

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA BRADY HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>
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F 000	INITIAL COMMENTS  Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/28/15 through 9/30/15. Avera Brady Health and Rehab was found not in compliance with the following requirements: F281, F425, and F514.	F 000		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 A. Based on record review, interview, and policy review, the provider failed to ensure physician's orders had been followed for three of six sampled residents (2, 11, and 18) that received sliding scale insulin (injected medication given to lower blood sugar with the dose based on current blood sugar level). Findings include:  1. Review of resident 2's last signed 9/28/15 physicians's orders revealed: *She was admitted on 6/1/11. *Her diagnoses included diabetes (disease affecting blood sugar levels). *She was on a constant carb (carbohydrate) diet. *She had orders for glucometer (blood sugar checks) testing four times a day with sliding scale insulin. -There was a specific dose to give based on the glucometer results. -There was no order to hold the sliding scale if	F 281	1. Corrective action for each finding a. <del>Adjusted glucometer times, sliding scale times and insulin times for consistency throughout building.</del> b. <del>Adjusted Omeprazole administration times to align with 2015 Nursing Drug Handbook.</del> <i>See updated POC</i> 2. Changes made to the system <i>below. JH 11/12/15</i> a. <del>Education on glucometer times, scheduled insulin administration times and sliding scale insulin times.</del> b. <del>Glucometer times changed to ensure consistency throughout the building. Sliding scale insulin times changed to administration with meal insulin or with meal</del> c. <del>Education on giving medications according to drug handbook.</del> <i>See updated POC below. JH 11/12/15</i>	10/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Julie Hoffmann</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>10/22/15</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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F 281	<p>Continued From page 1 she did not eat. *She also had orders for two oral medications for her diabetes.</p> <p>Review of resident 2's diabetic flowsheets from March 2015 through September 2015 revealed her sliding scale insulin had been held by the nurse: *In March, four times at 12:00 noon. -On the back of the sheet documentation had included "not eating lunch." *In April, four times at 12:00 noon. -On the back was "refusing to eat," "not eating," "resident do not eat," and "ref [refused] lunch." *In May, four times at 12:00 noon. -On the back was "not eating lunch" and "not eating." *In June, four times at 12:00 noon. -On the back was "ref lunch" and "ref to eat." *In July, three times at 12:00 noon and one time at 4:00 p.m. -On the back was "due to not eating," "due to emesis [vomiting]," and "refused to eat." *In August, one time at 6:00 a.m., ten times at 12:00 noon, and one time at 6:00 p.m. -On the back was "refused to eat," "ref lunch," "due to not eating," "refused supper." *In September, ten times at 12:00 noon. -On the back was "ate poorly at lunch" and "ref lunch."</p> <p>Review of resident 2's interdisciplinary notes from March 2015 through September 2015 in the electronic medical record and the paper medical record revealed: *One nursing note on 7/18/15 that stated the noon insulin was held due to the resident refused to come out for dinner and refused to eat. *There were no other notes regarding the insulin</p>	F 281	<p>3. <b>Monitoring performance</b>  <del>a. Monitor Blood Sugar times and times of scheduled insulin administration.</del>  <del>b. DON/ADON to audit MARS to determine time of SS insulin administration.</del>  <del>c. Monitor times of Omeprazole Administration.</del>  <del>d. Audits will be completed weekly for 1 month, followed by every 2 weeks for 1 month, followed by monthly for 2 months.</del>  <del>e. DON/ADON/Designee will report compliance quarterly to Administrative QI team.</del>  <i>See updated POC below.</i>  <i>JH. 11/12/15</i></p> <p>1. <b>Corrective action for each finding</b>  a. Adjusted glucometer times, sliding scale insulin times, and scheduled insulin times, for residents 2, 11, 13, 14, and 18, and all other residents receiving these services to ensure consistency throughout building.  b. Adjusted omeprazole administration times for residents 19 and 21 and all other residents who receive this medication to align with 2015 Nursing Drug Handbook.</p>	11/12/15 JH.
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F 281	<p>Continued From page 2 being held. *There was no mention the physician had been notified of the insulin that was held by the nurse.</p> <p>Interview on 9/28/15 at 2:45 p.m. with registered nurse (RN) A revealed: *Resident 2 had orders for sliding scale insulin ordered by her physician. *If the nurse held the sliding scale insulin they would have documented on the back of the flow sheet the reason it was held. *The nurse typically gave the insulin after they knew the residents had eaten. *If the resident did not eat they might have held the insulin because of the potential risk of low blood sugar. *The physician would not be updated each time it was held but would have been updated on glucometer test results on rounds.</p> <p>Interview on 9/29/15 at 9:30 a.m. with RN B revealed: *The nurse would have decided if the sliding scale insulin should be held when the resident was not eating. *Sometimes they had a physician's order to hold the insulin if a resident did not eat. *Resident 2 did not have an order to hold her sliding scale insulin if she did not eat.</p> <p>Interview on 9/29/15 at 9:35 a.m. with the director of nursing (DON) revealed: *She was not aware of resident 2 having a history of low blood sugar levels. *Resident 2 refused to eat sometimes. *She felt the nurses used their judgement to decide when to hold sliding scale insulin. *They would not necessarily update the physician every time they held a medication.</p>	F 281	<p><b>2. Changes made to the system</b></p> <p>a. Education on consistency of Glucometer testing times, scheduled insulin administration times with meals, and sliding scale insulin administration times with meals, was given by the director of nursing (DON) and the consultant pharmacist on 10/15/15 for all nurses who could attend. The remaining nurses received the education on 10/20/15 or 10/21/15 from the DON. The medication aides received the education on 10/19/15 from the DON.</p> <p>b. Education on administration of omeprazole according to the 2015 Nursing Drug hand book was given by the DON and the consultant pharmacist on 10/15/15 for all nurses who could attend. The remaining nurses received the education on 10/20/15 or 10/21/15 from the DON. The medication aides received the education on 10/19/15 from the DON.</p> <p><b>3. Monitoring performance</b></p> <p>a. The DON/assistant director of nursing (ADON)/designee will audit MARS to determine: times of glucometer testing, time of sliding scale insulin administration, time of scheduled insulin administration, and time of omeprazole administration.</p>		

