

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/1/15 through 6/3/15. Sunset Manor Avera Health was found not in compliance with the following requirements: F226, F241, F252, F253, F280, F309, F323, F329, F425, and F441.	F 000	<i>Addendums noted with an asterisk per 7/9/15 telephone to facility DoW. JK/SDOAH/JJ</i>	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review the provider failed to thoroughly investigate: *Three of three unwitnessed falls for one of six sampled residents (9). *Bruises of unknown origin for one of one sampled resident (8). Findings include: 1. Review of resident 9's medical record revealed he had fallen on 2/19/15, 3/23/15, and 5/6/15. Those falls had been unwitnessed. Review of resident 9's incident reports revealed: *The reports had consisted of three pages titled: -Resident Incident Report. -Resident Incident Follow-up.	F 226	Correct to the individual: System change will correct the cited deficiency. *Resident 8 and 9's incident reports were reviewed. Due to the date of the reports no further changes could be made. JK/SDOAH/JJ Correct to all others: * [redacted] will be educated on the correct procedure on completing an incident report* by 6/29/15. JK/SDOAH/JJ System correction: Investigation form was added to the incident report. SSD/DNS will complete * investigation within 5 days of the incident. Administrator will sign off on all completed incident reports. Audits will be completed 2 times per week for 4 weeks, weekly for 4 weeks and then monthly for 4 months* by the DNS or designee. JK/SDOAH/JJ Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. *The DNS or designee will be responsible for reporting all audits to the QAPI team for review. JK/SDOAH/JJ	7-20-15

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

TITLE

(X6) DATE

Administrator

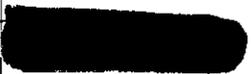
6-25-15

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.

JUN 29 2015
If continuation sheet Page 1 of 40
SD DOH L&C

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

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OMB NO. 0938-0391

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F 226	<p>Continued From page 1</p> <p>-Post Incident Actions.</p> <p>*On 2/19/15 he had been found sitting on the bathroom floor with no apparent injuries.</p> <p>*On 3/23/15 he had been found on the floor in his bedroom. He had a skin tear to his left elbow.</p> <p>*On 5/6/15 he had been found on the dining room floor by housekeeping staff.</p> <p>*There had been no documentation an investigation had been conducted for the above falls.</p> <p>Review of resident 9's 4/30/15 Minimum Data Set (MDS) assessment revealed he had short and long term memory problems.</p> <p>Interview on 6/3/15 at 3:30 p.m. with the director of nursing (DON) and licensed social worker revealed:</p> <p>*The documentation provided was all they had regarding the unwitnessed falls mentioned above.</p> <p>*They had not documented any conversations with staff or what had been occurring prior to the fall to rule out neglect or abuse.</p> <p>Surveyor: 22452</p> <p>2. Review of resident 8's medical record revealed:</p> <p>*A 10/13/14 admission date.</p> <p>*Diagnoses of Alzheimer's (memory) disease and Parkinson's disease (neurological disease).</p> <p>Review of resident 8's 1/27/15 through 2/17/15 nursing notes revealed:</p> <p>*1/27/15- "Resident has a 7.0 centimeter (cm) by 2.0 cm purple discoloration on her lower left buttock cheek. Bruise is of unknown origin. Resident does wander around the unit and tends to bump into furniture."</p> <p>*1/28/15- "Two bruises noted to left buttock</p>	F 226	<p>Correction Date: July 20, 2015</p> <p>*  JK(SDDH)JS</p>	

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F 226	Continued From page 2 cheek. Both measuring approximately 7.0 cm in diameter. Outer cheek bruise is faint green/yellow in color, inner buttock bruise is purple in color." *1/29/15 at 1:42 p.m.- "Resident is being picked up by occupational therapy [OT] to evaluate and treat decline in activities of daily living [ADL] approved by physician." *1/29/15 at 3:33 p.m.- "Resident has two bruises on her left lower buttock cheek. That measures 7.0 cm by 3.0 to 5.0 cm. The outer bruise is a light green and the inner one is a purple that is breaking up. After measuring the bruise we assisted the resident up and she went over to her bedroom chair to sit. She first bends down to sit then steps in front of the chair. In doing this she hits her buttocks on the arm of the chair. This reporter noticed that she does the same at the dining room table. It was also reported by night shift that the resident got stuck between the end of her mattress and her foot board the other night and could not figure out how to step over the bed frame. The resident has been picked up by OT to work with the resident and staff with her ADLs." *2/4/15- "Resident is becoming increasingly more difficult to toilet. She will not or is not capable of taking direction. She will not sit down on the toilet without many repeats to sit down on the toilet." *2/6/15- "Difficult to dress/toilet as she is disoriented and does not follow commands well. Extensive assistance with dressing and toileting." *2/7/15- "Resident's left lower arm and wrist are slightly swollen. Resident has had a fall [2/5/15] where she was found on her right side." *2/10/15- "Resident is disoriented [confused] to person, place, and time. She does not make her needs known. She is toileted frequently. All ADLs are done by staff with frequent cueing and instruction. She is becoming increasingly more difficult to direct as she does not follow directions	F 226			

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F 226	<p>Continued From page 3</p> <p>when given. No new skin issues are noted. She is generally cooperative with staff, but can occasionally can be difficult due to diagnosis of dementia [memory loss]."</p> <p>*2/12/15- Certified nursing assistant [CNA] G reported bruising on resident's right buttocks and the upper right back of her leg. Both bruises are deep purple in color. The buttocks measures 13.0 cm long and 5.0 cm wide and the leg measures 15.0 cm by 7.0 cm. CNA G stated that there was a small bruise on her right buttock two days ago when she gave her a bath and was reported to the charge nurses. Bruises are of unknown origin. Resident is difficult to toilet as she stands up almost immediately after sitting her down. Location of the bruises are at the locations of where the buttocks and the upper leg would meet the toilet. Resident is currently working with OT. Will discuss with them alternative ways of toileting the resident. Resident has been picked up by OT to monitor resident during ADLs and educate staff on ways to cue the resident to stay seated while helping her with her ADLs. Resident is a two person assist for all ADLs."</p> <p>Review of resident 8's two unknown date/time incident reports revealed: *"CNA G reported that the resident has a bruise on her left buttock cheek that she found while bathing the resident on 1/26/15. Resident has a 7.0 cm by 2.0 cm purple discoloration on her lower left buttock cheek. -Immediate action taken was bruise measured. -Physician was notified. -No documentation the family had been informed. -Medical risk factors possibly related to incident are confusion/disorientation and incontinency. -There was no documentation of any signatures who had prepared or who had reviewed the</p>	F 226		

