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

ORIGINAL

PRINTED: 04/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435079		04/01/2015

NAME OF PROVIDER OR SUPPLIER: UNITED RETIREMENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 405 FIRST AVE, BROOKINGS, SD 57006

(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: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/30/15 through 4/1/15. United Retirement Center was found not in compliance with the following requirement(s): F164, F221, F241, F280, F281, F309, F314, F323, F353, F431, and F441.	F 000	Addendums noted with an asterisk per 4/29/15 telephone to facility DON. KG/SDDOH/MF	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Yvonne Gaspar
TITLE: Interim Administrator
(X6) DATE: 4/29/15

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 contract; or the resident. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to: *Maintain residents' personal information in a private and secured manner. *Ensure residents were weighed in a private area in one of four neighborhoods (Robinsview). Findings include: 1. Observations on 3/31/15 at 6:05 p.m. revealed the Morningview medication cart sitting in the hallway close to the front entrance door. On top of the medication cart were: *Four empty medication cards with information of the name and the medications for resident 20. *One empty medication card with information of the name and the medication for resident 21. 2. Random observation from 3/30/15 through 4/1/15 revealed: *On 3/30/15 at 5:00 p.m. was a pink folder located on a table in the Robinsview hallway by rooms 324 and 326. *The outside of the folder was marked "wheelchair weight log info [information]." *There was a piece of paper half out of the folder with names of residents in the Robinsview hallway that included information for weighing the residents. *The above folder remained in that same area throughout the entire survey from 3/30/15 through 4/1/15. Random observations during the above time	F 164	Medication cards for residents 20 and 21, and all other residents, will be kept in confidential areas where they cannot be observed by others. The nurse involved received verbal counsel on 3/31/15. The scale has been moved to a private area. Staff instructed on rationale (4/13/15). Two new chair portable scales have been ordered on 4/21/15. All staff will be educated on HIPAA and maintaining privacy during weights and patient care at mandatory inservices on 4/28/15, 4/29/15, and 4/30/15. Weekly audits by observation throughout the facility will be conducted by DON, or designee, for 3 months and reported at monthly QAPI committee meetings to ensure that resident privacy is maintained. When QAPI committee determines otherwise, based on compliance, the frequency of the audits may be changed or discontinued.	4/30/15

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F 164	Continued From page 2 period revealed: *Residents had been weighed on a scale in the Robinsview hallway by rooms 324 and 326. *During that time different staff and residents had been in the area during the weighing of resident's. Interview on 4/1/15 at 10:00 a.m. with the administrator revealed she agreed: *The above personal information should not have been in a public area. *Residents should not have been weighed in a public area. 3. Interview on 4/1/15 at 11:45 a.m. and at 2:30 p.m. with director of nursing (DON)/registered nurse (RN) A and DON/RN B revealed: *The above personal information should not have been in a public area. *Residents should not have been weighed in a public area. *It was not appropriate to keep full and empty medication cards on top of the medication cart when not attended. Review of the provider's undated Admissions Packet revealed: *"Resident Bill of Rights: -The resident is assured confidential treatment of his/her personal and medical records. -The resident is treated with consideration, respect and full recognition of his/her dignity and individuality including privacy in treatment and in care for their personal needs."	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of	F 221		

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F 221	Continued From page 3 discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to properly assess one of one sampled resident (13) who had a lap tray [tray placed over the top of a wheelchair]. Findings include: 1. Observation and interview on 4/1/15 at 11:20 a.m. in resident 13's room revealed: *Certified nursing assistants (CNA) D and E assisted the resident to transfer from the bed to the wheelchair. *After the resident was in her wheelchair the CNAs placed: -A splint on her left hand. -A lap tray onto her wheelchair. *The lap tray was secured with a velcro strap to each side of the wheelchair arms. *The surveyor asked the resident to demonstrate the ability to remove the lap tray. *The resident had been unable to remove the tray. *Interview at the above time with CNAs D and E regarding the resident's lap tray revealed: -They had never seen her remove the lap tray. -They felt she would be unable to remove the lap tray due to her physical limitations. Review of resident 13's medical record revealed: *A 4/15/12 admission date. *Diagnosis of cerebral infarction (stroke) with left sided weakness. *There was not an order for use of a lap tray on	F 221	*Two other residents identified at risk had assessments completed and care plans were updated. KEISDOH/MF The lap tray on Resident 13 has been removed. An arm rest has been ordered on 4/10/15, with an estimated delivery date before 5/1/15, to ensure comfort of paralyzed arm, which is currently supported with pillows. Resident 13's Care Plan has been updated. The Use of Restraint Policy has been updated on 4/23/14 to reflect compliance with ongoing assessments of restraints. All staff will be educated to understand what constitutes a restraint and the Use of Restraint Policy at mandatory inservice trainings on 4/28/15, 4/29/15, and 4/30/15. This facility maintains a restraint-free philosophy. Care Plans will be reviewed with the MDS quarterly assessment, and with change of condition, by an interdisciplinary team to ensure ongoing compliance of the restraint policy. Weekly audits on a minimum of three quarterly assessments will be conducted by DON, or designee, for 3 months and reported to QAPI committee. When the QAPI committee determines otherwise, based on compliance, the frequency of audits may be decreased or discontinued.	4/30/15

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F 221	Continued From page 4 the most recent 3/2/15 physician's orders. *There were no nursing assessments completed for the use of a lap tray. Review of the 1/20/15 quarterly Minimum Data Set (MDS) assessment regarding resident 13 revealed: *A Brief Interview for Mental Status (BIMS) assessment (memory test) score of 9 (indicated moderate memory impairment). *Her vision was moderately impaired. *She required extensive assistance of two staff members with bed mobility (repositioning), transfers, moving between locations, dressing, toileting, and personal hygiene. *She had impairment on one side with range of motion (movement of body). *She was not steady during moving from a seated to a standing position, moving on and off the toilet, and surface-to-surface transfers (between bed and chair or wheelchair). *A diagnosis for cerebrovascular accident (CVA) (stroke). *Was on a turning and repositioning program. *Received antidepressant (for depression) medication. *Physical restraints were marked as not used. *The 1/26/15 mini-careplan completed by the MDS nurse revealed the CNAs were to "put on tray to W/C (wheelchair), off at mealtime." *The main careplan with the following revision dates revealed: -11/3/14: "I am at risk for falling." I had a CVA nearly two years ago which limited my mobility in which I need staff assistance with transfers. -5/20/14: "I have a tray that attaches to my w/c. I can remove the tray myself if I want to." -2/28/14; "I need staff assistance for repositioning and transfers d/t [due/to] history of left sided CVA	F 221		

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F 221	Continued From page 5 and limited ROM [range of motion] on left side." -2/28/14: "I have impaired communication." -2/28/14: "I have a past left sided CVA which has affected my ability to effectively make my needs know and understand others." -9/14/13: "I need assistance with my ADLs [activities of daily living]." -2/28/14: "I had a left sided CVA a couple of years ago in which my left side has decreased function and I require staff assist." -11/4/13: "I had a stroke prior to admission to facility. It affected my left side in which I have decreased ROM and limited to no ability on that side." -11/4/13: "I am able to remove the tray on my own if I need to." -5/20/14: "I am dependent on staff for repositioning." -11/30/13: "Nursing rehab [rehabilitation]/restorative: Dressing/Grooming program: Staff needs to dress my left side." Interview on 4/1/15 at 10:25 a.m. and at 2:10 p.m. with registered nurse (RN)/MDS coordinator C regarding resident 13's lap tray revealed: *At 10:25 a.m. she confirmed: -The family wanted the lap tray. -The resident was able to remove the lap tray. -The lap tray was on the care plan. *At 2:10 p.m. she confirmed: -She had not completed any formal restraint assessment prior to the placement of the lap tray. -The resident had been able to remove the lap tray when it had been initiated in 2012. -The family had requested the lap tray due to the resident "yelling out a lot" and had multiple falls. -She had not coded the MDS as a restraint. -She had been unaware the resident was unable to remove the lap tray.	F 221		

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F 221	Continued From page 6 -She agreed the lap tray would have been a restraint if the resident had been unable to remove it. Interview on 4/1/15 at 2:30 p.m. with the administrator regarding resident 13 revealed if a resident was unable to remove a lap tray she would consider it a restraint. Review of the provider's revised 10/4/10 Use of Restraints policy revealed: *"The resident has the right to be free from any physical or chemical restraint. They may only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried and prevent to be unsuccessful. -Shall only be used after a Pre-Restraining assessment has been completed by the MDS-coordinator or charge nurse, upon written order of a physician and after obtaining consent from the resident and/or representative."	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observations, interview, and policy review, the provider failed to ensure: *Two of two randomly observed residents (18 and 19) did not have to wait for staff to become available to assist them with eating in the	F 241		

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F 241	Continued From page 7 Robinsview dining room while the other residents had been served. *One of two sampled residents (6) was removed from the dining room table in a timely manner after completing their meal in Robinsview dining room. Findings include: 1. Observation on 3/31/15 from 11:15 a.m. through 12:05 p.m. regarding resident 18 revealed he had been in a wheelchair in the adjacent television area to the Robinsview dining room. All the other residents had been in that dining room eating. He had been brought into the dining room at 12:00 noon. He was the last person served at 12:03 p.m. Staff had to assist him with eating. The other residents at that table who needed assistance were finished eating. Observation on 3/31/15 from 4:35 p.m. through 5:35 p.m. regarding residents 18 and 19 revealed both residents were in the television area adjacent to the Robinsview dining room. All the other residents had been in that dining room eating. Both residents were brought to the dining room at 5:30 p.m. The other two residents at that table had already been served and had been eating with staff assistance. Interview on 3/31/15 at 5:35 p.m. with certified nursing assistant R revealed those residents had to wait to eat until staff were available to assist them since they needed help. She had been passing beverages and had to complete that task before she could assist the above two residents. Review of the provider's undated Nutrition Services policy revealed when staff were assisting residents food orders for all residents at	F 241	Residents 6, 18, and 19, and all other residents who require assistance with dining, will be evaluated to ensure seating/dining occurs so all residents at the table are served/ assisted in a timely manner to enhance socialization and dining experience. Three additional staff members have completed the Assisted Dining Course on 4/13/15, which will allow additional staff availability during meal times. Daily staffing assignment sheet will be modified to include assignment of staff to cover the floor or dining room during meal times. Nutrition Services policy was reviewed and dated 4/21/15. Quality of Life and Dignity Policy was reviewed and dated 4/22/15. Staff will be educated on the Quality of Life and Dignity Policy and Nutrition Services Policy during mandatory all-staff meetings held on 4/28/15, 4/29/15, and 4/30/15. Weekly observation audits will be completed by the DON, or designee, in each dining room for one meal per dining room per week for three (3) months and reported at monthly QAPI committee meeting. When QAPI committee determines otherwise, based on compliance, the frequency of audits may be decreased or discontinued.	4/30/15