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F 281	<p>Continued From page 3</p> <p>Further interview on 9/29/15 at 11:55 a.m. with the DON revealed: *Per their pharmacy consultant it was okay to hold sliding scale insulin at the nurse's discretion. *She agreed resident 2 did not have physician's orders to hold her sliding scale insulin if she did not eat. *She was unable to find documentation the physician had been notified regarding the held insulin by nursing. *She agreed the insulin was not given as ordered by the physician. *They had no specific policy about holding medications.</p> <p>Interview on 9/30/15 at 8:20 a.m. with licensed practical nurse (LPN) C regarding resident 2 revealed: *She held the sliding scale insulin per nursing discretion, because she knew the resident did not eat well at times. *The resident had not had a low blood sugar in the past, but she held the insulin to keep that from happening. *She had not updated the physician on holding the resident's insulin in a long time, and she stated she probably should have. *She agreed there was no physician order to hold the insulin when the resident did not eat.</p> <p>Surveyor: 22452 2. Review of resident 11's paper medical record and electronic medical record (EMR) revealed: *A 2/3/11 date of admission. *Diagnosis of diabetes mellitus. *She had orders for glucometer testing twice a day (BID) at 6:00 a.m. and 4:00 p.m. *There were orders to administer sliding scale</p>	F 281	<p>b. The audits will be completed weekly for 1 month, followed by every 2 weeks for 1 month, and then monthly.</p> <p>c. The DON/ADON/designee will report compliance to the Administrative QI team monthly for the next three months and then will continue to report compliance to the Administrative QI team monthly until the Administrative QI team determines it is no longer required.</p>		

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F 281	<p>Continued From page 4</p> <p>Novulin insulin depending on her glucometer readings: -Under 60: Supplement (food or drink). -60-140: No insulin. -141-200: 2 units insulin. -201-250: 4 units insulin. -251-300: 6 units insulin. -301-350: 8 units insulin. -Greater than 350: Call doctor. *There was no physician's order to hold the sliding scale insulin.</p> <p>Review of resident 11's March 2015 and June 2015 medication administration record (MAR) revealed: *3/30/15 at 4:00 p.m., Glucometer reading 170. "Sliding scale insulin held due to refusing to eat supper." *6/5/15 at 4:00 p.m., Glucometer reading 198. "Sliding scale insulin held as resident didn't eat supper." *6/28/15 at 3:00 p.m., Glucometer reading 143. "Held sliding scale insulin. Resident sleepy." *There was no documentation the physician had been informed of the above held insulin.</p> <p>3. Review of resident 18's paper medical record and EMR record revealed: *A 10/14/14 date of admission. *Diagnosis diabetes. *She had orders for glucometer checks three times a day (TID) at 6:00 a.m., 11:00 a.m., and 5:00 p.m. *There were orders to administer the following sliding scale Humalog insulin depending on her glucometer readings: -60 to 150: No insulin. -151-200: 2 units insulin. -201-250: 4 units insulin.</p>	F 281		
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F 281	<p>Continued From page 5</p> <p>-251-300: 6 units insulin. -301-350: 8 units insulin. -Greater than 350: Call doctor.</p> <p>*There were orders to administer Humalog insulin 4 units every morning and 6 units at noon and at suppertime in addition to the sliding scale insulin orders.</p> <p>*There were no physician's orders to hold the sliding scale insulin or scheduled insulin.</p> <p>Review of resident 18's June 2015 through September 2015 MAR revealed:</p> <p>*There was no documentation (blank area on MAR) on 6/7/15 at 6:00 p.m., 6/16/15 at 8:00 a.m., and on 6/29/15 at 8:00 a.m. her scheduled Humalog insulin had been administered.</p> <p>*There was no documentation of glucometer readings on 7/10/15, 7/18/15, and on 7/19/15 at 5:00 p.m. or if sliding scale insulin had been administered.</p> <p>*There was documentation on 7/4/15 at 6:00 a.m. "Initial sugar [glucometer reading] was 59. Recheck glucometer 157. No insulin given prior low blood sugar."</p> <p>*There was documentation on 7/19/15 at 6:30 a.m. "Blood sugar 171. Aide gave resident snack. Was cold and clammy." There was no documentation the sliding scale insulin was held or administered.</p> <p>*There was documentation on 7/29/15 at 6:00 a.m. "Held morning insulin blood sugar was 31 at 2:15 a.m. After snack was up to 171."</p> <p>*There was documentation Humalog insulin 4 units (scheduled dose) was held at 8:00 a.m. There was no documentation why the insulin had been held.</p> <p>*There was documentation on 9/6/15 at 12:00 noon "Insulin held related to not eating."</p>	F 281		