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F 226	<p>Continued From page 4 incident report." *"Bruising on resident's right buttocks and the upper right back side of her leg. Both bruises are deep purple in color. The buttocks measures 13.0 cm long and 5.0 cm wide and the leg measures 15.0 cm by 7.0 cm. -Immediate action taken was bruises measured. -Physician was notified. -Medical risk factors possibly related to incident are inability to understand directions, confusion/disorientation, and incontinency. *There was no documentation of any signatures who had prepared or who had reviewed the incident report." *No documentation the family was notified.</p> <p>Review of resident 8's 2/9/15 OT plan of care revealed: *"Patient [resident] self care needs are met by staff. Does require dependence for self cares." *"Patient is toileted by staff but needs constant supervision due to patient getting up before finished and the need for maximum physical and verbal cues for sequencing and initiating movement. All home management tasks are met by staff."</p> <p>Interview on 6/3/15 at 2:30 p.m. with the director of nursing and the social worker regarding resident 8 revealed: *The only investigation they had done for the multiple bruises of unknown origin was make a referral to OT. *They did not need to talk to any staff specifically that provided care to her, as they knew that the bruises had been caused due to her bumping into furniture. *There had been random observations of her walking into furniture.</p>	F 226			

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F 226	<p>Continued From page 5</p> <p>*They did not feel in was necessary to pad her toilet seat in any way or utilize any type of hip protectors related to her repeated bruising on her buttocks.</p> <p>*They had not followed their abuse policy to inform her family of the bruises of unknown origin.</p> <p>Review of the provider's March 2015 Abuse Prohibition policy revealed:</p> <p>*Staff should have:</p> <ul style="list-style-type: none"> -Documented clear, concise, and indisputable (arguable) evidence in order to protect the resident. -Documented in the resident's chart the resident's and caregiver's explanation of what had occurred. <p>*The administration should have completed a thorough investigation of the incident including interviews with staff, residents, and family as appropriate.</p> <p>*They should have completed a written report of those findings.</p> <p>Review of the provider's undated Nursing Policy and Procedure Manual Resident Incident policy revealed staff were to notify the family of the incident and necessary treatment.</p>	F 226		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 241	<p>F 241</p> <p>Correct to the individual: Designated CNA will sit with Resident 10 during meal services to assist with queuing and ensuring resident is as independent as possible per family request.</p>	7-20-15

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F 241

Continued From page 6
Surveyor: 32355
Based on observation, interview, record review, and policy review, the provider failed to ensure one of five sampled residents (10) who required supervision and direction during two of two observed meals was assisted in a dignified manner. Findings include:

1. Review of resident 10's medical record revealed:
*An admission date of 9/26/08.
*Diagnoses of dementia (forgetfulness), mood disorder, anoxic brain damage (decreased oxygen to the brain), muscle weakness, lack of coordination (movement of arms and legs), abnormal posture, and dysphagia (difficulty swallowing).
*She was dependent upon staff to assist her with transfers, moving in bed, and set-up for meals.
*She had communication problems and was difficult to understand. The staff had to anticipate her needs.
*She had been able to feed herself by supervision and direction from the staff.
*Her range of motion was limited in both of her arms and legs.

Observation on 6/1/15 of resident 10 during the evening meal revealed:
*She had:
-Been seated in a wheelchair (w/c) at a table in the back of the dining room.
-Had been located approximately five feet from a table of residents who had required staff assistance with eating their meal.
-Been attempting to eat her meal with a curved spoon.
-Glasses of fluids were available for her to drink. Those glasses had lids on them with an opening

F 241

The dietary manager or designee
JK/SDDH/JJ

by 6/29/15
JK/SDDH/JJ

Correct to all others:
* will evaluate all others that need assistance in the dining room and ensure that the appropriate assistance is provided while following our dignity policy.

System correction:
Education will be completed with all staff on dignity policy and appropriate conversations/volume while in the dining room during meal times. Audits will be completed weekly times 4 weeks, monthly times 3 months* by the dietary manager or designee. JK/SDDH/JJ

Monitoring of System:
The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. *the dietary manager or designee will be responsible for reporting
Correction Date: all audits to the July 20, 2015 QAPI team for review. JK/SDDH/JJ


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F 241	<p>Continued From page 7</p> <p>to drink from.</p> <p>-Limited range of motion in her arms. In order for her to eat the food and drink the fluids she had to lean her body and head back to complete that process.</p> <p>-Attempted to eat her food and drink her fluids multiple times. On several of those occasions the fluid would run down her neck and the upper part of her chest area.</p> <p>-Rolled away from the table multiple times. During those times the staff sitting at the table next to hers would loudly direct her to pull herself back up to the table.</p> <p>-On several occasions yelled out at the staff in an attempt to get their attention. During those times the staff would again loudly direct her to eat her potatoes or finish her meal.</p> <p>-Not received direct assistance from the staff until the end of the meal , and no staff assisted her with eating. At that time they had assisted her with removing her clothing protector and cleansing her face.</p> <p>Observation on 6/2/15 of resident 10 during the dinner meal revealed she had attempted to feed herself by repeating the same process as written above. The staff continued to give her direction from a distance and speaking loudly. However no staff assisted her with eating.</p> <p>During both of the above observations the surveyor had been located approximately fifteen feet from the resident. The surveyor and the residents in the surrounding area were able to hear the staff giving her directions with eating.</p> <p>Interview on 6/3/15 at 1:15 p.m. with the director of nursing, Minimum Data Set coordinator, and dietary manager regarding resident 10 revealed:</p>	F 241			

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F 241	<p>Continued From page 8</p> <p>*They had been aware: -The resident had a difficult time with eating her food and drinking fluids. -Of the dignity concerns during meal time with the spilling of fluids and foods down her neck.</p> <p>*They had not been aware: -The staff were not assisting her with her food and fluids. -The staff were giving her direction and cueing loudly from a distance, so other residents could hear. *The family and staff wanted her to be as independent as possible. That had included feeding herself with minimal assistance. *They had considered moving her to the table with those residents who had required assistance from the staff for eating. They were worried she would have stopped feeding herself and expected the staff to assist her.</p> <p>Review of the provider's undated Dignity policy revealed: **"Each resident shall receive hospitable care and services in a manner and in an environment that maintains or enhances dignity and respect in full recognition of his or her individuality." **"Staff shall communicate directly with resident and not "around" resident, regardless of cognitive abilities."</p>	F 241		
F 252 SS=D	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p>	F 252	<p>F 252</p> <p>Correct to the individual: Resident 3, 6 and 16 will all be seated at a dining room table.</p>	7/20/15

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F 252	Continued From page 9 This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to have a homelike environment in the Sunset Villa dining room by using three bedside tables for three of seven residents (3, 6, and 16). Findings include: 1. Observation on 6/1/15 at 5:15 p.m. in the Sunset Villa dining room revealed: *Resident 3 had been sitting in a wheelchair at a bedside table facing away from the dining room table. -That bedside table had been directly behind the coffee table that was between the couch and recliner. *Residents 6 and 16 were sitting at bedside tables up against the wall facing the wall. *Resident 6 had been in a wheelchair and attempted to speak with staff and this surveyor. She had to turn in her wheelchair to look at people. Observation on 6/2/15 at 8:00 a.m. in the Sunset Villa dining room revealed: *Residents 6 and 16 were again sitting at the bedside tables pushed up against the wall. *Resident 16 sat sideways while eating his breakfast and was talking to staff and this surveyor. *Resident 6 had also been attempting to talk with staff. Interview on 6/3/15 at 10:00 a.m. with certified nursing assistant F regarding the bedside tables revealed: *She had worked in Sunset Villa for	F 252	Correct to all others: All bedside tables will be removed from the unit. * All staff will be educated on those changes by 6/30/15. JK/SDDH/JJ System correction: Two new tables will be purchased to accommodate all residents. Audits will be done weekly times four weeks and then monthly times four months* by the DNS or designee. JK/SDDH/JJ Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meeting with updates made as needed. * The DNS or designee will be responsible for reporting all audits to the QAPI team for review. Correction Date: July 20, 2015 * [REDACTED] JK/SDDH/JJ		