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F 241	Continued From page 8 that dining table should have been taken. Residents who required assistance should not have been assisted to the dining room until staff members were ready and available to assist them with dining. 2. Random observations on 3/31/15 from 3:00 p.m. through 6:35 p.m. of resident 6 revealed: *At 3:00 p.m. she had been lying in bed. *At 4:35 p.m. she had been sitting at the Robinsview dining room table in her wheelchair. *At 5:15 p.m. she had been served beverages, and then her food shortly thereafter. *At 5:50 p.m. she had finished eating. *At 6:00 p.m. she remained at the table. *At 6:20 p.m. she remained at the table. *At 6:35 p.m. she still remained at the table. *Several staff had walked past her since 6:00 p.m. without stopping to check on her. Interview on 3/31/15 at 6:35 p.m. with the interim administrator and director of nursing B regarding resident 6 revealed: *They were unaware she had been brought to the table at 4:35 p.m. *They both agreed two hours sitting at the table was too long. *She was supposed to be repositioned every two hours due to her having a pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to the tissue). *The interim administrator asked staff to assist her to her room at that time. 3. Review of the provider's August 2009 Quality of Life - Dignity policy revealed each resident should be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality.	F 241		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to update and revise care plans for 3 of 13 sampled residents (2, 5, and 6). Findings include: 1. Observation on 3/31/15 at 8:55 a.m. of resident 6 revealed she had been holding a small plastic Dixie cup. Observation on 3/31/15 at 11:20 a.m. of resident	F 280	X [redacted] KG/SDOH/TMF The Care Plans of Residents 2, 5, and 6 have been updated as of 4/20/15 to reflect current status needs. All Care Plans will be updated as needed and reviewed by the interdisciplinary team on a quarterly basis, or as condition changes.	4/30/15

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F 280	Continued From page 10 6 revealed: *She had been at the dining room table. *She had two small plastic Dixie cups in front of her. *She had pureed (blended to a soft creamy paste consistency) pork, potatoes, peas, and a lemon bar. *She did not have a divided plate. *One of the four cups in front of her had a handle on it. *Staff had been assisting her with eating. Observation on 3/31/15 at 5:15 p.m. of resident 6 revealed: *One of three cups had a handle. *She had been served pureed foods of hot ham and cheese sandwich, mixed vegetables, and potatoes. *Staff had poured her coffee into a small plastic Dixie cup. *She did not have a divided plate. *Staff had been assisting her with eating. Review of resident 6's 3/19/15 care plan revealed the following interventions: *"I need cueing with meals after set-up. I am a helping hand. Date initiated: 10/17/13. Revision on 1/9/14. *Staff supervise and encourage me to eat at each meal as I allow. Date initiated: 10/17/13. Revision on 9/29/14. *I have been needing more encouragement to eat my meals. I will be assisted with all meals and snacks. Date initiated: 9/29/14. Revision on 12/30/14. *I am provided divided plate and cups with handles to maintain independence - I have not been using this as frequently due to increased need for assistance. These will continue to be	F 280	Resident 6's Care Plan updated to use plastic Dixie cups until small plastic glasses arrive (ordered 4/21/15). Eliminated cups with handles, as she does not use. A regular plate is now used versus the divided plate, as she needs increased assistance with dining. The diet will be consistent with the National Dysphasia diet guidelines.	

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F 280	Continued From page 11 available as I need them. Date initiated: 10/17/13. Revision on 12/30/14. *I need staff sitting with me at all meals...My diet is NDD2 with pureed meats. I use a divided plate and cups with handles. Date initiated: 10/17/13. Revision on 3/26/15." *There had been no mention of using Dixie cups or having all her food pureed. Preceptor: 33265 Surveyor: 35121 2. Review of resident 2's undated care plan revealed: *Transfer (moving from place to place) with assistance of one to two staff. *"Use front wheeled walker and assistance of one staff with wheelchair [following] behind [her]." *Transfer with assistance of two with use of a pivot disk (a device that helps someone turn their legs when standing on it). Review of resident 2's 1/5/15 mini-care plan revealed she was to "transfer with [the] assistance of one [staff person] and [with] a gaitbelt [a device used to transfer people from one position to another]." 3. Review of resident 5's undated care plan revealed he: *Was able to wander about in the Memory Care Unit. *Used a wheelchair for locomotion (moving around). *Had not been ambulating (walking). Review of resident 5's mini-care plan revealed he needed assistance of one staff person for: *Bathing. *Locomotion.	F 280	* Nursing staff and the therapy department will be educated on the care plan policy by 4/30/15. KG/SDDOH/MF Resident 2's Care Plan and mini-care plan have been updated on 4/20/15 by RN MDS Coordinator to reflect assistance of 1 for transferring, bed mobility, and to utilize wheelchair, and all other activities. Resident 5's Care Plan and mini-care plan have been updated on 4/20/15 by RN MDS Coordinator to reflect an assist of 2 for transferring, bed mobility, repositioning, and toileting. Care Planning Policy will be updated 4/24/15 to reflect process for updating information on resident status. The updated policy will be distributed to the interdisciplinary team on 4/30/15. Weekly audits of a minimum of 3 Care Plan sets per week, comparing the Care Plans and mini-care plans, will be completed by DON, or designee, for 3 months and reported monthly to QAPI committee. When the QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued.	

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F 280	Continued From page 12 *Dressing. *Personal Hygiene. Review of resident 5's 3/3/15 Minimum Data Set (MDS) assessment revealed he needed assistance of two staff with: *Bathing. *Locomotion. *Dressing. *Personal Hygiene. 4. Interview on 4/1/15 at 12:40 p.m. with MDS coordinator G revealed: *The paper care plans were to have reflected the most up-to-date information. *The mini-care plans were to have reflected the most up-to-date information. *Each member of the care team was to have updated the areas of the care plan they were responsible for. *The charge nurse was to have made changes to the care plan as they occurred. *Whoever had made a change to the care plan was responsible for having updated the mini-care plan. Review of the provider's December 2010 Care Plans-Comprehensive policy revealed: *"Care plans are revised as information about the resident and the resident's condition changes." *"The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans." Review of the provider's August 2006 Using the Care Plan policy revealed: *"The MDS Nurse uses the care plan to complete the CNA's daily/weekly work assignment sheets and/or flow sheets."	F 280		

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F 280	Continued From page 13 *"Documentation must be consistent with the resident's care plan." Review of the provider's mini-care plan form revealed: *Only nursing staff could make changes to that mini-care plan. *The charge nurses would make changes by: -"Writing in the needed information on the mini care plan with initials and date." -"Writing the information on the first page of the residents care plan."	F 280		
F 281 SS=D	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: 29354 Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to follow nursing professional standards by not ensuring a nurse had not declared death for one of one sampled resident (16). Findings include: 1. Review of resident 16's closed (no longer in facility) medical record revealed: *She had been admitted on 3/5/15. *She had died on 3/6/15. *The nurse's note on 3/6/15 at 4:11 p.m. regarding her death revealed: -The "resident had passed away at 1040 (military time for 10:40 a.m.) today."	F 281		

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F 281	Continued From page 14 -There was a telephone "order received from the ER (emergency room) for TOD (time of death) and release body to funeral home." -There was no documentation at that time of a clinical assessment of the resident. -That note had been documented by a licensed practical nurse (LPN). Interview on 4/1/15 at 2:30 p.m. with registered nurse (RN)/director of nursing (DON) A and RN/DON B revealed they agreed: *The nurses called the time of death at the facility. *There was no documentation regarding clinical signs of death for resident 16. *The nurse that documented the note regarding resident 16's death was an LPN and not an RN. Review of the provider's undated Death of a Resident, Documenting policy revealed: *"Appropriate documentation shall be made in the clinical record concerning the death of a resident." *"A resident may be declared dead by a Licensed Physician or Registered Nurse with physician authorization in accordance with state law." Review of the South Dakota Board of Nursing 8/4/14 letter clarifying the intent of South Dakota Codified Law 34-25-18 and 34-25-18.1 pronouncement of death revealed: "The Board of Nursing has been advised by legal counsel that in order for pronouncement of death to be effective it must be accompanied by a certificate, which the law recognizes, stating the party died with the cause of death and since a nurse cannot sign a death certificate, a nurse cannot pronounce death."	F 281	In keeping with SD Board of Nursing clarification, the Death of a Resident Policy has been updated on 4/24/15 to reflect their recommendation that no resident will be pronounced dead by a nurse. The nurse will notify the physician of assessment, including cessation of breathing and absence of heartbeat. Nurses will be educated at a Nurses Meeting 4/24/15. This has been added to the nurse orientation checklist. The Death of a Resident Policy has been updated to remove, "A resident may be declared dead by a Licensed Physician or Registered Nurse with physician authorization in accordance with state law." All death charts will be audited by DON, or designee, for 3 months and reported to QAPI team. When QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued.	4/30/15

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F 309 F 309 SS=D	Continued From page 15 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review and interview, the provider failed to integrate the hospice plan of care with the provider's plan of care to specify who was responsible for care for one of one (11) sampled hospice resident. Findings include: 1. Review of resident 11's medical record revealed an admission to the facility on 12/2/14. Hospice care had started two days later. Review of resident 11's undated provider's care plan revealed: * "My family is planning for me to stay here under hospice care at this time." * "Hospice aid[e] visits. She assists me with my eating on occasion." * The equipment that hospice provided and how often hospice staff visited. * No further mention was made to specify what care for the resident hospice was to provide. Review of resident 11's 3/2/15 mini care plan for the certified nursing assistants (CNA) revealed she was on hospice care. There was no mention	F 309 F 309	*resident 11 and KG/SDDOH/MF *receiving their services KG/SDDOH/MF A telephone conference on 4/21/15 with Compassionate Care Hospice and DON and Interim Administrator addressed the expectations of services provided by Compassionate Care Hospice. The Hospice Provider was present on 4/22/15 to specify provider and hospice care for residents and update Care Plan to reflect current status. Also, the Hospice Provider met with MDS Coordinator to ensure that services are coordinated between the facility and hospice services and reflected on the care plan. A Hospice Policy has been developed on 4/24/15 to enhance direction/communication. Education will be provided for Nursing Staff by 4/30/15 by Director of Education, or designee. DON, or designee, will meet with other contracted hospice providers prior to admittance to facility. To monitor, weekly audits of Care Plans for all hospice residents will be completed by the DON, or designee, for 3 months and reported to QAPI committee until QAPI determines otherwise. Based on compliance, the audits may be decreased or discontinued.	4/30/15