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F 281	<p>Continued From page 6</p> <p>4. Interview on 9/30/15 with RN B regarding residents 11 and 18 revealed:</p> <p>*The nurses held insulin usually if a resident did not eat or ate poorly at meals.</p> <p>*If there was no documentation an insulin had been administered, it was likely the nurse had administered it but had not documented the administration.</p> <p>Surveyor: 35237 Review of the provider's June 2015 Non-Controlled Medication Order Documentation policy revealed:</p> <p>***B. Any dose or order that appears inappropriate considering the resident's age, condition, allergies, or diagnosis is verified by nursing with the attending physician.</p> <p>*C. The prescriber is contacted by nursing to verify or clarify an order (e.g. [for example], when the resident has allergies to the medication, there are contraindications to the medication, significant drug interactions are present, the directions are confusing).</p> <p>*D. The prescriber is contacted by nursing for direction when delivery of a medication will be delayed or the medication is not or will not be available."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St Louis, MO, p. 588, for medication administration related to assessing the patient's (resident) current condition revealed:</p> <p>***The ongoing physical or mental status of a patient affects whether a medication is given or how it is administered. Assess a patient carefully before giving any medication."</p> <p>***Notify the patient's health care provider if he or she is unable to take a medication. Assessment</p>	F 281		
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F 281	<p>Continued From page 7</p> <p>findings serve as a baseline in evaluating the effects of medication therapy."</p> <p>B. Based on observation, record review, interview, and drug handbook review, the provider failed to administer insulin according to the manufacturer's recommendations for five of six sampled residents (2, 11, 13, 14, and 18) receiving insulin. Findings include:</p> <p>1. Review of resident 2's last signed 9/28/15 physician's orders revealed: *She was admitted on 6/1/11. *Her diagnoses included diabetes (disease affecting blood sugar levels). *She was on a constant carbohydrate (carb) diet. *She had orders for glucometer (blood sugar checking device) tests four times a day with sliding scale Novolin R (fast acting) insulin. -The sliding scale determined the specific dose to give based on the glucometer results. *She also had orders for two oral medications for her diabetes.</p> <p>Review of resident 2's diabetic flowsheets from March 2015 through September 2015 revealed: *The Novolin R sliding scale physician's order remained the same. *The time for administration had been 6:00 a.m., 12:00 noon, 4:00 p.m., and 8:00 p.m.</p> <p>Observation and interview on 9/29/15 at 11:35 a.m. with RN B during and following resident 2's glucometer check revealed: *Novolin R was considered a fast acting insulin. *On the day shift she typically did glucometer checks before lunch and supper, and then gave the insulin after the resident had eaten. *The day nurse started that shift at 7:00 a.m.</p>	F 281			