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F 252	<p>Continued From page 10 approximately four years. *She thought resident 16 had been moved away from the table as he had grabbed at others food. *She was not sure why residents 6 or 16 would have been facing the wall during the above observations. *She usually had them face the dining room table.</p> <p>Review of resident 3 and 6's care plans revealed it had not been care planned for them to eat at bedside tables. Refer to F280, findings 2 and 3.</p> <p>Interview on 6/3/15 at 3:30 p.m. with the director of nursing and licensed social worker revealed they were unaware residents 3, 6, and 16 had been sitting at bedside tables facing away from the table. They could not explain why residents 6 and 16 had been facing the wall.</p> <p>Review of the provider's 2013 The Dining Experience: Staff Responsibilities policy revealed the dining area should have been attractive, functional, home-like, or restaurant-like with appropriate furniture.</p>	F 252		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure: *One of three observed dining rooms (main) had</p>	F 253	<p>F 253</p> <p>Correct to the individual: System change will correct the cited deficiency. *All staff will be educated on this system change by 6/30/15. JK/SDD/H/JJ</p> <p>Correct to all others: New dining room chairs and tables will be ordered. Public bathroom toilet was securely attached. The molding on door jams were either replaced or repaired. The wheelchairs were repaired, transfer aides were cleaned, kitchen drawers and shelves</p>	7-20-15

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F 253	<p>Continued From page 11</p> <p>chairs and tables that were kept in good condition/repair.</p> <p>*One of two observed public bathroom toilets (by the nurses station) was securely attached to the floor.</p> <p>*Molding on multiple resident-use door jams had been in good condition/repair with cleanable surfaces.</p> <p>*Multiple resident-use wheelchairs (w/c) had been in good condition/repair with cleanable surfaces.</p> <p>*Six of six transfer aides (device to assist residents with transfers) had been clean.</p> <p>*One of three kitchenette areas (Traumatic Brain Injury [TBI] Unit) that stored resident-use items had clean drawers and shelves.</p> <p>*Adequate draining of one of one whirlpool tub.</p> <p>Findings include:</p> <p>1. Observation on 6/2/15 at 11:00 a.m. of the main dining room revealed:</p> <p>*Nine brown wooden tables that had multiple exposed areas of unfinished wood. Those unfinished areas created an uncleanable surface. Multiple unidentified residents had been observed sitting at the tables with their arms and wrists resting on those exposed and unfinished surfaces.</p> <p>*Twenty-two dining room chairs had brown wooden arms with exposed and unfinished surfaces. Those unfinished areas created an uncleanable surface. Multiple unidentified residents had been observed sitting in those chairs. Their arms had been observed resting on those exposed and unfinished surfaces.</p> <p>Interview on 6/3/15 at 10:00 a.m. with the administrator and maintenance director revealed they were not aware the dining room tables and chairs had multiple areas of exposed and</p>	F 253	<p>in the TBI were cleaned and the drain on the whirlpool tub was repaired.</p> <p>System correction: Audits will be done two times weekly for four weeks, weekly for four weeks then monthly thereafter <i>* by maintenance or designee. JK/S000H/JJ</i></p> <p>Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. <i>* The maintenance supervisor or designee will be responsible for reporting all audits to the QAPI team for review.</i></p> <p>Correction Date: <i>July 20, 2015</i></p> <p><i>JK/S000H/JJ</i></p>	
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F 253	<p>Continued From page 12</p> <p>unfinished surfaces. The dining room tables and chairs had not been listed on the preventative maintenance program.</p> <p>2. Random observations from 6/1/15 through 6/3/15 revealed:</p> <ul style="list-style-type: none"> *A bathroom located by the nurses station. Several residents had been observed using this bathroom independently. Inside of the bathroom revealed a toilet that had: <ul style="list-style-type: none"> -No caulk around the base. -Been shifted to the right side and was leaking water all over the floor. *Multiple brown wooden entrance door jams leading into resident rooms throughout the facility. Those door jams had missing pieces of wood, making a rough and uncleanable surface. *Several unidentified resident-use w/cs had arm rests in poor condition with cracked areas of missing vinyl. Those areas had created an uncleanable surface. Several residents had been observed resting their arms on those areas. *Six resident transfer aides in various locations of the facility were dirty with black/brown colored debri on them. *The kitchenette in the TBI unit revealed several cupboards and drawers with cooking and serving utensils, bowls, and drinking cups in them. The surfaces were dirty with black/brown colored debri on them. <p>Interview on 6/2/15 at 9:00 a.m. with certified nursing assistant (CNA) K revealed:</p> <ul style="list-style-type: none"> *She had confirmed the items inside of the cupboards and drawers had been used by the therapy department when working with the residents. *The staff had been responsible for cleaning the counter tops on the cupboards. 	F 253		
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F 253	<p>Continued From page 13</p> <p>*She had been unsure who was responsible for the cleaning of the surfaces inside of the cupboards and drawers.</p> <p>Interview on 6/2/15 at 4:00 p.m. with CNA E revealed the night shift were to have cleaned the transfer aides every Friday night</p> <p>Interview on 6/3/15 at 9:45 a.m. with the administrator and maintenance director revealed: *They had not been aware of all the above areas of concern but confirmed the findings. *The maintenance director had been responsible for the upkeep and repair work in the facility. *The w/cs were on a monthly check, but he had not been aware that several of them required repair and replacement of arm rests. *The staff had mentioned the issues with the toilet in the public bathroom to him. The staff member had not put in a work-order for the toilet to be repaired according to facility policy. He had not remembered to repair it. *They confirmed the night shift staff were to have cleaned the transfer aides. *The staff in the TBI unit had been responsible for the entire cleaning of the kitchenette and had a cleaning schedule.</p> <p>Review of the provider's 6/28/10 Maintenance Director's Job Description revealed "The Director of Maintenance is directly responsible to the Administrator and shall assure that the overall facility and grounds are functionally and physically safe and sanitary for resident, clients, personnel and visitors."</p> <p>Surveyor: 33265 3. Observation and interview on 6/2/15 at 9:45</p>	F 253		

