

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2015
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NAME OF PROVIDER OR SUPPLIER TIESZEN MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST STATE ST MARION, SD 57043
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/28/15 through 7/30/15. Tieszen Memorial Home was found not in compliance with the following requirement(s): F221 and F441.	F 000	Addendums noted with an asterisk Per 9/3/15 telephone to facility administrator. JT/SDDOH/JJ	
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 discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, record review, and interview, the provider failed to ensure a restraint was assessed and used as the least restrictive device for one of one sampled resident (4) with a restraint. Findings include: 1. Random observation from 7/28/15 through 7/30/15 revealed resident 4 seated in her wheelchair with a restraint across her lap. Observation on 7/29/15 and on 7/30/15 during the breakfast meal revealed resident 4 seated in her wheelchair at the assisted dining table with the restraint across her lap. Review of resident 4's 11/6/14 Occupational Therapy (OT) Daily Treatment Note revealed: *The director of nursing (DON) and administration	F 221	*All residents with a device in place that could be considered a restraint will be assessed. JT/SDDOH/JJ Resident #4 will have a restraint assessment completed by the MDS nurse. If the assessment indicates the restraint is appropriate, it will continue to be used. If it is no longer appropriate, the MDS nurse will communicate with the facility DON and it will be removed. Any resident utilizing a restraint will have an assessment completed at the time of their quarterly assessment unless there is a significant change prior to the next quarterly assessment. The DON or designee will maintain a list of residents who are using any restraint on a log and monitor the assessment process completion dates, and the appropriateness of usage, weekly x 4 weeks. The DON will present the data to the QAPI committee at their monthly meeting for their review and further recommendations to ensure the policy on restraints is being followed. The DON or designee will monitor the removal of resident #4's restraint at meal times 3-5 x's per week to ensure nursing staff is following the care plan for resident #4. The logs will continue until their is 100% compliance for resident #4. The Director of Nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Laura Wilson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/21-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 24 2015

SDDOH LSC

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

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FORM APPROVED
OMB NO. 0938-0391

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F 221	Continued From page 1 agreed placing a special restraint on her wheelchair was the safest and least restrictive form of restraint. *The restraint prevented her from sitting on the floor in her room and scooting around. *The OT placed the restraint on her wheelchair. *She was unable to remove the restraint on command or by herself due to the restraints tight fit in the wheelchair. Review of resident 4's 11/6/14 care plan safety sheet revealed: *The restraint would be removed a minimum of every two hours. *The restraint would be removed while she was supervised at the meal table as well as for care. Review of resident 4's medical record revealed no further restraint assessments had been completed. Interview on 7/30/15 at 1:45 p.m. with the DON confirmed: *The restraint had been put on resident 4's wheelchair following OT's recommendation. *No restraint assessments had been completed. *Resident 4's restraint should have been removed when she was supervised at meal times. *The provide had no current restraint policy.	F 221	will present the logs to the monthly QAPI meeting for their review and further recommendations. All staff involved in resident care will be re-educated on resident #4's care plan on August 26, 2015*by the director of nursing. <i>JT/SODOH/JT</i>	9/10/15	
F 441 SS=E	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			

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F 441	<p>Continued From page 2</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030</p> <p>Surveyor: 32331 Based on observation, interview, product information, manufacture's recommendations,</p>	F 441			