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F 281	<p>Continued From page 8</p> <p>*The a.m. sliding scale was completed by the night nurse before leaving that shift.</p> <p>*Breakfast was typically around 8:00 a.m.</p> <p>*She was unsure when the night nurse actually would have given the a.m. insulin but agreed it would have been before 7:00 a.m.</p> <p>*She agreed the a.m. insulin would have been administered at least a half hour or more prior to the resident eating breakfast.</p> <p>2. Review of resident 13's last signed 9/8/15 physician's orders revealed: *She was admitted on 10/1/12. *Her diagnoses included hypoglycemia (low blood sugar levels) and diabetes. *She was on a diabetic diet. *She had orders for glucometer testing three times daily with sliding scale Novolog (rapid acting) insulin. -The specific dose to give was based on the glucometer results. *She also had orders for scheduled Levemir (long acting) insulin twice a day.</p> <p>Review of resident 13's diabetic flowsheets from March 2015 through September 2015 revealed: *The Novolog insulin sliding scale physician's order was four times daily from March through 7/24/15. -The time for administration had been 7:00 a.m., 11:00 a.m., 4:00 p.m., and at bedtime. *On 7/25/15 the Novolog sliding scale changed to three times a day. *The time for administration had been 7:00 a.m., 11:00 a.m., and 4:00 p.m.</p> <p>3. Review of resident 14's last signed 9/24/15 physician's orders revealed: *He was admitted on 7/7/15.</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>*His diagnoses included diabetes.</p> <p>*He was on a constant carb diet.</p> <p>*He had orders for glucometer testing twice daily with sliding scale Humulin R (fast acting type) insulin.</p> <p>-The specific dose to give was based on the glucometer results.</p> <p>Review of resident 14's diabetic flowsheets from July 2015 through September 2015 revealed:</p> <p>*The Humulin R sliding scale was four times daily from 7/7/15 through 7/23/15.</p> <p>-The time for administration had been 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m.</p> <p>*On 7/23/15 the insulin sliding scale had changed to twice a day and remained the same through September.</p> <p>-The time for administration had been 6:00 a.m. and 5:00 p.m.</p> <p>Surveyor: 22452</p> <p>4. Review of resident 11's paper medical record and EMR record revealed:</p> <p>*Diagnosis of diabetes mellitus.</p> <p>*She had orders for glucometer testing BID at 6:00 a.m. and 4:00 p.m.</p> <p>*There were orders to administer sliding scale Novulin insulin depending on her glucometer readings:</p> <p>-Under 60: Supplement (food or drink).</p> <p>-60-140: No insulin.</p> <p>-141-200: 2 units insulin.</p> <p>-201-250: 4 units insulin.</p> <p>-251-300: 6 units insulin.</p> <p>-301-350: 8 units insulin.</p> <p>-Greater than 350: Call doctor.</p> <p>Review of resident 11's August 2015 MAR revealed for the sliding scale Novolin insulin it</p>	F 281			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>avera brady health and rehab</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>
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F 281	<p>Continued From page 10 was documented as administered on:</p> <ul style="list-style-type: none"> <li>*8/20/15 at 7:01 a.m. for a glucometer reading of 201.</li> <li>*8/27/15 at 6:17 a.m. for a glucometer reading of 166.</li> </ul> <p>5. Review of resident 18's paper medical record and EMR record revealed:</p> <ul style="list-style-type: none"> <li>*A 10/14/14 date of admission.</li> <li>*Diagnosis diabetes.</li> <li>*She had orders for glucometer checks TID at 6:00 a.m., 11:00 a.m., and 5:00 p.m.</li> <li>*There were orders to administer the following sliding scale Humalog insulin depending on her glucometer readings:               <ul style="list-style-type: none"> <li>-60 to 150: No insulin.</li> <li>-151-200: 2 units insulin.</li> <li>-201-250: 4 units insulin.</li> <li>-251-300: 6 units insulin.</li> <li>-301-350: 8 units insulin.</li> <li>-Greater than 350: Call doctor.</li> </ul> </li> </ul> <p>Review of resident 18's June 2015 through September 2015 MARs revealed Humalog sliding scale insulin was documented at the following times and for the following test results as administered on:</p> <ul style="list-style-type: none"> <li>*6/5/15 at 6:00 a.m.: 182.</li> <li>*6/6/15 at 5:17 a.m.: 151.</li> <li>*7/1/15 at 6:00 a.m.: 169.</li> <li>*7/21/15 at 6:00 a.m.: 166.</li> <li>*7/27/15 at 5:06 a.m.: 166.</li> <li>*9/4/15 at 6:36 a.m.: 171.</li> <li>*9/6/15 at 6:14 a.m.: 247.</li> <li>*9/18/15 at 4:20 a.m.: 154.</li> <li>*9/19/15 at 4:39 a.m.: 222.</li> <li>*9/22/15 at 4:58 a.m.: 155.</li> <li>*9/25/15 at 5:05 a.m.: 157.</li> <li>*9/27/15 at 6:40 a.m.: 181.</li> </ul>	F 281		
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F 281	<p>Continued From page 11 *9/29/15 at 4:34 a.m.: 186.</p> <p>Surveyor: 35237 6. Interview on 9/29/15 at 11:55 a.m. with the DON revealed: *Novolin R, Humulin R, Humalog, and Novolog were considered fast acting insulins. *Per the consultant pharmacist it did not have to be given with food. *She agreed the night nurse would have completed the a.m. glucometer and sliding scale insulin administration prior to leaving that shift. *Breakfast was not until around 8:00 a.m. *She confirmed the night nurse would have given the sliding scale insulin prior to knowing if the resident had eaten breakfast or not. *She agreed the a.m. sliding scale insulin administration was completed differently than the lunch and supper administrations.</p> <p>Interview on 9/30/15 at 8:30 a.m. with LPN C revealed: *She would have done glucometer checks before lunch and supper, and then administered the insulin after the meals when she knew what the resident had eaten. *She was unsure why the a.m. sliding scale insulin was administered differently. *She agreed the night nurse would have completed the a.m. sliding scale insulin prior to the day shift starting at 7:00 a.m. -They would not have known what the resident would have eaten for breakfast, since their shift ended prior to that meal. *Novolin R was a fast acting insulin and would have been working in an hour or so. -Administering it could have caused a potential low blood sugar for that resident if they had not eaten.</p>	F 281		

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F 281	<p>Continued From page 12</p> <p>Interview on 9/30/15 at 11:25 a.m. with the DON revealed: *She confirmed there were some a.m. glucometer tests documented as being done between 4:00 a.m. and 5:00 a.m. -That was a long time prior to the 6:00 a.m. and 7:00 a.m. scheduled sliding scale time of administration. -She would have expected them to be done within the hour before or after the time scheduled for administration. *She was unable to confirm when the night nurses actually administered a.m. insulin. *She agreed there was a potential to cause a low blood sugar if the resident had not eaten and had been administered fast or rapid acting insulin. *The nursing department would have used their Nursing 2015 Drug Handbook as a reference regarding medication administration.</p> <p>Interview on 9/30/15 at 1:30 p.m. with the consultant pharmacist regarding sliding scale insulin revealed: *She had been consulting for this facility for over ten years. *She felt Humalog or Novolog should have been administered 15 minutes before or after a meal. *She felt Humulin or Novolin R was a little slower acting and could have been given 30 minutes before a meal. *She would have liked insulin given closer to the time residents would have eaten due to the risk of hypoglycemia.</p> <p>Review of Wolters et al., Nursing 2015 Drug Handbook, 35th Ed., revealed: *Pages 756 through 759 covered regular (short acting) insulins, including Humulin and Novolin R,</p>	F 281		