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F 309	Continued From page 16 of what care hospice was to provide. Interview on 4/1/15 at 2:00 p.m. with CNA N regarding resident 11 revealed: * CNA N usually worked with the resident. * Hospice "came in the morning and did all of the morning care for the resident including helping her with breakfast." * The facility staff provided the rest of the resident's care. * CNA N stated she knew what care hospice had provided that day by "verbal communication." Interview on 4/1/15 at 5:00 p.m. with the director of nursing revealed she was unaware of the need to specify provider and hospice care for residents. No hospice specific policy on resident care plans existed.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO 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 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to update interventions and follow their policy for two of	F 314	The Skin Assessment and Pressure Ulcer Prevention and Treatment Policy was updated on 4/24/15 to include comprehensive assessment, implementation of appropriate individualized interventions, monitoring and evaluating response to preventative efforts and treatments, and documentation. All nursing staff will be educated at a mandatory meeting on 4/24/15. All other direct care staff will receive this education on mandatory training dates of 4/28/15, 4/29/15, and 4/30/15.	4/30/15

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F 314	Continued From page 17 three sampled residents (3 and 6) who developed pressure ulcers (sores caused by unrelieved pressure that resulted in damage to the tissue) while residing at the facility. Findings include: 1. Review of resident 6's weekly pressure ulcer flow sheets revealed: *On 1/2/15 a stage II pressure ulcer (reddened area with a break in the skin) measuring 0.5 centimeters (cm) by 0.5 cm had developed on her tailbone. *The following measurements: -On 1/6/15 0.5 cm by 0.2 cm. -On 1/13/15 0.4 cm by 0.8 cm. -On 1/20/15 1.0 cm by 0.5 cm. -On 1/26/15 0.7 cm by 1.2 cm. -On 2/3/15 1.1 cm by 2.0 cm. -On 2/10/15 1.0 cm by 1.3 cm. -On 2/17/15 1.0 cm by 0.7 cm. -On 2/24/15 0.8 cm by 0.6 cm. -On 3/2/15 0.3 cm by 0.2 cm. -On 3/9/15 0.4 cm by 0.4 cm. -On 3/16/15 0.1 cm by 0.3 cm. -On 3/23/15 it had been closed. -On 3/30/15 it had been closed. *There had been no measurements for depth of the pressure ulcer. *On 1/20/15 the treatment had changed. *From 1/20/15 through 3/23/15 the pressure ulcer had gotten larger in size before getting smaller again. *During that timeframe: -The treatment had not changed. -There had been no documentation of notification to the physician. Review of resident 6's 1/20/15 fax to the physician revealed: *Staff had requested a change in treatment.	F 314	Residents 3 and 6 pressure ulcers (PUs) are currently healed and physicians were notified of current condition as of 4/13/15.Residents 3 and 6 will be monitored for 30 days using daily skin observations and documented. Braden Scale assessments will be completed quarterly, and if there is a significant change. Residents 3 and 6 are currently receiving nutritional supplements as recommended by the Registered Dietician. Residents' Care Plans have been updated to reflect current status. 13 pressure relieving mattresses were ordered 4/21/15, and mattresses will be placed on residents 3 and 6's beds upon arrival. Resident 6, and all other residents at risk to develop PUs,will be identified by observation, monitoring nutrition, and using Braden Scale with appropriate interventions put in place to first prevent PUs from developing, and in instance of a new PU, increased repositioning, notification of family and physician, with treatment initiated per order. *IOW KG/SDDOH/MF Resident 3's ROHO cushion is in place. Resident 3 was screened by Physical Therapy Assistant for a high ROHO, which, due to the height, prevented him from using the arm rests to reposition, and, therefore, limited independent weight shifting.	

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F 314	Continued From page 18 *They had asked to start "2x2 foam dressing to pressure area on right buttock with skin prep [preparation] to periwound [tailbone] secured with mefix tape - change QD [every day] and PRN [as needed]." Observations on 3/31/15 of resident 6 at the following times revealed: *At 12:05 p.m. she had been taken to her room from the Robinsview dining room. *At 3:00 p.m. she had been lying in bed. *From 4:35 p.m. through 6:35 p.m. she had been sitting at the dining room table in her wheelchair. Review of resident 6's 12/23/14 and 3/17/15 Minimum Data Set (MDS) assessments revealed: *She had short and long term memory problems and could not complete the resident interview. *Her ability to make daily decisions was moderately impaired. *She needed extensive assistance of two staff members to move in bed, transfer, dress, use the bathroom, and complete personal hygiene tasks. *She needed extensive assistance of one staff member to eat. *She was frequently incontinent (inability to control) of bladder and bowel. *She had been at risk for pressure ulcer development. She had a device in her chair, was on a repositioning program, received pressure ulcer care, and had an ointment administered for preventative care. Review of resident 6's 3/19/15 care plan revealed: *She did not walk. *She was at risk for skin breakdown. Interventions for that focus area included the following:	F 314	All residents at high risk for PUs (Braden Scale of 13 or less) will be on a repositioning plan, have nutritional evaluation/intervention, and receive a pressure redistribution mattress. Weekly Skin Assessment Team will monitor Braden Scores throughout the facility and discuss plan of care for residents with Braden Score of 16 or less. If changes are needed in the plan of care, it will be shared with interdisciplinary team and physician, and family updated as needed. The Skin Assessment and Pressure Ulcer Prevention and Treatment Policy will reflect that preventative measures which will be put in place for residents who are at mild risk (Score of 16 of less on Braden Scale). Weekly audits of a minimum of 3 residents will be completed by the DON, or designee, to assure The Skin Assessment and Pressure Ulcer Prevention and Treatment Policy is being followed. The findings will be reported monthly to the QAPI committee for three months. When the QAPI committee determines otherwise, based on compliance, the frequency of audits may be decreased or discontinued.	

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F 314	Continued From page 19 -"I have a stage II pressure area to right buttock [bottom], nursing monitor area QD and MDS to measure weekly until healed. See TAR [treatment administration record] for tx [treatment] and wound book for measurements. Date initiated: 3/26/15. -Braden scale with each MDS and PRN. Date initiated: 10/16/13. Revision on 11/4/13. -I am on a turning plan. Date initiated: 10/16/13. Revision on 11/4/13. -I have a body pillow. Date initiated: 10/17/13. Revision on 11/4/13. -I have a cushion in my w/c [wheelchair]. Date initiated: 10/16/13. Revision on 11/4/13. -I have new shoes to provide my feet comfort and not cause any areas of breakdown. Date initiated: 10/16/13. Revision on 11/4/13. -I should lay down in the afternoon but would be nice to be up for afternoon activity. Date initiated: 10/16/13. Revision on 11/4/13. -I wear incontinent products to help keep my skin dry. Date initiated: 10/16/13. Revision on 11/4/13. -Nursing staff will follow my repositioning program. Date initiated: 10/16/13. Revision on 11/4/13. -Please see nutrition related focus for further nutrition related interventions. Date initiated: 9/29/14. -Staff will assist me with toileting, complete peri-cares [personal cares], and change my incontinent product when soiled per toileting plan. Date initiated: 10/16/13. Revision on 11/4/13. -Staff will observe my skin with cares and toileting. Date initiated: 10/16/13. Revision on 3/27/15. -Staff will put protective ointment to my bottom/back twice a day for my scratches. Date initiated: 10/16/13. Revision on 11/4/13." *She needed assistance with her activities of daily	F 314		

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F 314	Continued From page 20 living. She could use the bathroom but was frequently incontinent and was on a toileting program. That intervention had been revised on 3/26/15. *There had been no nutritional interventions, no pressure relieving mattress, and no interventions from the physician listed. Review of resident 6's Braden Scale for Predicting Pressure Sore Risk assessments revealed: *On 9/23/14 and 12/23/14 she was at moderate risk to develop a pressure ulcer. *On 3/17/15 she was at high risk for developing pressure ulcers. She had already developed a pressure ulcer at that time. 2. Review of resident 3's weekly pressure ulcer flow sheets revealed: *On 3/6/15 a stage II pressure ulcer measuring 0.4 cm by 0.4 cm had developed on his tailbone. -On 3/9/15 it had healed. *On 3/6/15 a stage II pressure ulcer measuring 0.6 cm by 0.5 cm had developed on his left buttock. -On 3/9/15 it had healed. *On 3/24/15 a stage II pressure ulcer measuring 0.2 cm by 0.2 cm had developed on his tailbone. *On 3/30/15 it had measured 0.2 cm by 0.5 cm. Observation and interview on 3/31/15 at 8:55 a.m. with an unidentified certified nursing assistant (CNA) revealed they were assisting resident 3 into the bathroom. Observation on 3/31/15 at 10:30 a.m. of resident 3 revealed he was resting in his recliner in his room.	F 314		

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F 314	Continued From page 21 Observation on 3/31/15 at 11:15 a.m. revealed resident 3 was in the dining room eating partially on his own, but staff were cueing him. Observation and interview on 3/31/15 at 11:45 a.m. with CNA E revealed: *She had taken resident 3 back to his room. *She had transferred him into his bed using a stand aid. *She had not gotten help to assist with the transfer. *She had not asked him if he needed to use the bathroom. *She had not assisted him with toileting. *She placed a long pillow under his right side to shift his weight. *She stated he used to walk, but he had become weaker. *He used to do a pivot transfer but that required two staff members, so they used the stand aid to transfer him. Observation on 3/31/15 at 3:00 p.m., 3:30 p.m., and 3:46 p.m. of resident 3 revealed he had been laying in bed in the same position as earlier at 11:45 a.m. The long pillow was still under his right side. Observation on 3/31/14 at 4:35 p.m. of resident 3 revealed he was at the table waiting for supper to be served. At 5:15 p.m. he was served a sandwich, steak fries, corn and peaches. He was eating the steak fries on his own, and staff sat down to assist him. Review of resident 3's 7/8/14 significant change MDS assessment revealed: *His thinking ability was moderately impaired. *He needed extensive assistance from two staff	F 314		