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F 441	<p>Continued From page 3</p> <p>and policy review, the provider failed to ensure appropriate sanitary practices were followed for:</p> <p>*Urinals and collection hats (a type of measuring container used in a toilet) on one of two floors (upstairs or second floor) by housekeeping staff person A.</p> <p>*Residents' sinks and toilets in two of four resident areas (North and Main halls) by housekeeping staff person B.</p> <p>Findings include:</p> <p>1. Interview on 7/30/15 at 8:35 a.m. with certified nursing assistant (CNA) C in the second floor regarding the cleaning of the residents' urinals and collection hats revealed:</p> <p>*Those resident items were placed and bagged in plastic bags after each days use and placed in an unmarked soiled utility room's sink on second floor.</p> <p>*The housekeeping department was responsible for cleaning those resident items.</p> <p>Interview and observation on 7/30/15 at 8:40 a.m. with housekeeping assistant A regarding the cleaning of the residents' urinals and collection hats revealed:</p> <p>*The cleaning of those above items were the responsibility of the housekeeping department for all residents that had used them.</p> <p>*Those above items were bagged and placed in the soiled utility rooms on the first and second floors by the CNAs.</p> <p>*She demonstrated she used the EcoLab Oasis 499 HBV Disinfectant (a cleaner and disinfectant) for cleaning the urinals and hats by:</p> <p>-Those above items were located in the utility room's sink on the second floor.</p> <p>-That above product was the only one she had used on those items to clean them between</p>	F 441	<p>1. Housekeeping staff member A and all other housekeeping staff as well as other resident care staff will be re-educated on the proper procedure to disinfect resident urinals and collection hats by the facility infection control nurse and the housekeeping supervisor *by 8/28/15. JT/5000H/JJ</p> <p>2. Housekeeping staff member B as well as all other housekeeping staff and other resident care staff will be re-educated on the proper porcedure to properly disinfect resident toilets and sinks by the facility infection control nurse and the housekeeping supervisor *by 8/28/15. JT/5000H/JJ</p> <p>The infection control nurse and/or Housekeeping supervisor will conduct random checks 3-5 x's per week to determine proper procedures are being followed by both staff members A & B as well as any other housekeeping staff. A log of these checks will be presented to the QAPI committee for their review and further recommendations by the Housekeeping Supervisor.</p> <p>3. The infection control nurse and Housekeeping supervisor will review the current Housekeeping policies and procedures and update the information as deemed appropriate. All Housekeeping staff will be re-educated on any changes that are made to the policies and procd dures as they are reviewed. The Housekeeping supervisor will present any new or updated policies and procedures to the QAPI committee on a monthly, as needed basis.</p> <p>the house keeping staff and to JT/5000H/JJ</p>	<p>9/10/15</p>

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F 441	<p>Continued From page 4 residents' uses.</p> <p>*After using the cleaner on the urinals and hats she let the chemical sit for a "few seconds" and then wiped it down with a dry cloth.</p> <p>*She had not let the urinals and hats air dry prior to placement in a drawer on the side of the sink.</p> <p>Interview on 7/30/15 at 9:00 a.m. with housekeeping assistant B regarding the cleaning of the residents' urinals and collection hats revealed:</p> <p>*The cleaning of those items were the responsibility of the housekeeping department.</p> <p>*Those items were bagged and placed in the soiled utility rooms on the first and second floors by the CNAs.</p> <p>*She used the EcoLab Oasis 499 HBV Disinfectant for cleaning and disinfecting the urinals and hats.</p> <p>Surveyor: 34030</p> <p>2. Observation and interview on 7/29/15 at 11:30 a.m. of housekeeping assistant B cleaning a resident room revealed:</p> <p>*She worked mostly full time hours at this time.</p> <p>*She cleaned residents rooms for the north and main hallway resident areas that was approximately half of the facility.</p> <p>*While cleaning the residents toilet and sink she:</p> <ul style="list-style-type: none"> -Used Oasis 499, a spray disinfectant. -Sprayed it on the surface areas of the toilet and sink. -Immediately wiped off the disinfectant with a dry cloth. <p>*She cleaned all her rooms that way.</p> <p>Interview on 7/29/15 at 2:45 p.m. with the head of maintenance and housekeeping revealed:</p> <p>*The product label for the Oasis 499 showed</p>	F 441		
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F 441	<p>Continued From page 5</p> <p>surfaces needed to be wet for ten minutes in order to kill all germs. *He agreed the housekeeper had not left the disinfectant on the sinks and toilets long enough.</p> <p>Interview on 7/29/15 at 3:00 p.m. with the infection control nurse revealed she agreed the resident's toilets and sinks had not been adequately disinfected.</p> <p>Review of the provider's undated Restroom Cleaning and the Toilet and Urinal Disinfection and Cleaning procedures revealed no mention of how long the disinfectant was to be left on surfaces for adequate disinfection to occur.</p> <p>Surveyor: 32331 3. Review of the EcoLab Oasis 499 HBV Disinfectant Material Safety Data Sheet revealed the product was a cleaner and disinfectant.</p> <p>Review of the EcoLab Oasis 499 HBV Disinfectant's product label for directions as a urinal disinfectant and cleaner revealed a ten-minute contact time was necessary.</p> <p>Interview on 7/30/15 at 10:00 a.m. with the infection control nurse and the maintenance and housekeeping supervisor regarding the cleaning of the residents' urinals and collection hats revealed: *The EcoLab Oasis 499 HBV Disinfectant was the product to have been used. -It was to have remained wet for a ten-minute contact time and allowed to air dry when used on urinals and collection hats. -Those above items had not been disinfected properly. *Both agreed the manufacturer's instructions had</p>	F 441		