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F 281	<p>Continued From page 13 and lispro (rapid acting) insulins, including Humalog.</p> <ul style="list-style-type: none"> <li>-Indications and dosages for adults and children older than age 3 included to "inject subcutaneously [injected under the skin] within 15 minutes before or after a meal."</li> <li>-The onset of action was one-half to one hour for rapid insulins and one to two and one-half hours for intermediate insulins.</li> <li>-The peak action was two to three hours for rapid insulins and four to fifteen hours for intermediate insulins.</li> <li>-Possible adverse reactions included hypoglycemia (low blood sugar).</li> <li>-Possible interactions included drug to food. "May cause hyperglycemia [high blood sugar] or hypoglycemia. Urge caution and monitor patient's diet."</li> <li>*Pages 759 through 762 covered Novolog (rapid acting) insulin.</li> <li>-Indication and dosages for adults and children age 2 and older included to "give 5 to 10 minutes before start of meal by subcutaneous injection in the abdominal wall, thigh, or upper arm."</li> <li>-The onset of action was 15 minutes.</li> <li>-The peak action was one to three hours.</li> <li>-Possible adverse reactions included hypoglycemia.</li> <li>-Contraindications and cautions included "Use cautiously in patients susceptible to hypoglycemia and hypokalemia [low potassium], such as those who have autonomic neuropathy [symptoms caused by nerve damage] or are fasting, taking potassium-lowering drugs, or taking drugs sensitive to potassium level. "</li> </ul> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th ED., St Louis, MO, p. 603, for insulin preparation</p>	F 281		
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F 281	<p>Continued From page 14 (administration) revealed:</p> <p>*"Insulin is classified by rate of action, including rapid, short, intermediate, and long acting. To provide safe and effective care, you need to know the onset, peak, and duration for each of your patients' ordered insulin doses. Refer to a medication reference or consult with a pharmacist if you are unsure of this information."</p> <p>*"Insulin is ordered by a specific dose at select times. Correction insulin, also known as sliding-scale insulin, provides a dose of insulin based on the patient's blood glucose level."</p> <p>*"The term correction insulin is preferred because it indicates that small doses of rapid or short-acting insulins are needed to correct a patient's elevated blood sugar."</p> <p>Surveyor: 22452</p> <p>C. Based on observation, record review, interview, and policy review, the provider failed to ensure physicians' orders were followed for the administration of medications for two of eight sampled residents (19 and 21). Findings include:</p> <p>1. Observation of resident 19 on 9/29/15 at 8:40 a.m. revealed:</p> <p>*She was sitting at the dining room table in her wheelchair.</p> <p>*She had not started to eat her breakfast.</p> <p>*RN B administered her morning medications to her that included her omeprazole (stomach medication).</p> <p>Review of resident 19's September 2015 MAR revealed the omeprazole was scheduled every day at 7:00 a.m.</p> <p>Interview at that time with RN B regarding resident 19 revealed:</p>	F 281			

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F 281	<p>Continued From page 15</p> <p>*She knew the omeprazole should be given thirty minutes prior to eating, but the resident's appetite was often poor and she did not eat her meal.</p> <p>*They usually always gave her the omeprazole when she was at the breakfast table.</p> <p>2. Observation of resident 21 on 9/28/15 at 5:35 p.m. revealed:</p> <p>*She was sitting at the dining room table.</p> <p>*RN E administered the following medications to her:</p> <ul style="list-style-type: none"> <li>-Docusate (stool softner).</li> <li>-Acetaminophen.</li> <li>-Donzepezil (memory).</li> <li>-Gabapentin (pain).</li> <li>-Levetiracetam (control seizures [abnormal body movements]).</li> <li>-Metoprolol (blood pressure).</li> <li>-Paroxetine (depression).</li> <li>-Ropinirole (Parkinson's [nerve disorder]).</li> </ul> <p>*RN E punched out the above medications from the 9/27/15 slot in the medication cards that were left in the card from that date.</p> <p>*The above medications were not documented as administered on 9/27/15 at 5:30 p.m. The slots next to all the medications were left blank.</p> <p>Interview at that time with RN E regarding resident 21 revealed:</p> <p>*She was not sure why the 9/27/15 5:30 p.m. medications remained in the medication cards.</p> <p>*It was likely they had been omitted since the nurse had not initialed the MAR.</p> <p>Review of the provider's June 2015 General Rules for Administration of Medication policy revealed:</p> <p>**"Check MAR. If in doubt, check with original order on the chart. Give on time or within an hour</p>	F 281			