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F 253	Continued From page 14 a.m. on Sunset Manor with certified nursing assistant J in the whirlpool tub room revealed: *When the stopper was pulled from the plug the water leaked out onto the east side of the tub room floor. *The tub leaked whenever you pulled the plug out. Interview on 6/2/15 at 11:45 a.m. with the maintenance person revealed there was not a large enough pipe to take the volume of water released from the whirlpool tub when the plug was pulled to drain the tub.	F 253		
F 280 SS=E	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.	F 280	F 280 Correct to the individual: Residents 3, 5, 6, 7, 8 and 10's care plans have been corrected. Correct to all others: Education was done with all care plan members and nursing staff on proper procedure to updating care plans* by 6/29/15. JK/S000H/JJ System correction: <u>Care Plans will be reviewed and revised by the care team in care conferences weekly*</u> The members will sign off on the care plans once updates are completed. Copies of the care plans will go into the resident chart, CNA chart and nurse's chart. Audits will be done weekly times four weeks and then monthly times 4 months* by the DNS or designee. JK/S000H/JJ Monitoring of System:	7-2015

of those resident's care plans that are scheduled to be reviewed. JK/S000H/JJ

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F 280	<p>Continued From page 15 This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure 6 of 12 sampled residents' (3, 5, 6, 7, 8, and 10) care plans were updated and revised with measurable goals and followed by direct care givers. Findings include:</p> <p>1. Review of resident 8's 10/13/14 through 6/2/15 care record revealed she: *Was admitted on 10/13/14. *Had diagnoses of Parkinson's disease (neurological disorder) and Alzheimer's disease (memory loss). *Had six unwitnessed falls. *Had frequent bruises of unknown origin on the buttocks and legs. *Declined in activities of daily living (ADL) (dressing, bathing, and toileting). *Was disoriented (confused) to person, place, and time. *Was dependent upon staff for all her care. *Had been evaluated by occupational therapy (OT) for her decline in ADLs. *Was assisted with eating.</p> <p>Review of resident 8's 10/14/15 care plan revealed: *"She will not decline in ADLs." *"She needs cues and reminders when eating." *"Staff will assist with toileting and provide incontinence (unable to control urine) care with each episode." *"Fall risk and risk for injuries related to impaired cognition (memory recall), incontinence, and use of antipsychotic (mood altering medication), antianxiety, and antidepressant medications."</p>	F 280	<p>The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. <i>the DNS or designee will be responsible for reporting all audits</i> Correction Date: <i>July 20, 2015 to the QAPI team for review.</i>  JK/SDDOH/JJ</p>		

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F 280	<p>Continued From page 16</p> <p>*There was no documentation related to her bruises of unknown origin and any preventative measures to alleviate (stop) them.</p> <p>Interview on 6/3/15 at 10:00 a.m. with certified nursing assistant (CNA) G regarding resident 8 revealed she:</p> <p>*Thought OT recommended two staff assist her with toileting to prevent her from "plopping" down on the toilet.</p> <p>*Was not aware of any other recommendations from OT.</p> <p>Interview on 6/3/15 at 10:05 a.m. with CNA H regarding resident 8 revealed she thought when OT was working with her they used two staff to assist her with toileting. But now one staff member could do it.</p> <p>Surveyor: 32335</p> <p>2. Observation on 6/1/15 at 5:15 p.m. and on 6/2/15 at 9:30 a.m. in the Sunset Villa dining room revealed:</p> <p>*Resident 3 had been sitting in a wheelchair at a bedside table facing away from the dining room table.</p> <p>*That bedside table had been directly behind the coffee table that was between the couch and recliner.</p> <p>Review of resident 3's medical record revealed he left during the weekdays to participate in a structured work activity.</p> <p>Review of resident 3's undated care plan revealed his sitting at a bedside table facing the wall for meals and his time going to a structured work activity during the week was not addressed.</p>	F 280		
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F 280	<p>Continued From page 17</p> <p>3. Observation on 6/1/15 at 5:15 p.m. and on 6/2/15 at 8:00 a.m. in the Sunset Villa dining room revealed: *Resident 6 had been sitting at a bedside table up against the wall, and she was facing the wall. *She was in a wheelchair and attempted to speak with staff and this surveyor. She had to turn in her wheelchair to look at people.</p> <p>Review of resident 6's undated care plan revealed her sitting at a bedside table facing the wall for meals was not addressed.</p> <p>Surveyor: 32355</p> <p>4. Review of resident 5's medical record revealed: *An admission date of 9/11/08. *Diagnoses of depression (sadness), anxiety, schizophrenic (loss of contact with reality), seizures (uncontrollable body movements), dysphagia (difficulty swallowing), and aspiration pneumonia (fluid in the lungs). *In April 2015 he acquired a respiratory infection with a decline in his health status requiring more assistance from staff with activities of daily living. *During his declining status in April 2015 he had experienced an increase in falls and weight loss. Therapies had been ordered by his primary physician to assist him with strengthening and safety.</p> <p>Review of resident 5's undated care plan revealed since 2009 he had been on a weight control diet. His goals and approaches for nutrition had not been reviewed since 7/18/13. There was no indication he had experienced a recent decline in his health condition with weight</p>	F 280		
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F 280	<p>Continued From page 18 loss and the need for speech therapy.</p> <p>Continued review of resident 5's undated care plan revealed no documentation to support he had a recent health decline with weight loss, falls, and an increased need for staff assistance and therapies.</p> <p>5. Review of resident 7's medical record revealed: *An admission date of 8/11/05. *Diagnoses of dementia (forgetfulness), dysphagia, and cerebral vascular accident (stroke) with left sided weakness. *She had decreased coordination and muscle control to both of her legs and arms. *She had worn a Kentucky collar during meals to assist with proper positioning of her neck. *She was to have been laid down for one hour in the morning and one hour in the afternoon to relax her neck and improve her posture. *The staff were to have assisted her to the toilet and change her incontinent product every two hours. *In February 2015 her primary physician had ordered occupational therapy to assist her with better positioning while in her w/c.</p> <p>Observation on 6/1/15 at 3:30 p.m. of resident 7 revealed she had been laying in her bed with a brace on her left hand.</p> <p>Random observations on 6/2/15 from 8:00 a.m. through 11:40 a.m. revealed: *At 8:00 a.m. she had been sitting in her w/c in the dining room eating breakfast. She had no brace on her left hand or her neck. *From 9:25 a.m. through 11:05 p.m. she had continued to sit in her w/c in the day room by the</p>	F 280		
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F 280	<p>Continued From page 19</p> <p>nurses' station. She did not have a brace on her left hand.</p> <p>*From 11:30 a.m. through 12:00 noon she had been in the dining room eating her noon meal. She did not have a brace on her neck or left hand.</p> <p>*She had not been observed resting in her bed during any of that time frame.</p> <p>Random observations on 6/2/15 from 1:45 p.m. through 4:00 p.m. revealed resident 7 had been laying in her bed. She did not have a brace on her left hand.</p> <p>Interview on 6/2/15 at 5:00 p.m. with CNA E regarding resident 7 revealed:</p> <p>*The staff were to have repositioned and assisted her every two hours.</p> <p>*She was to have laid down to rest after breakfast and after her noon meal.</p> <p>*She was unsure about the blue brace for her left hand. She had believed that restorative therapy was to have put the brace on the resident's left hand.</p> <p>*The resident had just received a new wheelchair after working with therapies to help with better positioning.</p> <p>Interview on 6/3/15 at 9:20 a.m. with CNA A regarding resident 7 revealed:</p> <p>*She confirmed she had been assisting the resident the day before. The day had been very busy, and she could not remember if they had assisted her after breakfast and before her noon meal.</p> <p>*She had recently started staying up for longer periods at a time due to her new w/c. The w/c could recline back.</p> <p>*The staff would check and change the resident's</p>	F 280		

