25/14 at 10:20 a.m. revealed she: *Was unaware CNA G had not completed her two-step TB screening. *Revealed the employee had not provided proof of prior immunizations or health records to the provider at the time of the survey. *Agreed her expectation would have been that state requirements were to have been followed and stated "we are out of compliance."	S 235		