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F 281	Continued From page 16 before or after scheduled time." **MAR's must be checked at end of shift to be sure all appropriate spaces are initialed. Do not initial or chart medications in any way for another nurse."	F 281			
F 425 SS=D	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 observation, record review, and interview, the provider failed to ensure there was accurate documentation, control, and administration of a controlled medication for one of one sampled resident (20). Findings include:	F 425	1. <b>Corrective actions for each finding</b> a. <del>Followed up with nurses and med aide to determine location of controlled medication. Unable to correct previous unaccountability.</del> 2. <b>Changes made to the system</b> a. <del>Education will be provided on accountability of all medications including controlled medications.</del> b. <del>Nurses and med aides will double check MARs and medications at end of shift. If MAR is unsigned, the charge nurse will contact the nurse or medication aide dispensing those medications.</del> 3. <b>Monitoring performance</b> a. <del>Audits will be completed on MARS by DON/ADON/designee weekly for 1 month followed by every 2 weeks for 1 month followed by monthly for 2 months.</del> b. <del>DON/ADON/Designee will report compliance quarterly to Administrative QI team.</del> <i>See updated POC below. 11/12/15 JH</i>	10/23/15	

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F 425	<p>Continued From page 17</p> <p>1. Observation of resident 20 on 9/28/15 at 5:45 p.m. revealed: *Registered nurse (RN) D administered the following medications to her: -Docusate (stool softner). -Lorazepam (controlled antianxiety). -Naproxen (pain). *There was a Naproxen and docusate pill in the 6:00 p.m. slot in the medication cards for 9/22/15. *There was not a lorazepam in the 9/22/15 slot for 6:00 p.m.</p> <p>Review of resident 20's September 2015 medication administration record (MAR) revealed: *Documentation on 9/22/15 at 6:00 p.m. on the back of the MAR "All medications held as resident vomiting." *There was documentation "held" (H) on 9/22/15 at 6:00 p.m. for the Naproxen and the docusate. *The 9/22/15 at 6:00 p.m. slot for the lorazepam was left blank.</p> <p>Interview at that time with RN D regarding the above revealed she: *Was uncertain why the lorazepam for the 9/22/15 at 6:00 p.m. had been punched out of the medication card when there was documentation all the supper medications had been held. *Could find no documentation the lorazepam had been given on 9/22/15 at 6:00 p.m. *Stated there should have been documentation on the MAR next to the lorazepam it had been held instead of the spot left blank.</p> <p>Review of the provider's June 2015 General Rules for Administration of Medication revealed: *"Chart any omission or refusal of a scheduled medication and the reason for the omission or</p>	F 425	<p>1. <b>Corrective actions for each finding</b> a. The DON followed up with nurses and medication aides to determine the location of controlled medication. We were unable to correct previous unaccountability.</p> <p>2. <b>Changes made to the system</b> a. Education on the accountability of all medications including controlled medications was given by the DON and consultant pharmacist on 10/15/15 for all nurses who could attend. The remaining nurses received the education on 10/20/15 or 10/21/15 from the DON. DON educated medication aides on 10/19/15. Nurses and medication aides will double check all medication administration records (MARs) and medications at the end of each shift. If documentation is missing on a medication that was to be given, the charge nurse will contact the nurse or medication aide assigned to administer the medication as soon as possible after the missing documentation is identified and within normal working hours for the employee being called.</p> <p>3. <b>Monitoring performance</b> a. The DON completed an audit on all MARs and medications to determine compliance with documentation of medications administration. DON/ADON/ designee will continue auditing fifty percent of all MARs and medications to determine</p>	11/12/15 JH

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F 425	Continued From page 18 refusal."	F 425	compliance with documentation of medication administration.		
F 514 SS=E	<p>***On the MAR place an R [refused] with a circle around it in the appropriate square and dispose of medication accordingly."</p> <p>***Do not initial that a medication has been given until after it has been given."</p> <p>***MARs must be checked at end of shift to be sure all appropriate spaces are initialed."</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to document end of life care for two of three sampled residents (15 and 17). Findings include:</p> <p>1. Review of resident 17's paper medical record and electronic medical record (EMR) revealed: *A 12/12/14 date of admission.</p>	F 514	<p>b. Audits of MARs and medications will be completed weekly for 1 month, followed by every 2 weeks for 1 month and then monthly.</p> <p>c. The DON/ADON/designee will report compliance to the Administrative QI team monthly for the next three months and then monthly until the Administrative QI team determines it is no longer required.</p> <p>1. <b>Corrective actions for each finding</b></p> <p>a. <del>Will have documentation every shift of condition at end of life.</del> <i>See updated POC below JH 11/2/15</i></p> <p>2. <b>Changes made to the system</b></p> <p>a. <del>Will educate charge nurses on documentation of end of life cares.</del></p> <p>b. <del>Documentation will be made in the form of a nurses' note or in specific interventions to be monitored at end of life or after death.</del> <i>See updated POC below JH 11/2/15</i></p> <p>3. <b>Monitoring performance</b> <i>See updated POC below JH 11/2/15</i></p> <p>a. <del>Clinical coordinators will monitor documentation for all residents at end of life for a period of 3 months. DON/ADON will report quarterly to Administrative QI.</del></p>	<p><del>10/23/15</del> <del>11/2/15</del> 10/23/15 JH.</p>	

