

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2015
NAME OF PROVIDER OR SUPPLIER PHILIP NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 503 WEST PINE POST OFFICE BOX 790 PHILIP, SD 57567	
(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: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/14/15 through 9/16/15. Philip Nursing Home was found not in compliance with the following requirements: F166, F225, F280, F329, F368, F372, and F520.	F 000	*Addendums noted with an asterisk per 10/26/15 per telephone with facility DON. NS/SPDOTT/EL	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on interview, record review, and policy review, the provider failed to inform five of five randomly interviewed residents of resolutions to grievances brought up in the resident council meeting minutes from April 2015 through September 2015. Findings include: 1. Group interview on 9/15/15 from 10:30 a.m. through 11:15 a.m. with five residents revealed: *They did not receive any feedback as to how concerns brought up at resident council had been addressed or resolved. *They did not understand the point of resident council since "nothing ever gets done." Surveyor: 35237	F 166	F166 – Grievances from Philip Nursing Home resident’s council will be addressed or resolved at monthly meetings and documented as such in the resident council meeting notes as a standing agenda item in the following manner: Each grievance will be listed along with how each grievance has been addressed or resolved in the council meeting notes. Beginning in October the meeting notes will be recorded by an Activities/SSD staff each month as stated above during each meeting. The Activities Coordinator or designee will monitor each resident meeting for addressed or resolved grievances and report to the QA committee quarterly, or until corrected.	 11/5/15

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

Olaf Olson

TITLE

CEA ADMINISTRATOR

(X6) DATE

10/7/15

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.

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

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F 166	<p>Continued From page 1</p> <p>Review of the resident council notes from April 2015 through September 2015 revealed:</p> <ul style="list-style-type: none"> *May, they had requested to buy a bowling game, and flowers and vegetables to plant. *June, new concerns were "too much cold food being served particularly cold hamburgers and fries. Pres. [president] [resident name] received a cold waffle that morning. [resident name] mentioned being served too much pasta for supper." -There was no mention regarding the requests from the May meeting. *July, there was no mention of the concerns from May or June. *August, there was: <ul style="list-style-type: none"> -A "suggestion of serving less pasta or at least not so frequently." -Mention of "no produce from the tomatoe and cucumber plants we have planted." -"[resident name] reminded us about exploring the option of getting table bowling." *September there was no mention regarding the concerns from the August meeting. <p>Interview on 9/15/15 at 1:45 p.m. with activity aide/certified nursing assistant/restorative aide E revealed:</p> <ul style="list-style-type: none"> *There was currently no activity coordinator until the beginning of October when the new one would be starting. *She was in charge of the activities and restorative departments currently. *The same group of residents usually attended the council meetings every month. *They had brought up concerns about the food frequently. *Social services staff, the dietary manager, and activities staff attended the council meetings. *The department that was involved with the 	F 166		

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F 166	Continued From page 2 concern would have addressed it. *They usually reviewed the notes from the previous month's meeting with the residents. *They had not always let the residents know what they had done to address their concerns. *They had not documented in the notes what they had done to address the concerns. Interview on 9/16/15 at 11:00 a.m. with the director of nursing revealed: *Staff worked on the concerns that were brought up from resident council meetings. *They had not always gotten back to the residents what they had done to correct those concerns, and they should have. Review of the provider's 5/1/02 Grievance policy revealed: *The objective was "to promote patient/resident satisfaction with his or her care and stay at [provider's name]." *The procedure for registering and resolving grievances included: -a. Register grievance with Director of Nurses or Administrator. -b. Director of Nurses or Administrator will discuss problem with patient/resident and anyone else involved to determine validity. Discussion will be individually and collectively. -c. If the patient/resident and family are still unsatisfied they will be invited to appear at a Governing Board meeting."	F 166			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225			

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F 225	<p>Continued From page 3</p> <p>mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to report to the state</p>	F 225	<p>F225 – The Director of Nursing updated the policy for reporting significant injuries to the state of SD based on the guidelines as set forth by the SDDOH found at http://doh.sd.gov/documents/Providers/Licensure/Reporting_Final.pdf along with the resource materials. An In-service will be conducted with the nursing staff on October 7th to educate staff how and when to report significant injuries incurred by residents. The DON will monitor all facility incident fall reports to assure that the properly state mandated reports are sent within the recommended time frame. The DON will monitor and report findings at QA meetings quarterly, or until corrected.</p>	<p><i>OK</i> <i>11/5/15</i></p>	