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F 314	Continued From page 22 members to move in bed, transfer, walk in his room, dress, and use the toilet. *He needed extensive assistance from one staff member to move in the hallways and bath. *He ate independently. *He was occasionally incontinent of urine. *He was not at risk for pressure ulcers but had a device in his chair. Review of resident 3's quarterly 10/7/14 MDS assessment revealed: *His thinking ability was not impaired. *He needed extensive assistance from one staff member to move in bed, transfer, walk in his room, move in the hallways, dress, use the toilet, complete his personal hygiene and bath. *He needed supervision of one staff member to eat. *He was occasionally incontinent of urine. *He was not at risk for pressure ulcers, but had a device in his chair and used a preventative ointment. *He had improvements since his last MDS on 7/8/14. Review of resident 3's significant change 12/9/14 MDS assessment revealed: *Staff had identified he had long and short term memory problems and could not complete the resident interview. *He needed extensive assistance from two staff members to move in bed, transfer, move in the hallways, dress, use the toilet, and complete personal hygiene. *He needed limited assistance from one staff member to walk in his room. *He had not walked in the hallway. *He needed extensive assistance from one staff member to eat.	F 314		

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F 314	Continued From page 23 *He was frequently incontinent. *He was at risk for developing pressure ulcers. He had a device on his chair and used a preventative ointment. Review of resident 3's significant change 3/10/15 MDS assessment revealed: *His thinking ability was moderately impaired. *He needed extensive assistance from two staff members to move in bed, transfer, move in the hallways, dress, use the toilet, and complete personal hygiene. *He needed extensive assistance from one staff member to eat and bath. *Walking in his room or in the hall had not occurred. *He was frequently incontinent of urine. *He was at risk for developing pressure ulcers. He had a device on his chair and bed and used a preventative ointment. Review of resident 3's 10/7/14, 12/9/14, and 3/10/15 Braden Scale for Predicting Pressure Sore Risk assessments revealed he was at risk for developing pressure ulcers. The 10/7/14 Braden scale assessment did not match the 10/7/14 MDS assessment that indicated he was not at risk. Review of resident 3's 3/19/15 care plan revealed: *He needed assistance with his activities of daily living. -An intervention for that focus area included being on a toileting plan due to being frequently incontinent of bladder and occasionally incontinent of bowel. *He was at risk for skin breakdown (pressure ulcers and or abrasions). Interventions for that	F 314		

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F 314	Continued From page 24 focus area included the following: -"Dietary will monitor intakes. Date initiated: 10/17/13. Revision on 11/4/13. -I am encouraged to change positions often to relieve pressure off my bottom. Date initiated: 10/17/13. Revision on 11/4/13. -I am frequently incontinent of bladder and occasionally incontinent of bowel. Staff assist with toileting. Staff assist with changing incontinent product when soiled. Date initiated: 10/17/13. Revision on 12/19/14. -I do have a diagnosis of depression and take antidepressants and see [name of mental health provider]. Date initiated: 10/17/13. Revision on 11/4/13. -I feel that I get up frequently enough throughout the day. Date initiated: 10/17/13. Revision on 11/4/13. -I had pressure areas to my bottom that occurred on 3/6/15 and resolved on 3/9/15. Monitor area x [times] 30 days and continue preventative tx [treatment]. Date initiated: 3/19/15. -I have a pressure relieving cushion in my w/c [wheelchair] along with my recliner. Date initiated: 10/17/13. Revision on 3/19/15. -I have a transfer bar on my bed. My Braden is 17 [at risk for pressure ulcers]. Date initiated: 1/24/14. Revision on 3/19/15. -I have diabetes, nursing will monitor lab [laboratory tests] and blood sugars as ordered. Date initiated: 4/17/14. -I will consume protein with each meal. Encourage me to consume 4 ounces milk with my breakfast cereal and offer me PB [peanut butter] if I have toast. I do not want scheduled snacks at this time. Date initiated: 7/13/14. -Labs will be monitored as ordered. Date initiated: 10/17/13. Revision on 11/4/13. -Staff assist with positioning. I am on a	F 314		

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F 314	Continued From page 25 re-positioning plan. Date initiated: 12/19/14. -Staff will observe for [skin] breakdown with cares and toileting. Date initiated: 4/17/14. Revision on 7/15/14." Review of resident 3's 3/19/15 repositioning plan revealed he was to be repositioned every two hours during awake hours and on rounds at night. That involved completely lifting him and removing all weight from his bottom and other dependent areas. Two staff members were to be used. The goal was to prevent skin breakdown related to pressure, they indicated they had met that goal. Review of resident 3's 3/19/15 toileting schedule revealed he was to be "offered the toilet at get up, every two hours during awake hours, and offer the toilet on rounds at night." He was to be assisted by two staff members. Interview and document review on 4/1/15 at 11:50 a.m. with MDS coordinator C regarding resident 3 revealed: *They had changed his cushion in his wheelchair from a high ROHO cushion to a low ROHO cushion. *She did not know when that had occurred. *He currently had the low ROHO cushion in his chair. *Physical therapy (PT) had made the change but had not documented it anywhere. *PT had provided her a document with the kind of ROHO cushions they were. *The high ROHO cushion would be used for "those unable to independently shift weight." *The low ROHO cushion would "maximize stability and prevents risk of potential tissue breakdown...It is for those who can independently shift weight and transfer."	F 314		

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F 314	Continued From page 26 *According to the above MDS assessments he could not shift his weight or transfer independently. Review of resident 3's interdisciplinary notes revealed a note on 3/9/15 titled "Communication - with physician." The note stated "new chair cushion placed on 3/6/15." That was the date the first pressure ulcer had developed. 3. Interview and document review on 4/1/15 at 10:45 a.m. with director of nursing B and MDS coordinator C regarding residents 3 and 6 revealed: *Neither resident currently had a pressure relieving mattress on their bed. *They only had overlays in the building. There were no pressure relieving mattresses that they were aware of. *Staff had discussed buying all new mattresses for the facility, but that had not happened. *They had asked the supervisor of housekeeping in front of this surveyor if they had pressure relieving mattresses. She said no there were none in the building. *They had attempted the overlay on resident 3's bed, but he would move around so they took it off. *She was unsure of when they had attempted that. *Resident 6 had never had any type of pressure relieving mattress. *Resident 6 had developed her pressure ulcer because of the staffing issue. *She had not been getting assisted to the bathroom which prompted them to initiate the red dot program (a system where a red dot is placed with the individual and once a CNA finds the dot after assisting the resident the CNA reports to the	F 314		

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F 314	Continued From page 27 charge nurse and turned in the red dot). *They had started the red dot program back in February 2015. *On 3/19/15 the red dot had been placed with resident 6 at 8:17 a.m. and not found until 12:30 p.m. *They had not contacted resident 6's physician since 1/20/15 to request a change in pressure ulcer treatment. *The care plan revision date would be when the intervention had last been revised. *Nutritional interventions for wound healing had been started after the development of the pressure ulcers. *They had not been following their Skin Assessment and Pressure Ulcer preventative policy. *They did not have an interdisciplinary team (IDT) to address residents at risk for pressure ulcer development. Review of the provider's 4/6/13 Skin Assessment and Pressure Ulcer Prevention and Treatment Policy revealed: *Residents identified to be at risk for skin breakdown or who currently had skin breakdown would have specific interventions care planned by the IDT. *If a resident had a pressure ulcer daily documentation was to be completed by a licensed nurse. *A consultant wound nurse could have been consulted if needed.	F 314		
F 323 SS=D	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		

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F 323	Continued From page 28 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		
	This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on observation and interview, the provider failed to keep cleaning supplies separated from personal care products in one of three (Morning View) whirlpool tub rooms. Findings include: 1. Observation on 3/31/15 at 10:50 a.m. of the Morning View wing whirlpool tub room revealed: *Spray container of Vindicator (a cleaning, deodorizing, and disinfectant solution) was on the second shelf of the top cupboard on the right side of the whirlpool tub along with residents' personal hair care product sprays. *The label on the spray bottle for Vindicator stated it could cause eye irritation. Interview on 4/1/15 at 10:48 a.m. with the directors of housekeeping and maintenance revealed they agreed the cleaning supplies should have been stored separately from the personal care items. A policy regarding chemical safety was requested but was informed on 4/1/15 at 11:43 a.m. by the director of nursing/registered nurse A there were no safety policies regarding chemicals. B. Based on observation, interview, and policy review, the provider failed to keep one of three		Cleaning supplies are now stored in a locked and labeled cupboard separated from resident care products. Resident care supplies are stored and marked in large bags or plastic containers and kept in resident rooms. Staff will be educated by DON, or designee, during mandatory all staff education held 4/28/15, 4/29/15, and 4/30/15. A policy regarding chemical safety will be developed by 4/28/15 to be presented at mandatory all staff training held 4/28/15, 4/29/15, and 4/30/15. Weekly audits will be done on a minimum of one whirlpool tub room by DON, or designee, for 3 months and reported to QAPI team. When the QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued.	4/30/15

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F 323	Continued From page 29 whirlpool tubs (Morning View) free of a possible skin and tissue injury hazard. Findings include: 1. Observation on 3/31/15 at 10:50 a.m. of the Morning View wing whirlpool tub room revealed: *An S hook was holding the leg plate of the tub chair down and back. *Any resident who used the whirlpool tub could have had a leg or legs come in contact with either of the two open ends of the S hook causing skin and tissue injury. Interview on 4/1/15 at 10:43 a.m. with the director of maintenance revealed he: *Had not known the leg plate was being secured back with S hooks and a bungee cord. *Agreed the open ends of the S hook. The contact could have injured a resident's leg while using the whirlpool tub. Review of the provider's 2001 Safety and Supervision of Residents policy revealed safety risks and environmental hazards were to have been identified on an ongoing basis through: *Employee training. *Employee monitoring. *Reporting processes. *Quality Assurance safety reviews. Review of provider's undated Integrity Bath Cleaning Procedure revealed the staff were to have notified maintenance of any issues with equipment in tub room.	F 323	The S hook/bungee cord was removed by maintenance on 4/1/15 and the Director of Environment Services educated Maintenance staff not to use bungee cords in patient care areas. All staff will be educated at mandatory all staff training held 4/28/15, 4/29/15, and 4/30/15 on modifying equipment, [redacted] the importance of safety and cleanable surfaces*, and reporting to maintenance Weekly audits will be completed on a minimum of one whirlpool tub room by DON, or designee, for 3 months and reported to QAPI team. When QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued. K6/5000H/MF	
F 353 SS=G	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or	F 353		

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F 353	Continued From page 30 maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Surveyor: 35121 Surveyor: 29354 Surveyor: 35237 Surveyor: 32335 Based on observation, record review, and interview, the provider failed to maintain adequate staff to prevent care issues and meet basic care needs for: *Two of four sampled residents (3 and 6) who had developed pressure ulcers (sores caused by unrelieved pressure that resulted in damage to	F 353		