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F 280	<p>Continued From page 20</p> <p>incontinent brief. They would not have assisted her to the toilet.</p> <p>*She was to always wear the blue brace to her left hand. She also believed restorative therapy had been responsible to assist the resident with that brace.</p> <p>Review of resident 7's undated care plan revealed no documentation to support:</p> <p>*She had recently received a new w/c and could stay up for longer periods at a time.</p> <p>*She had required the use of a blue brace to her left hand everyday.</p> <p>*Occupational therapy had recently been working with her on positioning with the new w/c and during meal times.</p> <p>*The Kentucky collar had been discontinued.</p> <p>*The staff were to have checked and changed her incontinent brief without toileting her.</p> <p>*Her nutritional needs had not been reviewed and revised since 6/18/14.</p> <p>6. Observation on 6/1/15 at 5:45 p.m. of resident 10 revealed she had been sitting in a w/c in the dining room. She did not have any braces on her legs.</p> <p>Random observations on 6/2/15 from 8:30 a.m. through 3:30 p.m. revealed when she had been sitting up in her w/c she had braces on both of her legs. When she had been resting in her recliner the braces had been removed.</p> <p>Interview on 6/3/15 at 9:30 a.m. with CNA A revealed resident 10 was to have worn braces to her legs every day. They were to have been removed when she was laying down.</p> <p>Review of resident 10's undated care plan</p>	F 280		
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F 280	<p>Continued From page 21 revealed "[Resident's name] wears AFO's [braces] to bilateral lower legs for transfers only per her and her families request."</p> <p>7. Interview on 6/3/15 at 1:30 p.m. with the director of nursing, Minimum Data Set coordinator (MDS), and dietary manager revealed:</p> <ul style="list-style-type: none"> *The MDS coordinator had been responsible to ensure the residents' care plans had been reviewed and revised. *All departments were responsible for their own updating of the care plans. *The dietary manager confirmed she had not consistently reviewed and revised the care plans to reflect the resident's current health status. *They had been not been aware of all the discrepancies with care and the care plans as observed above on all three of those residents. *They had agreed the care plans should have: <ul style="list-style-type: none"> -Reflected the resident's current health status. -Been reviewed and revised more frequently. <p>Review of the provider's undated Care Plan policy revealed:</p> <ul style="list-style-type: none"> *"A comprehensive care plan will be developed for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial problems, needs, and/or strength that are identified in the initial assessments." *"The comprehensive care plan will be periodically reviewed and revised by a team of qualified persons after each assessment review." *"Care plan elements must include specific problems/needs/strengths, specific goals, and interdisciplinary approaches/interventions." 	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	<p>Continued From page 22 HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure effective chronic pain management for 1 of 12 sampled residents (3) who voiced and exhibited signs and symptoms of pain during personal care. Findings include:</p> <p>1. Observation on 6/2/15 from 8:40 a.m. through 9:10 a.m. with licensed practical nurses (LPN) C and D assisting resident 3 with personal care revealed: *The resident had been laying in bed on his right side. *Both of his: -Legs had been bent and pulled up to his stomach area. -Arms had been bent and pulled up to his chest area. -Hands were bent inwards towards the palm of his hands. *He had been awake, alert, and able to understand both of the LPNs conversation and direction. *During the entire process of cleansing and dressing resident 3 the LPNs had to stretch, pull</p>	F 309	<p>F 309</p> <p>Correct to the individual: Resident 3's care plan updated to reflect pain with non-pharmacological interventions. A pain patch was added to the individual. PAINAD tool has been put in place.</p> <p>Correct to all others: <i>*all JK/SOOTH/JJ</i> Education was given to nursing staff and med-aides on PAINAD, pain monitoring and non-pharmacological interventions <i>*on 6/29/15.</i> Pain policies were given to all individuals <i>*JK/SOOTH/JJ</i> educated. <i>*the PAINAD tool will be used to evaluate all residents for pain with cognitive impairment. JK/SOOTH/JJ</i></p> <p>System Correction: PAINAD has been added to all MARS on all units. Audits will be completed weekly times four and then monthly times four <i>*by the DNS or designee. JK/SOOTH/JJ</i></p> <p>Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. <i>*The DNS or designee will be responsible for reporting all</i> Correction Date: <i>audits to the QAPI team for review. JK/SOOTH/JJ</i> July 20, 2015</p> <p><i>* [Redacted] JK/SOOTH/JJ</i></p>	7-20-15
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F 309	<p>Continued From page 23</p> <p>his legs, arms, and hands.</p> <p>*He had become very anxious prior to and during any movement of his legs and arms.</p> <p>*During the entire time frame he cried out and voiced several times "owe, that hurts."</p> <p>*He had yelled out louder as his anxiety level increased.</p> <p>*The LPNs had informed him of every movement they had to perform for him. On several occasions they had told him that "It's going to hurt." Loudly he would repeat what they had said.</p> <p>*The LPNs had not asked the resident or offered to stop during the entire process of performing personal care and dressing the resident.</p> <p>*LPN C had informed the resident "It it will be better when we are done and you are out to breakfast. You can have your pain medication then."</p> <p>Surveyor: 32335 Review of resident 3's undated care plan revealed:</p> <p>*There had been no problem area for pain.</p> <p>*Under the behavioral problem area there had been one intervention that stated "Monitor resident for signs of pain and offer prn [as needed] pain meds [medications] as ordered."</p> <p>*Under the activities of daily living problem area there had been one intervention that stated "Staff to monitor resident for pain (aggressiveness, agitation) and encourage/administer pain med as ordered."</p> <p>*There had been no other interventions listed for pain.</p> <p>*He had behaviors of yelling out, hitting, spitting at staff, and refusing medications and care.</p> <p>Review of resident 3's interdisciplinary notes</p>	F 309		

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F 309	Continued From page 24 revealed: *On 3/19/15 a weekly charting note read "Continues with behaviors of hitting, biting, spitting, raising voice, swearing, and pinching." *On 3/31/15 at 5:29 p.m. the behavior note stated "Resident threw supper tray away from himself and raised his voice." *On 4/9/15 the weekly charting note read "Continues with behaviors of hitting, spitting, biting, raising voice, swearing, pinching and making sexually inappropriate remarks. Will monitor." *On 4/27/15 the behavior note stated "Resident had a number of behaviors this morning - he pinched staff when dressing him for the day. He spit water at staff when assisting him brush his teeth. When eating breakfast he threw his breakfast cereal at therapy - threw his milk and orange juice at staff." *On 4/30/15 the weekly charting note stated "Complains of various pain; takes scheduled and PRN hydrocodone APAP [pain medication] 7.5/325 mg [milligrams]...Continues to have behaviors of hitting, slapping, biting, pinching, grabbing, raising voice, swearing, throwing items, and making sexually inappropriate remarks. Will monitor." *On 5/5/15 the behavior note stated "[Resident name] started the morning very demanding and belligerent [threatening] he was spitting, hitting, throwing things and trying to pinch staff. He was verbally loud and aggressive with therapy staff when they were trying to work with him. He ate all of his breakfast and was quiet with no behaviors on the drive to [work]. Upon pickup from [work] - staff reported that he was very verbally aggressive, spitting, hitting, and throwing things from across the work room." *On 5/21/15 the weekly charting note stated	F 309			