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F 225	<p>Continued From page 4</p> <p>agency a fall that resulted in a serious injury for one of five sampled residents (6) who had falls. Findings include:</p> <p>1. Review of resident 6's medical record revealed: *She had a fall on 9/6/15 at 8:10 p.m. while transferring herself in her room. -That fall resulted in a broken left arm. *The Fall Checklist stated "N/A" (not applicable) for the report to state section. -Comments were "no abusive suspected."</p> <p>Interview on 9/16/15 at 11:00 a.m. with the director of nursing revealed: *Resident 6's fall on 9/6/15 had not been reported to the state agency. *Charge nurses normally completed the reports with her help as needed. *She confirmed any fall with serious injury should have been investigated and reported.</p> <p>Review of the provider's reviewed May 2015 Reporting and Investigating Resident Abuse and Misappropriation of Property policy revealed "Any alleged abuse, neglect, or misappropriation will be reported to the Department of Health, Licensure and Certification within 24 working hours after an internal investigation has been completed and determined that a possible reportable incident occurred. The appropriate state mandated Abuse Investigation form will be completed and sent within 24 hours. The follow up report will be completed within 5 working days by the Director of nursing (does not include weekends or holidays). In the event the completion of the investigation will exceed 5 working days, the Department of Health, Licensure and Certification must be contacted</p>	F 225		

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F 225	Continued From page 5	F 225		
F 280 SS=E	<p>and informed of the reason for the delay." 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans had been updated to reflect current residents' needs for five of nine sampled residents (1, 3, 4, 5, and 6). Findings include:</p> <p>1. Review of resident 5's 7/21/15 through 7/28/15 nurses' notes revealed he had been found with a phone cord wrapped around his arm on 7/21/15.</p>	F 280	<p>F280 – Resident 1, 3, 4, 5, and 6 and all resident care plans have been reviewed and revised to reflect current resident care needs. DON will hold state mandated nursing In-service October 7th to educate nursing how and when to revise resident care plans. DON or designee will audit five care plans weekly for one month, then monthly for 5 months or until corrected and report findings to QA committee quarterly.</p> <p>1. Resident 5's care plan has been revised to reflect his depression and monitor behaviors/statements for suicide ideation. DON or designee will audit five care plans weekly for one month, then monthly for 5 months or until corrected and report findings to QA meeting quarterly.</p>	

9/16
11/5/15

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F 280	<p>Continued From page 6</p> <p>He stated to a certified nursing assistant (CNA) at that time:</p> <ul style="list-style-type: none"> *He planned to wrap the cord around his neck and pull the blankets up. *He wanted to find a hammer, so the CNA would hit him in the head. <p>The above was reported to the nurse and frequent checks of his status were started.</p> <p>Continued review of documentation in the nurses notes through 7/28/15 revealed:</p> <ul style="list-style-type: none"> *The social services designee (SSD) had visited with him about his statements. *He stated he got "bouts of depression once in a while but then it passes." *He stated "I get lonely." *The physician had ordered an anti-depressant shortly after that incident had occurred. <p>Review of resident 5's 9/2/15 physician's orders revealed he had been prescribed:</p> <ul style="list-style-type: none"> *Celexa (anti-depressant) 10 mg (milligrams) daily for depression. *Temazepam (help with sleep) 15 mg as needed for sleeplessness. *Ativan (anti-anxiety) 0.5 mg every six hours as needed for anxiety (nervousness). <p>Review of resident 5's last updated 7/16/15 care plan revealed there was no:</p> <ul style="list-style-type: none"> *Focus area, goal, or interventions for his depression. *Mention of his use of the above medications and the need to watch for side effects. *Mention of his suicidal thoughts or appropriate interventions. <p>Interview on 9/15/15 at 4:30 p.m. with licensed practical nurse (LPN) A revealed:</p>	F 280			

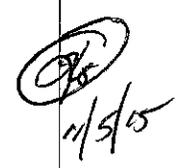
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F 280	<p>Continued From page 7</p> <p>*She confirmed the depression, medications, and suicidal thoughts were not mentioned in resident 5's care plan.</p> <p>*Care plans were usually updated with the quarterly Minimum Data Set assessments.</p> <p>*Care plans should have been updated when there was any change in a resident's status.</p> <p>*Every nurse was responsible for updating the care plans to keep them current.</p> <p>2. Review of resident 3's medical record revealed:</p> <p>*He had been admitted on 5/13/15.</p> <p>*He was admitted with a Foley catheter (tube that drains urine from the bladder into a bag).</p> <p>*He had pulled out the catheter on 9/1/15.</p> <p>*A physician's order had been obtained on 9/2/15 to discontinue the catheter.</p> <p>*He was to have been placed on a prompted toileting program.</p> <p>Review of his revised 8/13/15 care plan revealed:</p> <p>*He had a Foley catheter. That focus area had not been discontinued after 9/1/15.</p> <p>*There was no mention of the need for a prompted toileting plan.</p> <p>Interview with LPN A on 9/15/15 at 4:30 p.m. revealed she confirmed resident 3's care plan had not been updated to reflect his current toileting needs. She stated as soon as the catheter was discontinued the care plan should have been changed.</p> <p>Surveyor: 22452</p> <p>3. Review of resident 1's 12/15/14 care plan with a 8/27/15 revision date revealed:</p> <p>***Assist the resident to choose simple comfortable clothing that enhances the resident's</p>	F 280	<p>2. Resident 3's care plan has been reviewed and revised to reflect that his Foley catheter is DC'd and placed on a prompted toilet program. DON or designee will audit five care plans weekly for one month, then monthly for 5 months or until corrected and report findings to QA meeting quarterly.</p>		