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F 353	Continued From page 31 the tissue) after admission into the facility. *Two of two random observed residents (18 and 19) who needed assistance with eating. *Two of four sampled residents (2 and 5) in the memory support unit who had declines in their activities of daily living. Findings include: 1. Review of resident 3 and 6's medical record revealed they had developed pressure ulcers after admission into the facility. Refer to F314, findings 1, 2, 3 and 4. 2. Random observations and interview on 3/31/14 regarding residents 18 and 19 revealed they had to wait for staff to be available before they could eat. Refer to F241, finding 1. Preceptor: 33265 Surveyor: 35121 3. Observation on 3/31/15 from 9:05 a.m. through 12:09 p.m. of resident 2 in the Memory Care Unit (MCU) lounge revealed at: *9:05 a.m. she was asleep in a recliner with her feet elevated on the foot rest. *11:10 a.m. she had remained asleep in the recliner in the same position. *11:12 a.m. a licensed practical nurse had awoken her and administered her medications to her. *11:38 a.m. she had remained awake in the recliner in the same position. *11:42 a.m. she had fallen asleep in the recliner in the same position. *1153 a.m. she had awoken. *11:58 a.m.: -She asked CNA N to take her to the dining room table. -CNA N asked her to "wait a few minutes."	F 353	Residents 3 and 6 Pressure Ulcers (PUs) are currently healed and physicians were notified of current condition as of 4/13/15. Residents 3 and 6 will be monitored for 30 days using daily skin observations. During quarterly MDS the Braden Scale assessments will be completed, and if there is a significant change. Residents 3 and 6 are currently receiving nutritional supplements as recommended by the Registered Dietician. Residents Care Plans have been updated to reflect current status. Residents 2, 5, 18, and 19, and all other residents who require assistance with dining, will be evaluated to ensure seating/dining occurs so all residents at the table are served/assisted in a timely manner to enhance socialization and dining experience. To assist in dining, 3 additional staff have completed the Assisted Dining Course on 4/13/15. Resident 2 has a repositioning plan in place, and is part of the plan of care. Resident 2, and all other residents at risk in Memory Care, will be assessed quarterly with MDS assessment, and with significant change, and an appropriate repositioning plan will be instituted based on needs. Resident 5's mobility was assessed by the Physical Therapy Assistant and an updated restorative plan put in place on 4/23/15. All staff will receive education on the Nutrition Services and Quality of Life and Dignity Policy, which includes the importance of assistance in a timely manner during dining experience on 4/28/15, 4/29/15, and 4/30/15.	4/30/15

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F 353	Continued From page 32 -CNA N assisted another resident to the bath room. *12:07 p.m. CNA N assisted her to the dining room table. Interview on 3/31/15 at 10:30 a.m. with CNA N revealed she stated: *Resident 5 had been on a walking program but was no longer walking. *Six residents had been on a walking program. *Six residents now required the assistance of two staff members. *They (staff): -No longer performed the walking program because they "don't have time to do much more than the basic care." -"I have to choose between helping a resident go to the bathroom or walking another one. I need to help the one who needs to use the bathroom first." -"We are short [not working with full staff] a lot." *A worker had called in and they "begged" her co-worker who was to leave at 10:00 a.m. to stay. *She would be working alone on Sunshine today from around 2:15 p.m. through 4:30 p.m. *Her schedule reflected she was to be in Morningview unit for her whole shift. *Staffing issues had been a problem starting back in October 2014. 4. Observation on 3/3/15 from 11:35 a.m. through 12:12 p.m. of resident 5 in the MCU revealed: *11:35 a.m. he was at the dining room table in his wheelchair with his eyes closed. *11:50 a.m. his food was sat in front of him. *12:12 p.m. CNA N had begun assisting him with eating. Surveyor: 29354	F 353	All resident call lights should be answered within 10 minutes. If there is a delay in intervention, this resident needs to be made aware of approximate time of interventions. On 4/26/15 the Administrator will conduct the facility's Annual Meeting and share with attendees (which includes Board Members, residents, families, and staff) the facility's plan to recruit and retain staff members, and seek input from stake holders present. This topic will be addressed at the Resident Council meeting 4/24/15 and periodically at residents' request. Staff turnover is expected to continue at semester time, due to number of nursing students employed. Historically, school breaks have impacted staffing. To be proactive, contracts have been completed with staffing agencies to supplement staff during these times. A staffing recruitment and retention committee has been meeting weekly to develop ideas and strategies. A sign-on bonus and referral bonus have been implemented for Full and Part Time Nursing Staff which is retroactive to 3/1/15. The facility has contracted with staffing agencies to schedule CNAs and RN/LPNs to assist residents and staff while in the process of hiring and training new employees. HR staff visited Brookings High School CNA class on 3/9/15, participated in a city-wide job fair 3/25/15, and expanded job posting advertisements to include increased radio advertisements, Elkton newspaper, Town Shopper, 3rnet.org, craigslist.com, as well as local flyers posted in the area. HR staff will attend a Nursing Student forum on 4/28/15 in attempt to recruit CNAs and nursing staff.	

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F 353	Continued From page 33 5. Confidential interview on 3/31/15 at 10:30 a.m. with a small group of residents revealed: *A few of the residents felt the staff had not answered their call lights at night. One resident had waited forty minutes and finally shut the call light off him/herself. *One resident felt there had been a problem with call lights being answered in the late afternoon and after the evening meal. *One resident felt the staff would place dependent (required staff assistance) residents in the dining room at 5:00 p.m. and make them wait until 7:00 p.m. before taking them back to their rooms. *A few residents felt the evening shift needed more help. *One resident felt there had been "a big turnover in staff at the end of each semester." *One resident felt there was not enough staff on the night shift or on the weekend shift to help the residents. *One resident felt the staff "brush off" what we ask for." Preceptor: 29354 Surveyor: 35237 6. Interview on 3/30/15 at 4:50 p.m. with RN J revealed: *The provider had been having staffing issues that affected resident care. *The decreased staffing was more evident in the late afternoon, at evening, and at night. *She felt administration was trying to work on the problem, but they could do a better job. *Sometimes there were only three CNAs for the whole building. -She felt that was not enough for seventy-eight residents.	F 353	On April 11 & 12, the Interim Administrator discussed with federal and state legislators workforce challenges currently impacting long term care advocating for changes in reimbursement that would enhance the opportunity to recruit and retain qualified staff. They were also encouraged to engage their colleagues' in these discussions and recognize the commitment of the long term care staff in caring for the country's most vulnerable citizens. *through 2015 KG/SDDOH/MF Director of HR will submit a monthly report to QAPI committee that will include vacant positions, turnover rates (both regret and non-regret), and recruitment activities. *The MDS coordinator will notify the DON, or designee weekly of all significant changes. The DON, or designee will report to QAPI committee for 3 months. When the QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued. KG/SDDOH/MF	

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F 353	Continued From page 34 Interview on 4/1/15 at 10:30 a.m. with activity coordinator K revealed: *The activity department had recently been down one staff member. *The provider had been using the remaining activities staff as CNAs at times because of the shortage of CNAs. *That sometimes the activity documentation would not get done, because activities was working on the floor. Surveyor: 32335 Multiple random interviews on 3/31/15 and on 4/1/15 with the interim administrator, the director of finance, director of nursing A, and director of nursing B revealed they had been experiencing staffing issues. They had a 2 percent unemployment rate in the city and were finding it difficult to find new employees. They had attempted an incentive program in February 2014. They had began using a temporary service today. Interview on 3/31/15 at 2:30 p.m. with human resources generalist Q revealed: *It could not be determined who was working on which unit on any given day based on the staffing calendar and twenty-four hour staff sheets. *This surveyor had requested who had been working in the memory support unit on 3/27/15, but she had not provided that information by the end of the survey. *If someone was scheduled on one unit and pulled to work a few hours on a different unit that was not put on the calendar. *Time cards would not have reflected what unit they had worked on.	F 353		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=E	Continued From page 35 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 29354	F 431	Nursing staff will count controlled medications that are stored in the refrigerator in the medication room during shift to shift count effective 4/19/15. All Scheduled II-IV controlled substances are stored in a secured medication room or cart and only accessible to licensed nursing, Pharmacy, and medical personnel designated by the facility. All medication room security codes were reset and restricted to only nurses on 4/15/15. Nursing staff have been instructed to keep their medication room code secure and not share with other staff. DON will keep track of all nursing staff medication room codes and remove codes of staff who no longer work at the facility. This will be monitored through observation and if a security breech is suspected, codes will be reset. With a suspected breech, an investigation will occur, which may include disciplinary action, and security codes will be reset. Bottles of fluticasone will be stored with the lids on in individual bags in the medication cart effective 4/24/15. The facility will update Delivery and Receipt of Routine Medication Deliveries, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, and Inventory Control of Controlled Substances Policies in conjunction with Omnicare Representative and/or consultant Pharmacist to ensure safety and security of medications throughout the facility. Nursing Staff have been informed of the new process that will be completed by only licensed nurses effective 4/24/15.	4/30/15

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F 431	Continued From page 36 Surveyor: 35237 Based on observation, interview, and policy review, the provider failed to: *Maintain accountability for eight of eight controlled medications in one of one medication room refrigerator. *Properly secure controlled medications from unauthorized personnel in one of one medication room. *Properly store six of six nasal sprays in two of four observed medication carts (Sunshine and Southridge). Findings include: 1. Observation on 4/1/15 at 1:30 p.m. of the medication room revealed: *Two opened bottles of lorazepam intensol (an oral controlled [governement monitored due to the high potential for abuse] anxiety medication) in the door of the refrigerator with count sheets attached to the outside of each bottle by a rubber band. *Three sealed bottles of lorazepam intensol in the door of the refrigerator without any count sheets. *Two sealed vials of lorazepam injectable (an intramuscular [injection] controlled anxiety medication) without any count sheets. *One opened vial of lorazepam injectable with no count sheet. Interview on 4/1/15 at the same time as the above observation of the medication room with the Minimum Data Set assessment (MDS) nurse G revealed: *She had been unsure if the nurses counted the above controlled medications at shift change to ensure accountability. *Each nurse had their own code to get into the	F 431	*Weekly audits will be done by the DON, or designee for 3 months and reported to QAPI team. When the QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued. KG/SDOOH/MF	

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F 431	Continued From page 37 medication room. *She agreed all nurses had access to the medication room, refrigerator, and those controlled medications. *She agreed there would be no way of knowing if or when one of those controlled medications went missing. Interview on 4/1/15 at 2:30 p.m. with registered nurse (RN)/director of nursing (DON) A and RN/DON B revealed: *There was no tracking system of the controlled medications in the medication room. *There would be no way of knowing if or when one of those controlled medications went missing. *All the nurses had their own code to the medication room. *Three other non-nursing staff had access to the medication room that included the human resources director, the human resources generalist, and the medical records director. Review of the provider's revised 1/1/13 Delivery and Receipt of Routine Medication Deliveries policy revealed: *"After taking delivery, Facility should place medications in the appropriate location for use." *The facility should "Immediately log controlled substances into Facility's controlled medication inventory system and should store such controlled substances in compliance with Applicable law." Review of the provider's revised 1/1/13 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy revealed: *The "facility should ensure that only authorized Facility staff, as defined by facility, should have	F 431		