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F 309	<p>Continued From page 25</p> <p>"Today resident has been noted to be yelling out frequently. When asked if he had pain, resident stated no. When asked if he had back pain resident repeated 'back pain.' Resident was given a PRN hydrocodone/APAP 7.5/325 mg. Resident continued to yell out for about twenty minutes but was noted to be resting with eyes closed after a half hour."</p> <p>*There had been no documentation regarding non-pharmacological (non-medication) interventions attempted for his pain.</p> <p>Interview on 6/2/15 at 3:00 p.m. with the Sunset Villa coordinator regarding resident 3 revealed: *He had not verbally complained of pain everyday. *She agreed he could be in pain due to his contractures (shortening and hardening of muscles). *They had not given him his pain medication prior to getting him up that morning, because they had not wanted him to choke on his pills. *They had not discussed any other forms of pain medication such as a patch. *They had not attempted any non-pharmacological interventions.</p> <p>Interview on 6/3/15 at 3:30 p.m. with the director of nursing (DON) and licensed social worker revealed: *They had talked with the family today to switch his pain medication to a patch instead of a pill. *They agreed some of his behaviors could be related to pain. *They had not attempted any non-pharmacological interventions.</p> <p>Review of the provider's May 2015 Pain Management policy revealed:</p>	F 309		

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F 309	Continued From page 26 *Tools that measured non-verbal indicators of pain shall be used for severely cognitively impaired residents. *A plan of care should be implemented. *There should have been ongoing monitoring and documentation of the effectiveness of the pain management program. *Interventions to minimize medication side effects should be implemented.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation and interview, the provider failed to ensure: *Five of twelve observed dining room chairs in one of three dining rooms (main) had been in good condition/repair. *Three of eight observed exit doors (north wing, south wing, and the lounge area) security alarm had activated and the digital panel had displayed the exit doors upon opening. Findings include: 1. Observation on 6/2/15 at 11:10 a.m. in the main dining room revealed: *Several dining room chairs that had cloth	F 323	F 323 Correct to the individual: The system change will correct the cited deficiency. Correct to all others: New dining room chairs will be ordered. All exit door alarms were fixed. Education will be completed with all staff on the procedure of door alarms and the door exits will be included in the daily maintenance check log to ensure they are working properly. * Education of the system change to all staff was completed on 6/3/15. System correction: JK/SDDOK/JJ Chairs will be replaced and exit doors will be working properly. Audits will be completed two times weekly for four weeks, then weekly for four weeks and then monthly thereafter. * by maintenance or designee. JK/SDDOK/JJ Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. * The maintenance supervisor or designee will be responsible for reporting Correction Date: all audits to the QAPI team for review. July 20, 2015 JK/SDDOK/JJ	7-2015

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F 323	<p>Continued From page 27</p> <p>coverings and wooden arm rests.</p> <p>*One of those chairs had an arm rest that was detached from the chair. It was hanging loosely on the side of the chair with a sharp pointed screw exposed where the arm rest had detached. The unidentified resident who had been sitting in that chair was observed independently transferring himself.</p> <p>*The back covers on four of the dining room chairs had been detached from the chairs. There had been several exposed sharp staples in those detached areas. Four unidentified residents had been observed independently transferring themselves in and out of those chairs.</p> <p>Interview on 6/3/15 at 10:15 a.m. with the administrator and maintenance director revealed they had not been aware the above dining room chairs had been in poor repair. They confirmed the staples and screw had created the potential for injury to the residents.</p> <p>2. Random observations on 6/2/15 from 8:30 a.m. through 2:00 p.m. revealed:</p> <p>*A digital panel located above the north wing door and at the end of hallway one.</p> <p>*At the end of the south and north wing hallways were exit doors.</p> <p>*Both of the doors were unlocked and when they were opened:</p> <p>-The alarms did not sound.</p> <p>-The north wing hallway displayed across the digital panel indicating it had been opened.</p> <p>*The south wing door had not been displayed on the digital panel as having been opened.</p> <p>*No staff had been observed checking the doors or the digital panels upon opening them by the surveyor.</p>	F 323 *	 <i>JK/SADH/JJ</i>	

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F 323	<p>Continued From page 28</p> <p>Random observation on 6/2/15 from 10:20 a.m. through 2:00 p.m. of the lounge revealed:</p> <ul style="list-style-type: none"> *An exit door on the west wall. *The door had been unlocked and easily opened by the surveyor. *The exit door opened to a small enclosed area and a second steel door. That second steel door had been labeled as an exit door. *An alarm did not sound when the second exit door was opened by the surveyor. That exit door opened to a cemented sidewalk that slanted downwards and lead to the back of the building. *The back of the building had not been secured and was located by several houses, sheds, and garages. *No staff had been observed checking both of the doors or the digital panels upon opening them by the surveyor. Staff could be heard in the lounge area and the hallways close by. <p>Interview on 6/2/15 at 3:15 p.m. with the administrator revealed:</p> <ul style="list-style-type: none"> *The exit doors should not have alarmed when they were opened. *When the exit doors are opened without a code, a signal would go to the staff's pagers. *The digital panel should have displayed what door had been activated and the computer at the desk would have indicated what door had been opened. <p>Interview on 6/3/15 at 10:20 a.m. with the administrator and maintenance director confirmed the above interview and observation of the exit door located in the lounge area. They had not been aware the digital panels were not working correctly. Further observation confirmed the digital panels had not been working when the north door had been opened during that interview.</p>	F 323			

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F 323

Continued From page 29
The checking of the exit doors had been on the maintenance director's check list to monitor for security. They would have expected the exit doors to notify the staff through their pagers, the digital panels and the computer when they had been opened.

F 323

F 329
SS=D

The provider was asked for the policy and procedure on the exit door alarms. None was provided by the end of the survey.
483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

F 329

F 329
Correct to the individual:
Resident 3's physician orders reflect all current diagnosis.

7-20-15

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

resident's
JK/S000H/JJ

their
scheduled
JK/S000H/JJ

Correct to all others:
Education will be given to all nursing staff to ensure all medications have a diagnosis by 6/29/15. JK/S000H/JJ
System correction:

All medications and diagnosis will be reviewed with MDS. Any discrepancies will be reported to the physician and corrected. Audits will be done weekly times four and then monthly times four* by the DNS or designee. JK/S000H/JJ

Monitoring of System:
The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. * The DNS or designee will be responsible for reporting all
Correction Date: audits to the QAPI team for review. July 20, 2015 JK/S000H/JJ