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F 441	<p>Continued From page 6 not been followed. *Both agreed there was a potential for contamination.</p> <p>Review of the provider's revised 6/20/1993 Housekeeping Procedures sheet revealed the urinals were cleaned daily.</p> <p>Review of the provider's 2001 Cleaning and Disinfecting Non-Critical Resident-Care Items policy revealed: *It provided guidelines for disinfection on non-critical resident care items (those that come in contact with intact (not open or injured) skin. *Manufacturers' instructions were to have been followed for proper use of disinfecting products. *Steps in the procedure for urinals and measuring graduates (used to measure the volume of liquid) that would have included collection hats were to have: -Been rinsed with warm water after each use. -Been disinfected following manufacturer's dilution instructions. -Poured solution into the above and allowed to have set for ten minutes. -Flushed the solution down the toilet. -Allowed the above to have air dried.</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
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NAME OF PROVIDER OR SUPPLIER TIESZEN MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 312 EAST STATE ST MARION, SD 57043
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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 7/29/15. Tieszen Memorial Home 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 7/29/15 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 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain the one hour fire resistive rating of vertical openings.	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Karna Wilson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-21-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 033	<p>Continued From page 1</p> <p>*The west stair enclosure walls did not extend to the underside of the roof deck of the 1976 addition.</p> <p>*The north basement stair enclosure door was equipped with a twenty minute fire resistive door assembly.</p> <p>*The east and west stair enclosure doors were not provided with labels and contained glass vision panels.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation at 10:00 a.m. on 7/29/15 revealed a twenty minute fire resistive door assembly had been installed in the north stair enclosure from the basement. Review of the previous life safety code survey revealed the original 1 3/4 inch metal door had been replaced with the present door approximately eight years ago. 2. Observation at 10:30 a.m. on 7/29/15 revealed the upper and lower east and the upper west stair enclosure doors had not been provided with labels to identify the fire resistive rating. The upper and lower east stair enclosure doors had been equipped with a 35 by 21 inch vision panel. Review of the previous life safety code data identified that had been part of the original construction. 3. Observation at 10:45 a.m. on 7/29/15 revealed the west stair enclosure walls did not extend to the underside of the roof deck. Further observation revealed the exterior window was exposed to the 1976 addition roof. Review of the previous life safety code data identified that had been part of the original construction. 4. This deficiency affected the second floor smoke compartment and between twelve to 	K 033		

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K 033	Continued From page 2 fourteen residents.	K 033		
K 034 SS=C	<p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation, measurements, and record review, the provider failed to maintain conforming exit stairs (west stair enclosure). Findings include:</p> <p>1. Observation and measurement at 9:30 a.m. on 7/29/15 revealed the tread widths for the stairs in the west stair enclosure varied from 9 1/2 to 12 inches between adjacent stairs. Review of previous survey data identified that condition had been part of the original construction.</p> <p>This deficiency affected the second floor smoke compartment and between twelve to fourteen residents.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.</p>	K 034		F

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10647	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/30/2015
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S 000	Initial Comments Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/28/15 through 7/30/15. Tieszen Memorial Home was found not in compliance with the following requirements: S166 and S323.	S 000	<i>Addendums noted with an asterisk per 9/3/15 telephone to facility administrator. JT/SADOH/JJ</i>	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		

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

Diana Wilson

TITLE

Administrator

(X6) DATE

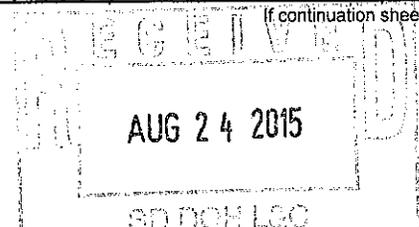
8/2/15

STATE FORM

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If continuation sheet 1 of 5