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F 431	Continued From page 38 possession of keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable law." *The "facility should ensure that Schedule II-IV controlled substances are only accessible to licensed nursing, Pharmacy, and medical personnel designated by facility." *The "facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security." Review of the provider's revised 1/1/13 Inventory Control of Controlled Substances policy revealed: *"A facility representative should regularly check the inventory records to reconcile inventory." *"Facility should regularly reconcile:" -"Current and discontinued inventory of controlled substances to the log used in Facility's controlled medication inventory system." -"Current inventory to the controlled medication declining inventory record and to the resident's MAR (medication administration record)." 2. Observation on 4/1/15 at 1:30 p.m. of the medication room with MDS nurse G revealed: *She entered a code into the keypad on the door to enter the room. *All the nurses had their own code to access the medication room. *There were controlled medications in the refrigerator. Interview on 4/1/15 at 2:30 p.m. with RN/DON A and RN/DON B revealed:	F 431		

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F 431	Continued From page 39 *All the nurses had their own code for the key pad to access the medication room *All nurses would have been able to access the controlled medications. *Three other non-nursing staff currently had a code to access the medication room that included the human resources director, the human resources generalist and the medical records director. *The provider had not disabled an employee's code when they were no longer employed at the facility. *There was a way to disable the code per the instruction manual, but they had not done that. *They agreed the previous employees that had a code to the medication room would still have access to the medication room and the controlled medications. Review of the provider's revised 1/1/13 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy revealed: *The "facility should ensure that only authorized Facility staff, as defined by facility, should have possession of keys, access cards, electronic codes, or combinations which open medication storage areas. Authorized staff may include nursing supervisors, charge nurses, licensed nurses, and other personnel authorized to administer medications in compliance with Applicable law." *The "facility should ensure that Schedule II-IV controlled substances are only accessible to licensed nursing, Pharmacy, and medical personnel designated by facility." *The "facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security."	F 431		

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F 431	Continued From page 40 3. Observation and interview on 4/1/15 at 1:50 p.m. with MDS nurse G of the Southridge (100 unit) medication cart revealed: *Two bottles of fluticasone (medicated) nasal spray laying on their sides in the bottom drawer of the cart next to other medications including nebulizers and inhalers. *One of the bottles did not have a cap over the applicator. *She agreed the bottles were not stored properly, and there would be a potential for contamination. Observation on 4/1/15 at 3:10 p.m. with RN H of the Sunshine (400 unit) medication cart revealed: *Four bottles of fluticasone nasal spray laying on their sides in the bottom drawer of the cart next to other medications including nebulizer medications and inhalers. Interview on 4/1/15 at 2:30 p.m. with RN/DON A and RN/DON B revealed they agreed the nasal sprays had not been stored properly and there was a potential for contamination. Review of the provider's revised 1/1/13 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy revealed: *The "facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding." *The "facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals." *"Topical (external) use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration."	F 431		

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F 441 F 441 SS=E	Continued From page 41 483.65 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	1. Cleaning chemicals for the South-ridge whirlpool tub were ordered and inserviced on 4/22/15 for CNA staff with ongoing inservicing included on the CNA Skills Orientation Checklist. *See page 45. KG15DDDH1MF 2. Cleaning chemicals for the Morning View and Robinsview whirlpool tubs have been ordered as of 4/22/15. A representative from MasterCare deemed the current products satisfactory. When chemical arrives, immediate education to direct care staff will be provided prior to product being utilized. Whirlpool tub cleaning has been added to the CNA Skills Orientation Checklist. *See page 44 KG15DDDH1MF The tub cleaning policy was updated to reflect the manufacturer's guidelines for the cleaning of the tub on 4/3/15 and 4/18/15. Signs were posted in each tub room on 4/6/15 for staff on appropriate cleaning of each whirlpool tub. New belt was replaced on Southridge wing whirlpool tub on 4/17/15. All padding was replaced by Maintenance Staff on the Southridge and Morningview whirlpool tubs on 4/20/15. Inspection of whirlpool tubs and padding/belts will be incorporated into preventative maintenance schedule. The DON, or designee, will complete weekly audits on proper cleaning of whirlpool tubs and ensure surfaces remain intact for three months and report monthly to QAPI committee. When QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued.	4/30/15

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F 441	Continued From page 42 This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review and procedure review, the provider failed to ensure all infection prevention measures were taken including: *Cleaning and disinfection of three of three whirlpool tubs following the manufacturer's instructions. *Padding in two of three whirlpool tubs (Morning View and Southridge) were cleanable surfaces. *Residents' laundered clothing were covered on all sides and on the top of two of two mobile residents' laundry carts when transported through the hallways. *Nebulizer equipment was properly cleaned after each use for two of two observations of one of one registered nurse (J). Findings include: 1. Observation on 3/31/15 at 10:15 a.m. in the Southridge wing whirlpool tub room revealed: *The tub was manufactured by the Apollo Corporation called the Advantage Bathing System. *A sign was posted identifying how to clean the tub room after a bath. The steps included: -"Spray tub with Vindicator (Suprox [multi-purpose cleaner] on Mondays)". -"Wait." No time amount for waiting had been identified. -"Scrub tub with brush." -"Rinse tub with water." -"Fill tub for next resident (only on MV tub)." 2. Observation on 3/31/15 at 10:44 a.m. of	F 441	A new covered linen cart arrived on 4/15/15, and will be used for the transportation of clean linens. The old linen cart has been removed from service. A Transportation of Linens policy was developed 4/22/15. Laundry Staff was educated on 4/22/15 and 4/23/15 by the Housekeeping/Laundry Supervisor. Resident 22, and other residents receiving nebulizer treatments will receive nebulizer therapy. Nebulizer Treatments Policy was revised 4/20/2015 to ensure appropriate delivery of therapy and cleaning equipment. Education will be provided by the DON, or designee, to nurses and UAPs on 4/24/15 and during mandatory all-staff meetings held on 4/28/15, 4/29/15, and 4/30/15. DON, or designee, will conduct weekly audits on the proper cleaning of a minimum of 3 nebulizers for three months and report findings monthly to QAPI committee. When QAPI committee determines otherwise, based on compliance, the audits may be decreased or discontinued. *(continued from page 42, #1) Education will be provided by environmental services, DON, or designee. KG/SDDOH/MF	

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F 441	Continued From page 43 certified nursing assistant (CNA) O in the Robin's View/Sunshine wings whirlpool tub room revealed: *The tub was manufactured by MasterCare called the Entree Bath. *There were no printed instructions on cleaning the whirlpool tub posted. *CNA cleaned and disinfected the tub. She: -Closed the tub door. -Sprayed the tub surfaces with Vindicator (a cleaning, deodorizing, and disinfectant solution). -Waited for fifteen minutes. -Sprayed the tub surfaces with warm water from a hand held spray wand. -Brushed tub surfaces with a long handled scrub brush. Had not scrubbed the tub surfaces when disinfectant was on the surfaces, but waited until the disinfectant had been sprayed off. -Sprayed the tub surfaces with warm water from a hand held spray wand again. -Let the tub air dry. 3. Observation on 3/31/15 at 10:50 a.m. of Morning View wing whirlpool tub room revealed: *The tub was manufactured by MasterCare called the Integrity Bath. *There were no printed instructions on cleaning the whirlpool posted. 4. Interview on 3/31/15 at 4:50 p.m. with the director of nursing (DON)/registered nurse (RN) A revealed: *She had no idea why the instructions posted in the Southridge wing whirlpool tub room stated to use a different cleaning solution on Mondays. *She would find the manufacturer's instructions for all three whirlpool tubs. Interview on 4/1/15 at 10:43 a.m. with the	F 441	*(continued from page 42, #2) Education will be provided by environmental services, DON, or designee. KG/SDDH/MF	

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F 441	Continued From page 44 maintenance director revealed: *He had given the manufacturers' instructions for the whirlpool tubs to the DON. *A vendor had stated the Vindicator product was the same as what the whirlpool tub manufacturers suggested to use. *He had no documentation from the manufacturers on using alternate cleaners/disinfectants. Record review of the February 2015 Apollo manufacturer's instructions revealed: *The whirlpool tub in the Southridge wing was to have been cleaned using two different products, both pumped through the jets to clean the system. Those were: -First cleaned with the Turbo Clean to remove residue, bacteria, and gross soils. -Next clean with Cid-A-L II quaternary (specific type) disinfectant.* *There were specific instructions on how much of each cleaning solution to use, how to pump through the air jets, how to rinse and clear cleaning solutions out of the jets. *The specific instructions from the manufacturer had not been followed. Record review of the 11/5/04 MasterCare manufacturer's instructions for the Entree Bath revealed: *The whirlpool in the Robin's View/Sunshine wings was to have been cleaned using a MasterCare disinfectant cleaner. *There were specific instructions on how much of the disinfectant to use. *Instructions included to scrub tub surfaces with the disinfectant. Review of the 2/18/13 MasterCare manufacturer's	F 441		

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F 441	Continued From page 45 instruction for the Integrity Bath revealed: *Directions for using MasterCare cleaner/disinfectant product. Review of the provider's revised 3/31/15 Cleaning Apollo Tub Policy revealed they were to: *Use Vindicator disinfectant. *Scrub tub surfaces ten minutes after spraying Vindicator on tub surfaces. Any area where dirt/material on the tub that would be dislodged by scrubbing would not get contact time needed with the disinfectant to kill germs. Review of the provider's undated Cleaning Entree Tub Policy revealed they were to: *Use Lysol IC cleaner/disinfectant, not the manufacturer's recommended cleaner/disinfectant or the Vindicator being used. *Scrub tub surfaces ten minutes after spraying Lysol IC on tub surfaces. Any area where dirt/material on the tub that would be dislodged by scrubbing would not get contact time needed with the disinfectant to kill germs. Review of the provider's undated Integrity Bath Cleaning Procedure revealed they were to: *Use the disinfectant wand on the tub to spray the tub surfaces with an unspecified disinfectant, not the Vindicatory spray bottle. *Scrub the tub surfaces with the disinfectant and then wait ten minutes. Interview on 4/1/15 at 3:00 p.m. with the DONs/RNs A and B revealed: *They were not aware they should be following the manufacturers' instructions regarding the cleaning of the whirlpool tubs. *They had no documentation from the manufacturers on using alternate	F 441		