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F 514	<p>Continued From page 19</p> <p>*She was admitted to hospice (end of life) care on 5/4/15.</p> <p>*She expired (died) on 6/12/15 at 3:10 p.m. at the facility.</p> <p>Review of resident 17's 5/7/15 hospice plan of care revealed: *Terminal diagnosis of chronic airway obstruction (breathing difficulties). *Symptoms problematic to patient (resident) will be managed with pharmaceutical (medication) and non-pharmaceutical (no medication) interventions.</p> <p>Review of resident 17's 6/9/15 physician's orders revealed: *Lorazepam (antianxiety medication) liquid 0.5-1.0 milligrams (mg) every four hours as needed (PRN) for agitation. *Morphine (narcotic pain medication) 5-10 mg every one hour PRN for pain.</p> <p>Review of resident 17's 6/9/15 through 6/12/15 EMR nurse notes revealed: *6/9/15 at 6:30 p.m., "Resident has been in bed all day. Resident's medications were held this morning, but when giving her the afternoon dose of Norco [narcotic pain medication] she had a difficult time taking her medication. Visited with resident's husband about getting rid of her medications and maybe seeing if we could get an order for liquid morphine and lorazepam and he is okay about this." *6/10/15 at 4:40 p.m., "Has been in bed all day today with spouse by her side. Morphine was given three times but resident did continue to complain of pain before she was able to have another dose. Hospice was notified and doctor ordered the resident to have a Duragesic patch</p>	F 514	<p><b>1. Corrective actions for each finding</b></p> <p>a. There will be documentation on every shift on those residents nearing the end of life and also at the end of life.</p> <p>b. No changes can be made to the documentation of resident 15 and 17 as they are deceased.</p> <p><b>2. Changes made to the system</b></p> <p>a. Education on the documentation required for those residents nearing end of life and those that have died was given by the DON on 10/15/15 for the charge nurses that could attend. The remaining charge nurses received the education on 10/20/15 or 10/21/15 from the DON.</p> <p>b. Documentation will be made in the form of a nurses' note or in specific interventions to be monitored at end of life or after death.</p> <p><b>3. Monitoring performance</b></p> <p>a. The clinical coordinators will audit the documentation on all residents near end of life and those that have died.</p> <p>b. Audits of near death and death documentation will be completed weekly for 1 month, followed by every 2 weeks for 1 month and then monthly and will be reported to the DON/ADON.</p> <p>c. The DON/ADON will report compliance to the Administrative QI team monthly for the next three months and then will continue to</p>	11/12/15 <i>JH</i>

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:  <b>435061</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>AVERA BRADY HEALTH AND REHAB</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>		
(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 514	<p>Continued From page 20</p> <p>[narcotic patch for pain]. Lorazepam was given once today. Staff did report some periods of apnea [no breathing]."</p> <p>*6/11/15 at 7:42 a.m., "Resident's husband with her until midnight. Resident has morphine two times, the last time at 6:30 a.m. Had oxygen on at 1.5 liters during the night. Appeared to rest comfortably."</p> <p>*6/12/15 at 11:14 a.m. by the chaplain, "Sat with daughter and prayed. Resident is saying to help me breathe. Prayed for resident and family."</p> <p>*6/15/15 at 3:32 p.m., "No pulse [heartbeat] or respirations [breathing] noted at 3:10 p.m. Pastoral care and next of kin [husband] notified at 3:10 p.m. Body was released to morgue [funeral home] at 4:10 p.m."</p> <p>*There was no nursing documentation of her condition from 6/11/15 at 7:42 a.m. until her death on 6/12/15 at 3:10 p.m.</p> <p>*There was no documentation the chaplain had informed the nursing staff of her increased difficulty breathing at 11:14 a.m.</p> <p>Review of resident 17's 6/12/15 PRN medication record revealed:</p> <p>*Morphine was documented as administered at 6:10 a.m., 9:40 a.m., and at 12:45 p.m.</p> <p>*There was no documentation lorazepam had been administered.</p> <p>Interview on 9/30/15 at 11:00 a.m. with the director of nursing (DON) regarding resident 17 revealed she:</p> <p>*Agreed there should have been some nursing documentation regarding her condition after 6/11/15 at 7:42 a.m. until her death on 6/12/15 at 3:10 p.m.</p> <p>*Was unsure whether the chaplain had informed the nursing staff of her complaints of breathing</p>	F 514	report compliance to the Administrative QI team monthly until the Administrative QI team determines it is no longer required.	