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10647	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/30/2015
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NAME OF PROVIDER OR SUPPLIER TIESZEN MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 312 E STATE ST MARION, SD 57043
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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 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain and/or provide an audible alarm for unattended exterior doors. The main entrance door alarm to the nursing home was not activated when unattended. The door separating the nursing home from the attached assisted living was not equipped with a door alarm. Findings include:</p> <p>1. Observation at 11:30 a.m. on 7/29/15 revealed the audible door alarm at the main entrance to the nursing home was not activated. Interview with the administrator at the time of the observation revealed the alarm was activated at 10:00 p.m. The staff located in the area that monitored the front entrance door left the facility between 5:30 p.m. and 6:00 p.m. That left four hours when the door would be unattended. They had a written procedure for turning off the exterior door alarm when the door was attended, but failed to account for the four hour period between</p>	S 166	<p>The facility will ensure that the front door to the facility will have an audible alarm during the hours for which it is unattended. The facility will ensure the door leading from the nursing home to the assisted living will be equipped with an audible door alarm.</p> <p><i>* The doors will be fixed by the door alarm company by 9/18/15. Monitoring of doors will be by the charge nurse until it is fixed. Monitoring of those doors after they are fixed will be completed by the maintenance supervisor on a weekly basis with the results of those audits completed and reported to the QA PI Committee by the maintenance (continued on page 3)</i></p>	9/18/15
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S 166	Continued From page 2 6:00 p.m. and 10:00 p.m. 2. Observation at 11:45 p.m. on 7/29/15 revealed the door leading from the nursing home to the assisted living was not equipped with an audible door alarm. Because the attached assisted living did not retain residents with cognitive impairment door alarms would not be required. Nursing home residents would be able to enter the assisted living when that door was unattended. They could then exit to the outside without staff knowledge.	S 166	<i>Supervisor on a monthly basis or until no longer deemed necessary. JT/SD00H/JT</i>	
S 323	44:04:08:04.02 DOCUMENTATION OF DRUG DISPOSAL If a...nursing facility has a licensed pharmacy, outdated or discontinued medications must be returned to the pharmacy for disposition. In the absence of a licensed pharmacy, the method of disposition of outdated or discontinued medications must be handled and recorded in the resident's medical record as follows: (1) Legend drugs not controlled under SDCL 34-20B must be destroyed by a professional nurse and another witness; (2) Medications controlled under SDCL 34-20B must be destroyed in the facility by a pharmacist and a registered nurse; and (3) Medications, excluding controlled substances listed in SDCL chapter 34-20B, in unit dose packaging which meets packaging standards in chapter 20:51:13:02.01 may be returned to the pharmacy pursuant to chapter 20:51:13:02.01. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18560	S 323		

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S 323	<p>Continued From page 3</p> <p>Surveyor: 35625</p> <p>Based on record review, interview, and policy review, the provider failed to ensure drug disposal (medications destroyed) was documented for two of two residents sampled (14 and 15) with closed records. Findings include:</p> <p>1. Review of resident 14's closed record revealed he: *Was admitted on 4/8/15. *Had passed away 5/30/15. *Had active prescriptions for the medications atenolol (to lower blood pressure) and terazosin (allows easier urination with an enlarged prostate) at the time of his death. -No documentation was found regarding the disposal or what had happened with the two medications upon the resident's death.</p> <p>2. Review of resident 15's closed record revealed she: *Was admitted on 9/15/10. *Had passed away 1/24/15. *Had active prescriptions for morphine sulfate (a controlled medication for pain) and levsin (decreases the motion or activity of the stomach and intestine) at the time of her death. -No documentation was found regarding the disposal or what had happened with the two medications upon the resident's death.</p> <p>3. Interview on 7/30/15 at 10:10 a.m. with the director of nursing revealed she: *Was unable to locate the disposition sheets from the pharmacy regarding the above medications. *Stated she would contact their pharmacy to obtain additional documentation regarding the medications. -No information was received by the conclusion of the survey.</p>	S 323	<p><i>* Resident 14 and 15 have been discharged and unable to change past events. JT/SAAH/JJ</i></p> <p>The director of nursing will revise the policy and procedures regarding the disposal of medications of residents who discharge from the facility to include the following: A Paper Medication/Treatment Record will be printed to indicate the active medications of the said resident. This record will be matched with the drugs at the facility to ensure all medications are properly accounted for. The resident's close chart will remain in the Medication room or other area as designed by the Director of Nursing. Once the medications have been properly accounted for the chart will then be transferred to the closed record area of the facility.</p> <p><i>* The consultant pharmacist, administrator, and the director of nursing will revise the policy and procedure for disposal of medications of residents who discharge from the facility by 9/10/15. Education to all licensed nursing staff will be completed on the disposal of those medications by 9/18/15 by the director of nursing. The director of nursing will maintain a log of all discharged residents and</i> <i>(Continued on Page 5)</i></p>	9/18/15
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S 323	Continued From page 4 *Acknowledged the medications should have had a record of whether they were destroyed or returned to the pharmacy upon each resident's death. Review of the provider's November 2007 Destruction of Medications policy revealed: *Medications that could legally be returned to the pharmacy for credit would be returned. *Destroyed medications were to be documented on the medication accountability sheet and flushed down the toilet or hopper in the presence of two nursing staff. *Controlled medications were to be destroyed by a licensed nurse and the pharmacist.	S 323	give that log to the administrator Audits will be completed by the administrator on the disposal of medications of residents who discharge from the facility and the administrator will present those results to the QAPI committee on a monthly basis or until no longer deemed necessary. JT/5000H/JJ	