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F 441	Continued From page 46 cleaners/disinfectants. 5. Observation on 3/31/15 at 10:15 a.m. in the Southridge wing whirlpool tub room revealed there was a belt used in the tub that had rough edges. Those rough edges could have damaged the skin. 6. Observation on 3/31/15 at 10:50 a.m. of the Morning View wing whirlpool tub room revealed each piece of padding and the belt used in the tub had cracks, rough areas with exposed internal foam, or holes in the covering making it a resident safety issue and also an uncleanable surface. 7. Interview on 4/1/15 at 10:43 a.m. with the maintenance director revealed: *He was unaware the padding was damaged in the Morning View tub. *He agreed the padding and belts were not able to be cleaned in the present condition. *He agreed the padding in the Morning View tub and the belts in both the Morning View and Southridge tubs needed to be replaced. Review of provider's undated Integrity Bath Cleaning Procedure revealed the staff were to have notified maintenance for any issues with equipment/tub room. Surveyor: 29354 8. Observation and interview on 3/31/15 at 2:35 p.m. with laundry aide F revealed: *She had been pushing a laundry cart down the hallway. *The laundry cart contained hanging resident's personal clothing.	F 441		

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UNITED RETIREMENT CENTER	405 FIRST AVE BROOKINGS, SD 57006

(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 441	Continued From page 47 *Two sides of the laundry cart were covered with a hanging shower curtain. *Two sides and the top of the laundry cart were uncovered exposing the personal clothing. *Interview at the above time with laundry aide F confirmed that was the way she had always delivered the personal clothing. Observation and interview on 4/1/15 at 9:50 a.m. with laundry aide F in the laundry room revealed: *A rack of personal clothing partially covered with a half sheet exposing the bottom portions of the clothing. *Interview at the above time with laundry aide F revealed: -The rack of residents' personal clothing was unmarked. -They would take the clothing to the residents to identify who the items belonged to. -She confirmed the clothing went to the main floor partially covered. Interview on 4/1/15 at 10:48 a.m. with the directors of laundry and maintenance revealed: *All sides of the linen carts used to transport residents' personal clothing were to be covered during the transporting of clothing through the building. *They were not aware the top of the linen carts also needed to be covered during the transporting of clothing. There was no policy for transportation of clean linen. Surveyor: 35237 9. Observation and interview on 3/31/15 from 9:07 a.m. through 9:22 a.m. during resident 22's	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 48 nebulizer treatments with RN J revealed she: *Added the Albuterol (medication) to the nebulizer jar and mask as directed. *Applied the mask and nebulizer to his face. *Turned the nebulizer machine on. *When the albuterol nebulizer treatment was completed she: -Turned off the machine. -Removed the mask. -Carried it to the resident's bathroom. -Placed the mask into the resident's sink. -Rinsed the mask and nebulizer jar with sterile saline. -Dried the mask with a paper towel. -Brought the mask and nebulizer jar out of the bathroom. -Placed the mask on his bedside stand. *At 9:22 a.m. she added the Budesonide (medication) to the nebulizer jar as directed. *Applied the mask and nebulizer to his face. *Turned the nebulizer machine on. *When the Budesonide nebulizer treatment was completed she: -Turned off the machine. -Removed the mask. -Carried it to the resident's bathroom. -Placed the mask into the resident's sink. -Rinsed the mask and nebulizer jar with sterile saline. -Left the mask and nebulizer jar on a paper towel beside the resident's sink to air dry. *Confirmed that was how she cleaned the nebulizers after each resident's use. Interview on 4/1/15 at 2:30 p.m. with RN/DON A and RN/DON B revealed: *The nebulizers should have been rinsed with sterile water and dried. *They agreed sterile saline was not what their	F 441		

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F 441	Continued From page 49 policy stated to use. *They would have expected the nurse to follow their policy. *They agreed their policy did not match the manufacturer's instructions. *They agreed there would be an increased risk of infection if the nebulizers were not cleaned properly. Review of the provider's January 2010 Respiratory Therapy policy revealed "Nebulizer equipment, excluding tubing, is to be rinsed out with sterile water and air dried after every use." Review of the 2014 DeVilbiss PulmoMate Nebulizer Manual revealed: *"All parts of the nebulizer, except tubing, should be cleaned according to the following instructions." -"Clean after every use." -"Wash all items, except tubing, in a warm water/dishwashing detergent solution. Rinse under warm tap water for 30 seconds to remove detergent resident. Allow to air dry."	F 441		

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

ORIGINAL

PRINTED: 04/15/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435079		03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RETIREMENT CENTER	405 FIRST AVE BROOKINGS, SD 57006

(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
K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/31/15. United Retirement Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/31/15. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		F
K 020 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain the one hour fire resistive rating of vertical openings in two randomly observed areas (elevator shaft on each level). Findings include:	K 020		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: LaVonne Gaspar
TITLE: Interim Administrator
(X6) DATE: 4/23/15

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.

APR 24 2015
SD DOH L&C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435079	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/31/2015

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K 020	Continued From page 1 1. Observation at 11:00 a.m. on 3/31/15 revealed the elevator separation doors on the first floor and in the basement were hollow metal doors with wire glass vision panels. The doors did not have identification tags to indicate a fire resistive rating. That deficiency affected the service wing smoke compartment only and should not affect resident safety. Review of previous survey data revealed that condition had existed since the original construction of the building. Because the elevator is in the service smoke compartment it did not affect any resident smoke compartments. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 020		

South Dakota Department of Health

ORIGINAL

PRINTED: 04/15/2015
FORM APPROVED

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	10601		04/01/2015

NAME OF PROVIDER OR SUPPLIER: UNITED RETIREMENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 405 1ST AVE, BROOKINGS, SD 57006

(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: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/30/15 through 4/1/15. United Retirement Center was found not in compliance with the following requirement(s): S206 and S253.	S 000	Addendums noted with an asterisk per 4/29/15 telephone to facility DON. KG/SDDOH/MF	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	A Director of Education position was established and filled on 4/16/15. A job description detailing this role and responsibilities was signed. The orientation program has been revised to include proper use of restraints, resident rights, confidentiality of resident information, incidents and diseases subject to SD mandatory reporting and the facility's reporting mechanisms, dining assistance, nutritional risks, and hydration needs of residents. Employees beginning employment 4/28/15 will receive the new orientation program. Staff hired prior to this date will receive mandatory training on these topics on April 28, 29 and 30. An annual training calendar has been developed by the Director of Education to cover the topics on an annual basis. An audit will be conducted by the Director of Education, or designee, of the education files of all new employees. This will be presented monthly to QAPI through 2015* by the Director of education, or designee. KG/SDDOH/MF	*4/30/15 [redacted] KG/SDDOH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: LaVonne M. Gaspar — TITLE: Interim Administrator — (X6) DATE: 4/23/15

STATE FORM 6899 NXL111 — If continuation sheet 1 of 12

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S 206	Continued From page 1 This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to ensure five of ten required annual staff trainings (Proper use of restraints, Resident rights, Confidentiality of resident information, Incidents and diseases subject to South Dakota mandatory reporting and the facility's reporting mechanisms, Dining assistance, nutritional risks, and hydration needs of residents) were provided to all staff. Findings include: 1. Review of the provider's 2014 non-clinical learning packet agenda revealed the following topics had not been addressed: *Proper use of restraints. *Resident rights. *Confidentiality of resident information. *Incidents and diseases subject to South Dakota mandatory reporting and the facility's reporting mechanisms. *Dining assistance, nutritional risks, and hydration needs of residents. Interview on 4/1/15 at 2:45 p.m. with the director of human resources (HR), HR generalist Q, and the interim administrator revealed they provided different educational training to non-clinical staff and clinical staff. The five training's mentioned above had not been covered in the non-clinical staff training.	S 206		
S 253	44:04:04:11.01 SECURED UNITS Each facility with secured units must comply with the following provisions:	S 253	X [redacted] KG/SDDH/MF	

South Dakota Department of Health

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S 253	Continued From page 2 (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician; (2) Therapeutic programming must be provided and must be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family; (5) Locked doors must conform to Sections 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Surveyor: 35121 A. Based on observation, interview, record review, and policy review, the provider failed to ensure residents living in the Memory Care (secured area in facility) Unit had meaningful activities for four of four sampled residents (2, 5, 11, and 12). Findings include: 1. Random observations from 3/30/15 through 4/1/15 in the Memory Care Unit (MCU) revealed residents:	S 253	Additional dementia specific supplies were purchased on 4/21/15 for use in the Memory Care Unit.	4/20/15 * [redacted] KG/SDDOH/MF

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S 253	Continued From page 3 *Had been in their wheelchairs, beds, or recliners unattended for long periods of time. *Had the opportunity for one group presentation in the unit given by activities coordinator L on Eiffel tower during lunch on 3/31/15. It was the only observed activity during the above time period. *Had not had any one-to-one activities in residents' (2, 5, and 12) rooms during the above time period. 2. Review of resident 2's 3/2/15 through 4/1/15 activities record revealed seventeen out of thirty-one days without any documented activities attended or offered. Review of resident 2's undated care plan revealed structured activities were to be provided including: *Encouraged to attend one activity daily: -Bingo. -Aromatherapy. -Stuffed animals. -Generations. -Religious activities. -Coloring. -Matching games. -Word searches. -Small group activities. *One-to-one visits. 3. Review of resident 5's 3/2/15 through 4/1/15 activities record revealed seventeen out of thirty-one days without any documented activities attended or offered. Review of resident 5's undated care plan revealed structured activities were to be provided including: *Religious services.	S 253	Residents 2, 5, 11, and 12 will have an activity assessment and their Care Plans reviewed and updated, if needed, by the Activity Coordinator by 4/28/15. The Activity Coordinator will complete an activity assessment and review and update [redacted] all Care Plans of all residents in the Memory Care Unit by 5/12/15. KG\SDDOH\MF Activity Staff were re-educated by the Activity Coordinator on 4/21/15 and 4/22/15 on the documentation of one to one activities and the dementia specific activity guidelines. Activity Coordinator has reassigned responsibilities within the activity department for one on one interactions specific to the Memory Care Unit. Activity Coordinator will develop a dementia specific checklist for all direct care staff routinely scheduled on the Memory Care Unit and they will be educated 5/7/15, 5/8/15, and 5/11/15. Re-education will be provided on resources available in the unit specific to dementia activities. The Director of Education will provide dementia specific education on 5/7/15, 5/8/15, and 5/11/15 including Hand in Hand Training. These sessions will be mandatory.	