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JK/S000H/JJ

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F 329	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to have an appropriate diagnosis for one of one sampled resident (3) prescribed olanzapine (Zyprexa) an antipsychotic medication (mood altering). Findings include:</p> <p>1. Review of resident 3's medical record revealed: *He had been admitted on 8/26/14. *He had been started on Zyprexa 2.5 milligram (mg) two times per day on 9/4/14.</p> <p>Review of a 10/6/14 note from the behavioral health facility working with resident 3 revealed he had been started on Zyprexa for agitation and aggression. His listed diagnoses were dementia with behavioral disturbances, alcohol dependence, and depressive disorder.</p> <p>Review of resident 3's acute care plan medication follow-up charting revealed: *On 10/6/14 the Zyprexa had been increased due to anxiety. *On 11/7/14 the Zyprexa had been increased due to increased anxiety. *On 11/26/14 the Zyprexa had been increased due to increased agitation. *On 1/28/15 the Zyprexa had been increased due to increased aggression.</p> <p>Review of resident 3's 4/13/15 behavioral health note revealed a description of "Age or TBI [traumatic brain injury] related to behavioral disturbances as evidenced by aggression, agitation, anxiety, and depression."</p>	F 329		
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F 329	<p>Continued From page 31</p> <p>Review of resident 3's 4/28/15 physician's orders summary sheet revealed the following diagnoses:</p> <ul style="list-style-type: none"> *Closed skull fracture. *Intestinal infection. *Urinary tract infection. *Disorder of penis. *Therapeutic drug monitoring. *Abnormal involuntary movements. *Lack of coordination. *Dementia (loss of mental ability). *Muscle weakness. *Malaise (feeling sick or uncomfortable) and fatigue. *Psychosis (generic term for mental state). *Weight loss. *Muscle spasm. *Constipation. *Acute venous embolism (blood clot within the vein). *Insomnia (inability to fall asleep or to stay asleep). *Convulsions (body muscles contract and relax rapidly and repeatedly). <p>Interview on 6/2/15 at 3:00 p.m. with the Sunset Villa coordinator revealed the Zyprexa had been used for his agitation and aggression. An appropriate diagnosis had been requested by this surveyor at that time and had not been provided by the time the survey team exited the facility.</p> <p>Review of the Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., Lexi-Comp, Ohio, 2011, p. 1276, revealed Olanzapine (Zyprexa) had the following warning: elderly patients with dementia-related psychosis treated with antipsychotics were at an increased risk of death. Zyprexa was used for the treatment of</p>	F 329			

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F 329	Continued From page 32 manifestations of schizophrenia; treatment of acute or mixed mania episodes associated with bipolar I disorder; maintenance treatment of bipolar disorder; acute agitation (patients with schizophrenia or bipolar mania).	F 329		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure: *Medications were available from the pharmacy for five of six sampled residents (11, 17, 18, 19, and 20).	F 425	F 425 Correct to the individual: The system change will correct the cited deficiency. * This system was discussed and reviewed with pharmacy on 6/15/15, 6/24/15, and 7/15/15. Will be completed by 7/15/15. Correct to others: Education will be given to charge nurses and med-aides on medication availability and the locking of the medication carts by 6/29/15. JK/5000H/JJ System Correction: When facility is notified of a medication unavailability, the charge nurse will notify MD immediately and inform pharmacy of any follow up orders. Nursing documentation will be completed in LTC. Administrator and DNS will be notified if needed. Audits will be completed weekly times four and then monthly times four for medication availability by the DNS or designee. Monitoring System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. * The DNS or designee will be responsible for reporting all audits to the OAPI team for review. Correction Date: July 20, 2015 * [Redacted] JK/5000H/JJ	7-20-15

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2015
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	<p>Continued From page 33</p> <p>*The medication cart was secured from unauthorized personnel, residents, and visitors during one of one random observation in the challenging behavior unit. Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 11's May 2015 medication administration record (MAR) revealed: *Symbicort (for asthma or chronic obstructive lung disease) unavailable from 5/8/15 at 7:00 a.m. through bedtime (HS) on 5/10/15. *Furosemide (fluid retention) 40 milligrams (mg) not available from 5/2/15 through 5/4/15 at 7:00 a.m. 2. Review of resident 17's May 2015 MAR revealed "Acetaminophen 325 mg two tablets not given/no supply" on 5/2/15 at HS. 3. Review of resident 18's May 2015 MAR revealed: *Patanol (for allergies) eye drops not available/on backorder from 5/30/15 at 7:00 a.m. through 5/31/15 at HS. *Metformin (diabetes) 500 mg not here from pharmacy on 5/13/15 at 8:00 a.m. 4. Review of resident 19's May 2015 MAR revealed Lithium (for bipolar disease [mood disorder]) 200 mg "awaiting to arrive from pharmacy" from 5/22/15 through 5/23/15 at HS. 5. Review of resident 20's May 2015 MAR revealed Olanzapine (treatment of schizophrenia [mood disorder] "not given/no supply" on 5/2/15 through 5/3/15 at HS. 6. Interview on 6/2/15 at 2:30 p.m. with the director of nursing regarding the above residents 	F 425		

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F 425	<p>Continued From page 34 revealed:</p> <ul style="list-style-type: none"> *Resident 11 refused to have his Symbicort ordered from the local pharmacy due to cost. They had not documented his refusal. *Hospice was aware his furosemide (removes extra fluids in the body) was not given as the pharmacy was unsure if hospice would pay for the medication. *She was unsure why the other residents' medications had not been sent by the pharmacy for them to administer. *They had not informed any of the residents' physicians of any of the omitted medications. *She was not aware that any of the residents experienced any negative consequences as a result of the omitted medications. *They had not followed their pharmacy policies for medications that were unavailable. <p>Review of the provider's 12/1/07 pharmacy Backorder policy revealed "When pharmacy temporarily cannot supply a medication for a new order or a refill order, facility should coordinate with pharmacy to obtain delivery or partial delivery from pharmacy or a third party pharmacy, or arrange for delivery of an alternative medication from pharmacy."</p> <p>Review of the provider's 12/1/07 Medication Shortages/Unavailable Medications policy revealed:</p> <ul style="list-style-type: none"> **Upon discovery facility staff should immediately initiate action to obtain the medication from pharmacy." ***If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the emergency medication supply to administer the dose." 	F 425		

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F 425	Continued From page 35 *"If the medication is not available in the emergency medication supply facility staff should notify pharmacy and arrange for an emergency delivery." *"If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or instructions." 7. Observation on 6/3/15 at 11:30 a.m. in the challenging behavior unit revealed: *The medication room door was open. *The medication cart was unlocked. There was a container of applesauce and an empty syringe on the top of the cart. *There was no licensed staff in the medication room. *There were residents with cognitive (poor memory recall) impairment in the hallway outside the medication room. *One random ambulatory (walking) resident entered the medication room. Interview on 6/3/15 at 11:30 a.m. with registered nurse I regarding the above revealed she: *Was the charge nurse on the unit and had just stepped out of the challenging behavior unit for a few moments to complete another task. *Should have locked the medication room prior to leaving the area.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	F 441 Correct to the individual: System change will correct the cited deficiency. Correct to other: Education will be given to all staff on hand washing. Education will also be given to	7-2015

by
6/29/15
JK/SPD/JSJ

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F 441	Continued From page 36 (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. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for: *One of three sampled residents (7) who received personal care by two of two certified nursing	F 441	nurses in regards to glove changes during cares and dressing changes. Nursing protocol will be reviewed with all nursing staff. System Correction: All employees will complete a hand washing competency. All new hires will be required to complete the hand washing competency upon hire. Audits will be done weekly times four and then monthly times four by the DNS or designee. Monitoring System: The results of the audits will be reviewed at the monthly QAPI meetings with updates as needed. The DNS or designee will be responsible for reporting all audits to Correction Date: the QAPI team for July 20, 2015 review. [REDACTED]	