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NAME OF PROVIDER OR SUPPLIER  <b>avera brady health and rehab</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>		
(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 514	<p>Continued From page 21</p> <p>difficulty at 11:14 a.m. The chaplain was only filling in for their regular chaplain who was not available.</p> <p>*Agreed there was no pharmacological or non-pharmacological interventions documented on 6/12/15 from 11:14 a.m. until 12:45 p.m. when the morphine was documented for comfort.</p> <p>*Did not have a policy specific to documentation for end of life care.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th ED., St Louis, MO, p. 721, for promoting comfort with dyspnea (difficulty breathing) in the terminally ill patient revealed:</p> <p>***Position for comfort and maximal respiratory excursion [movement from one point to another with idea of returning to normal position]."</p> <p>***Provide supplemental oxygen if comforting, reduce anxiety or fear, and provide effective pain management."</p> <p>***Use fan for air movement."</p> <p>***Administer anxiolytics [antianxiety medications] to ease breathing and apprehension."</p> <p>Surveyor: 33265</p> <p>2. Review of resident 15's paper medical record and EMR revealed:</p> <p>*A 6/25/12 date of admission.</p> <p>*She was admitted to hospice on 6/1/15.</p> <p>*She expired on 6/28/15.</p> <p>Review of resident 15's nurses notes revealed:</p> <p>*The last nurses note was made on 6/23/15 at 7:04 a.m.</p> <p>*The note stated:</p> <p>-The resident was repositioned every two hours by staff.</p> <p>-"Didn't require any pain med [medication]."</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER  <b>avera brady health and rehab</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>		
(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 514	<p>Continued From page 22</p> <p>Review of resident 15's hospice narrative revealed: * She was last seen by a hospice nurse on 6/26/15. *A comprehensive review was completed at that time. *The "resident was able to interact in a meaningful way." *The daughter stated the resident had "had almost nothing in orally since 6/20/15." *The resident's lung sounds were diminished and heart beat was irregular. *The resident was resting in bed with eyes closed. She had not appeared to be having any pain at the time of the assessment.</p> <p>Review of resident 15's death record revealed: *The date and time of the physical findings was 6/28/15 at 8:00 a.m. -No description of the physical findings was documented. *The family was present. -No identification of which family members were present was documented. *The primary care physician was notified. *The funeral home was notified, and the body was released to the funeral home on 6/28/15 at 9:30 a.m. *No identification of the disposition of the belongings and valuables was documented. *No postmortem (the care of the body after death) care was documented.</p> <p>Interview on 9/30/15 at 2:00 p.m. with the DON revealed she agreed: *There was no nursing care by provider staff other than the administration of medication documented after 6/23/15.</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA BRADY HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>
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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 514	<p>Continued From page 23</p> <p>*There was no documentation concerning the care following the death.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St Louis, MO, pg. 724, for documentation following a death revealed:</p> <p>*Documentation of a death provides a legal record of the event.</p> <p>**"Nursing documentation becomes relevant in risk management or legal investigations into a death underscoring the importance of accurate, legal reporting."</p> <p>***Documentation also validates [confirms] success in meeting patient goals."</p> <p>***Family members deserve and expect a clear description of what happened to their loved one."</p> <p>***A human body deserves the same respect and dignity as a living person and needs to be prepared in a manner consistent with the patient's culture and religious beliefs."</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA BRADY HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>		
(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 9/28/15. Avera Brady Health and Rehab (original building, 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 9/28/15 upon correction of the deficiency 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 document review, the provider failed to maintain a one hour fire rated	K 033			

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

*Julie Hoffmann*

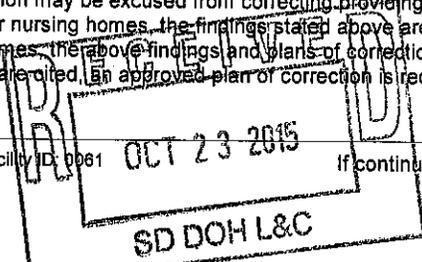
TITLE

*Administrator*

(X6) DATE

*10/22/15*

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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NAME OF PROVIDER OR SUPPLIER  <b>avera brady health and rehab</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>		
(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 033	Continued From page 1 path of egress from the basement and the second floor to the main level service area exterior of the building. Four randomly observed stairs from the basement and the second floor discharged onto the main level of the building. Findings include:  1. Observation at 11:00 a.m. on 9/28/15 revealed the basement and second floor stairs discharged into the main level corridor system. A continuous one hour fire rated protected path of egress was not maintained to the exterior of the building. Review of the previous life safety code survey on 7/30/13 confirmed those findings.  The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 033		F	

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA BRADY HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/28/15. Avera Brady Health and Rehab (center addition, 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 Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

TITLE

(X6) DATE

*Julie Hoffmann*

*Administrator*

*10/22/15*

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA BRADY HEALTH AND REHAB</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 9/28/15. Avera Brady Health and Rehab (north addition, building 03) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

TITLE

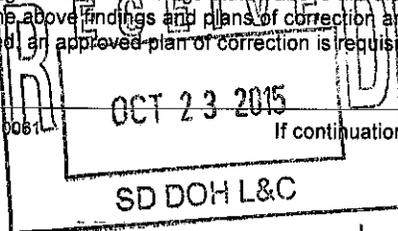
(X6) DATE

*Julie Hoffmann*

*Administrator*

*10/22/15*

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10652</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>avera brady health and rehab</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 S OHLMAN MITCHELL, SD 57301</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>Initial Comments</b></p> <p>Surveyor: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/28/15 through 9/30/15. Avera Brady Health and Rehab was found in compliance.</p>	S 000		

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

*Julie Hoffmann*

STATE FORM

6899

BST211

TITLE

*Administrator*

**RECEIVED**

**OCT 23 2015**

**SD DOH L&C**

(X6) DATE

*10/22/15*

Continuation sheet 1 of 1