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S 253	Continued From page 4 *Assistance with: -Listening to preferred music. -Group activities. -Watching soccer. 4. Review of resident 12's 3/2/15 through 4/1/15 activities record revealed seventeen out of thirty-one days without any documented activities attended or offered. Review of resident 12's undated care plan revealed structured activities were to be provided including: *Toileting. *Walking inside and outside. *Reorientation strategies: -Signs. -Pictures. -Memory boxes. *One-to-one activities: -Walks or physical activity. -Trivia games. -Encourage to speak in foreign language. -Offer fluids during activity. Interview on 4/1/15 at 9:18 a.m. with activities coordinator L revealed he: *Was the activities coordinator for the MCU and Southridge. *Had not been charting resident refusals of activities offered and declined. *Confirmed he had an activities calendar for the MCU. *Had not provided the calendar upon request. Surveyor: 34030 5. Review of resident 11's medical records revealed: *An admission on 12/2/14 with hospice care started two days later.	S 253	The May activity calendar in the memory care unit will reflect Dementia specific activities beginning 5/1/15.	

South Dakota Department of Health

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S 253	Continued From page 5 *Diagnosis that included dementia (decreased mental ability). Review of resident 11's undated care plan revealed: *She needed extensive help of one to two staff with her care. *Interventions for activities: -"Please assist me in listening to my books on tape." -"Please encourage me to attend musical groups in the chapel." -"Please include me in baking club activities. I may not actively participate but I will enjoy watching." -No other activities for resident 11 were documented. Review of resident 11's 3/2/15 mini-care plan for certified nursing assistant (CNAs) revealed "3/27/15: Encourage activities when I am alert." Observations on 4/1/15 from 11:00 a.m. through 2:00 p.m. of resident 11 revealed: *She had been seated in her wheelchair at the dining table and in the living area of the MCU. *She was not watching TV nor listening to music. *The only activity during that time had been an information reading prior to lunch. Interview on 4/1/15 at 2:00 p.m. with CNA N revealed she had not seen resident 11 listening to books on tape. Interview on 4/1/15 at 2:30 p.m. with licensed practical nurse I regarding resident 11's activities revealed: *"There was music therapy once a week and also music played on the unit." *There were no books on tape for resident 11.	S 253	Resident 11 will have an activity assessment completed by 4/28/15. The Care Plan will be updated to reflect current status by the Activity Coordinator. Resident 11's mini care plan will be reviewed and updated by the interdisciplinary team by 4/28/15.	

South Dakota Department of Health

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S 253	Continued From page 6 Interview on 4/1/15 at 3:15 p.m. with activity aide M regarding resident 11 revealed: *The activity director who usually worked with the residents in the memory care unit had left work for the rest of the day and was unavailable to interview. *She was unaware listening to books on tape had been on resident 11's care plan for activities, and they had not been providing them. *She had not mentioned any other activities being done with resident 11. Review of the provider's December 2006 Activities and Social Services policy revealed: *"The facility will provide activities, social events, and schedules that are compatible with the resident's interests, physical and mental assessment, and overall plan of care. *"Should a resident be considered to lack sufficient decision making capacity, mental incompetence, or physical capacity to participate in Activity and Social Service Programs, the Activities or Social Services Staff will document the reasons for any limitations in the resident's medical record (chart)." *"Activities will be scheduled periodically during the day, as well as during evenings, weekends, and holidays." Surveyor: 35121 B. Based on observation, interview, record review, and policy review, the provider failed to ensure residents living in the Memory Care (secured area in facility) Unit had acceptable reasons for being admitted to or remaining in a secured unit for three of four sampled residents (5, 11, and 16). Findings include:	S 253	The Activity and Social Services Policy was reviewed and revised to reflect specific dementia care activity guidelines by 4/24/15. Activity Coordinator, or designee, will perform a weekly audit of activity calendar to determine that each activity was offered, resident participation, and proper documentation, including refusal. Findings will be reported to QAPI monthly for three months. When the QAPI committee determines otherwise, based on compliance, the frequency of audits may be decreased or discontinued. Memory Care Unit Admission & Discharge criteria policies and quarterly Memory Care Unit Assessment form will be reviewed and revised by 4/30/15. Residents 5 and 11 will be assessed by the interdisciplinary team using the updated criteria, and, if found to be no longer appropriate for Memory Care Unit, a transition plan will be put in place to ensure care in another appropriate area. Resident 16 no longer resides at the facility.	

South Dakota Department of Health

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S 253	Continued From page 7 1. Review of resident 5's 3/3/15 Minimum Data Set (MDS) assessment revealed he needed extensive (dependent on others) assistance of two or more staff with: *Bed mobility. *Transfers (change positions). *Bathing. *Locomotion (moving from one place to another). *Dressing. *Personal Hygiene. *Toilet use. Interview on 3/31/15 at 10:30 a.m. with CNA H regarding resident 5 revealed he: *Had been on walking program. *Had been walking when she started in August 2014 but was no longer walking. *Required the assistance of two staff members. Interview on 4/1/15 at 3:05 p.m. with the director of nursing (DON) B revealed the MCU coordinators were: *Minimum data set (MDS) coordinator G. *Licensed social worker (LSW) P. Review of the 3/30/15 daily census report revealed there was an available bed located off the MCU. Surveyor: 34030 2. Observations on 4/1/15 from 11:00 a.m. through 2:00 p.m. of resident 11 revealed she resided in the MCU. Review of resident 11's medical record revealed: *An admission on 12/2/14 with hospice care started two days later. *A diagnosis of dementia (decreased mental ability). Review of resident 11's undated care plan	S 253	All other residents in Memory Care Unit will be assessed by the inter-disciplinary team at their next quarterly review, and as needed with change of condition, using the updated criteria. *by 4/30/15 and KG/SDDOH/MF	

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	10601		04/01/2015

NAME OF PROVIDER OR SUPPLIER: UNITED RETIREMENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 405 1ST AVE, BROOKINGS, SD 57006

(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 253	Continued From page 8 revealed: *She needed extensive assistance of one to two staff members with her personal cares. *"I live in the memory care unit." *"I am currently on hospice." *"I require staff assistance with all of my ADLs [activities of daily living.]" Surveyor: 35237	S 253		
	Surveyor: 29354 3. Review of resident 16's closed (no longer living in the facility) medical record revealed: *An admission date of 3/5/15. *She had died on 3/6/15. *The 3/5/15 Discharge Orders from the hospital stated: -Her discharge disposition was to the nursing home and hospice. -Admit to the Memory Care Unit. -All medications had been discontinued but the lorazepam oral concentrate (controlled anxiety medication) and the morphine sulfate (controlled pain medication). -Her discharge activity order was bedrest. -Her restorative potential was poor. *The 3/5/15 Nursing Admission Form revealed: -Her level of consciousness was lethargic (sleepy). -She was non-verbal. -She had a urinary catheter in place. -She had generalized weakness and was non-ambulatory.		Resident 16 no longer resides at the facility.	
	Interview on 4/1/15 at 2:30 p.m. with RN/DON A and RN/DON B regarding resident 16 revealed: *She had been admitted to the MCU because no other bed had been available in the facility at that time. *They stated that because she had been admitted		[redacted] KG15DJDH1MF	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10601		04/01/2015

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S 253	Continued From page 9 to the MCU they had asked for an order from the physician. *They agreed she had not needed to be in the MCU. Surveyor: 35121 Interview on 4/1/15 at 3:07 p.m. with the MDS coordinator G revealed she: *Was not aware: -She was the MCU coordinator. -Quarterly assessments were to have been completed for appropriateness of residents' placement in the MCU. *Had not seen the: -Admission criteria for the MCU. -Quarterly MCU assessment. *Stated resident 5 "should not be in the memory care unit." Interview on 4/1/15 at 3:18 p.m. with LSW P revealed she: *Was not aware quarterly assessments were to have been completed for appropriateness of residents' placement in the MCU. *Agreed they were not following the facility's policy for: -Quarterly assessments. -Discharging residents from the MCU when they no longer met the criteria to reside in the MCU Surveyor: 35237 Review of the provider's undated Memory Care Unit (MCU) Admission Criteria revealed: *"1. The unit designed for care of individuals with a primary diagnosis or Alzheimer's disease or a related irreversible dementia." *"2. Individuals who are being considered for admission will exhibit at least 2 of the following characteristics:" -"a. Significant memory impairment."	S 253	Ongoing assessment including quarterly, and change of conditions, will be completed by the interdisciplinary team. Weekly audits to monitor compliance with Memory Care assessment completion will be completed and reported to QAPI monthly for three months. When the QAPI committee determines otherwise, based on compliance, the frequency of audits may be decreased or discontinued. *by the DON or designee KG/SDDCH/MF	

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S 253	Continued From page 10 -"b. Short attention span." -"c. Difficulty with communicating own needs." -"d. Inability to perform ADL's (self care activities) independently." -"e. Impaired judgment requiring protection from self and/or others." -"f. Some degree of disorientation to person, place, time or situation." -"g. Inappropriate behavior (e.g. agitation, pacing, wandering, etc...) -"h. Needs a secure environment for safety, this is determined by the resident's attending physician or mental health professional." *"3. The individual is able to participate in and benefit from consistent, daily programming in a therapeutic environment." *"6. A physician's order must be obtained stating the individual requires a secured, semi-locked environment." *"7. Admission to the unit is contingent on an initial assessment period of up to 30 days. The resident will be evaluated by the MCU interdisciplinary team, in conjunction with the MDS (minimum data set assessment) process, for the appropriateness of placement on the unit. If after placement, it is determined by any member of the team to be inappropriate, it will be the responsibility of the MCU coordinator to convene a care conference to evaluate the appropriateness of placement and/or possible discharge from the MCU." *"9. A resident will be considered for the discharge or transfer from the Memory Care Unit when they no longer meet the admission criteria and the family or designated representative supports such decision." Review of the provider's undated Memory Care Unit Discharge Procedure Guidelines revealed: *The purpose was to "ensure a smooth transfer	S 253		

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S 253	Continued From page 11 from the Memory Care Unit when a resident is no longer appropriate for the level of care rendered on the Memory Care Unit." *"1. The MCU Interdisciplinary Team shall review residents on a routine basis to determine continued appropriateness on the unit." *"2. Areas to be reviewed include:" -"a. Assessment of resident's level of care (including the ability to feed, dress, and groom themselves." -"b. Assessment of concerns in resident's behavior." -"c. Resident's ability for locomotion and transfer." -"d. Assessment of resident's ability to benefit from planned structured activities." *"3. As a resident's condition changes, family will be informed and will be integral in the determining of placement of the resident, along with an attending physician." *"4. When MCU is no longer appropriate, the resident will be transferred off the unit as an appropriate bed becomes available."	S 253		