by 6/30/15 JK/SD00H/JJ

JK/SD00H/JJ

JK/SD00H/JJ

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F 441	<p>Continued From page 37 assistants (CNA) (B and E). *One of two sampled residents (3) who had a dressing change by one of two licensed practical nurses (LPN) (D). Findings include:</p> <p>1. Observation on 6/2/15 at 3:50 p.m. of CNAs B and E during personal care for resident 7 revealed: *They had prepared to perform personal care for resident 7. *They had sanitized their hands and put on clean gloves. *After they had completed the personal care for the resident they removed their soiled gloves and washed their hands. *Both CNA B and E washed their hands for five seconds.</p> <p>2. Observation on 6/2/15 at 8:50 a.m. with LPNs C and D during a dressing change for resident 3 revealed: *They had entered the resident's room to assist him with personal care and a dressing change to his coccyx (tailbone) area. *They sanitized their hands and put on clean gloves. *The resident had been laying on his right side in his bed. *He had been unable to move independently and required LPN C to assist him with proper positioning for personal care prior to his dressing change. *He had been incontinent (unable to control) of bowel movement. *With those gloved hands LPN D: -Assisted the resident to roll further on his right side. -Removed a soiled pad and urine soaked</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037		
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F 441	<p>Continued From page 38</p> <p>incontinent brief from underneath the resident.</p> <ul style="list-style-type: none"> -Cleansed the resident's bottom with wet wipes. -Removed a small tan sticky dressing from the resident's coccyx area. -Retrieved a clean wet wipe and washed the wound on his coccyx. -Retrieved a small tan dressing, opened it, and applied it to the wound. -Went to his closet, opened the curtain, and retrieved a clean incontinent brief. -Assisted LPN C to put on the clean incontinent brief. <p>*LPN D:</p> <ul style="list-style-type: none"> -Removed her soiled gloves, went to the sink in the bathroom, and turned on the faucet handles. -Washed her hands for eight seconds -Dried her hands, threw the hand towels away, and turned off the faucet handles with her clean hands. <p>Interview on 6/3/15 at 2:10 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *They had just recently done hand hygiene education. *She had confirmed the above technique used to provide personal care and the dressing change had not been sanitary. *She would have expected the staff to follow the provider's policy and procedures for hand washing and for proper dressing changes. <p>Review of the provider's undated Hand washing policy revealed:</p> <p>*Procedure:</p> <ul style="list-style-type: none"> - "Apply soap and work into lather over hands and wrists using friction for 20 seconds." - "Use clean paper towel to turn off water." <p>Review of the provider's undated Pressure Ulcer</p>	F 441		

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F 441	Continued From page 39 protocol revealed: *The DON confirmed the above protocol had included dressing change technique. *There had been no procedure in place on the protocol for when hand washing and changing soiled gloves should occur during a dressing change. No further policies and procedures had been provided upon request from the surveyor prior to exit on 6/3/15.	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 6/2/15. Sunset Manor Avera Health (1966 original and 1997 addition building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/2/15 upon correction of the deficiencies identified below. 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			
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain two conforming exits on each floor or fire section of the building. The east basement mechanical room had only one	K 032		F	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **7-07-15**

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.

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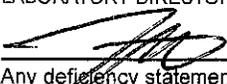
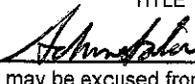
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/02/2015
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K 032	<p>Continued From page 1 conforming exit. Findings include:</p> <p>1. Observation at 11:30 a.m. on 6/2/15 revealed the exit stairway from the basement mechanical room discharged into the corridor system on the main level. The second exit from the basement mechanical room was through a window to an area well equipped with a fixed ladder. Review of the previous survey data indicated that condition had existed since the original construction.</p> <p>The deficiency would not affect any resident smoke compartments.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiency identified in K000.</p>	K 032			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2015
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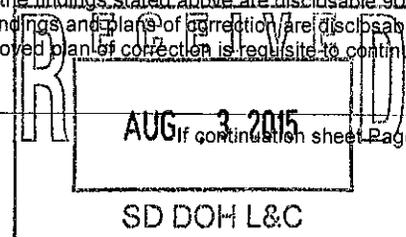
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 6/2/15. Sunset Manor Avera Health (2008 remodel building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for new health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE 7/27/15
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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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037
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S 000	Initial Comments Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/1/15 through 6/3/15. Sunset Manor Avera Health was not found in compliance with the following requirement: S301.	S 000	Addendums noted with an asterisk per 7/9/15 telephone to facility DON. JK/S200H/JJ	
S 301	44:04:07:16 Required dietary in-service training The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. 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 six of nine required dietary trainings (food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, and sanitation requirements) were given to all staff who handled food. Findings include: 1. Observation on 6/2/15 at 8:00 a.m. in the	S 301 by 6/30/15, JK/S200H/JJ	Correct to individual: No individuals were affected. Correct to others: No others were affected. System Correction: All staff in nursing facility will be trained on the nine required dietary trainings. The trainings will be included in new employee orientation and also done yearly at an All Staff meeting. Audits will be done on all new employees for 12 months* by the dietary manager or designee. JK/S200H/JJ Monitoring System: The results of the audits will be reviewed at the monthly QAPI meetings with updates as needed. *The dietary manager or designee will be responsible for reporting all audits to the QAPI team for review. Correction Date: June 30, 2015 * [Redacted] JK/S200H/JJ	6-30-15

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

[Signature]

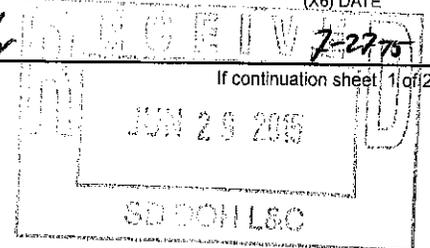
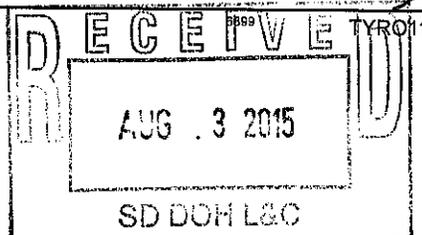
TITLE

Administrator

(X6) DATE

7-27-15

STATE FORM



If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 129 E CLAY ST IRENE, SD 57037
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 301	<p>Continued From page 1</p> <p>Sunset Villa unit revealed an unidentified certified nursing assistant (CNA) had been serving breakfast. She had prepared cereal and beverages for the residents.</p> <p>Observation and interview on 6/2/15 at 12:05 p.m. in the challenging behavior unit revealed CNA G had been serving the trays of food. She stated they prepared beverages and snacks for the residents.</p> <p>Interview on 6/3/15 at 9:15 a.m. with the dietary manager revealed they only provided the required nine dietary trainings to the kitchen staff. They had not included the staff from Sunset Villa or the challenging behavior unit in those trainings. All staff had received food safety, handwashing, and nutrition and hydration.</p>	S 301		
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