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F 280	<p>Continued From page 8 ability to dress self." **"The resident requires extensive assistance of one staff for toileting." **"Will be on prompted toileting upon rising, before and after meals and activities, at bedtime, and as needed." **"Currently has a Foley catheter [tube inserted into the bladder to drain urine]." **"The resident requires extensive assistance of one staff person to move between surfaces daily." **"Weight monitoring daily."</p> <p>Observation on 9/15/15 at 9:25 a.m. of resident 1 revealed CNAs G and H: *Transferred her by physically lifting her from the bed to her wheelchair. *Provided perineal (private area) care for bowel and bladder incontinence (no control). *Put a clean adult brief on her. *Did not assist her on the toilet. *Completely assisted her to put on her clothing. *Put a pair of Ted hose (support stockings) on her legs. *Did not obtain her weight.</p> <p>Interview at that time with CNAs G and H regarding resident 1 revealed she: *Could no longer tolerate being toileted. *Was only weighed weekly now. *Could not tolerate being transferred with the EZ stand (mechanical lift that requires the resident to be able to bear some weight on their legs) anymore. She would not hang on to the handles with her hands and would fall out.</p> <p>Surveyor: 35237 5. Review of resident 4's medical record revealed she had pressure ulcer (injured area of skin caused by too much pressure) areas to her left</p>	F 280	<p>3. Resident 1's care plan has been reviewed and revised to include extensive assist of two staff to transfer or use of total lift whichever the resident will tolerate, weights have been DC'd due to comfort cares only, change to "check and change" toileting with appropriate perineal care PRN. DON or designee will audit five care plans weekly for one month, then monthly for 5 months or until corrected and report findings to QA committee quarterly.</p>		

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F 280	<p>Continued From page 9 and right buttocks: *The right buttock area had first been observed on 8/13/15. *The left buttock area had first been observed on 8/16/15. *Those areas were currently being treated daily by the nurse.</p> <p>Observation and interview on 9/15/15 at 10:45 a.m. during resident 4's dressing change with registered nurse F revealed: *She currently had a pressure ulcer to her right buttocks. *The left buttocks pressure ulcer was as small as a pinpoint the other day, and now was healed. *The nurses did the dressing change and treatment to those areas daily.</p> <p>Review of resident 4's 9/10/15 reviewed care plan revealed: *There was no mention of the right and left buttock pressure ulcer areas. *There was a focus area for "potential for pressure ulcers and skin breakdown r/t [related to] fragile skin and incontinence." -Interventions for that focus area had not been revised since 12/8/14.</p> <p>6. Review of resident 6's medical record revealed: *She had a fall on 9/6/15 at 8:10 p.m. while transferring herself in her room. -That fall resulted in a broken left arm. *She was admitted to the hospital overnight following the fall and returned to the facility on 9/7/15. *Upon return she had: -A splint and sling to her left arm. -Physician's order for ice to her left arm three</p>	F 280	<p>5. Resident 4's care plan has been reviewed and revised to reflect current skin treatments and/or resolution of treatment. DON or designee will audit five care plans weekly for one month, then monthly for 5 months or until corrected and report findings to QA committee quarterly.</p> <p>6. Resident 6's care plan has been reviewed and revised to reflect recent fall resulting in fractured left arm and care of fractured left arm, pain control, increased ADL support by care staff and "High Risk" fall designation. DON or designee will audit five care plans weekly for one month, then monthly for 5 months or until corrected and report findings to QA committee quarterly.</p>	<p><i>OK</i> 11/9/15</p> <p><i>OK</i> 11/4/15</p>

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F 280	<p>Continued From page 10 times a day. -Physician's order for Oxycodone (strong pain medication) as needed.</p> <p>Interview on 9/15/15 at 11:15 a.m. of resident 6 revealed: *She had fallen about a week ago, had broken her arm, and hurt her knee. *She was able to get around in her room and bathroom by herself before she fell. *Since the fall she needed more help from the staff to get to the bathroom and move around.</p> <p>Observation on 9/15/15 from 8:55 a.m. through 9:15 a.m. of resident 6 revealed: *Two staff assisted her to get up from bed, stand, and to the bathroom. *She was wearing a splint, ace wrap, and sling to her left arm.</p> <p>Review of resident 6's 7/31/15 reviewed care plan revealed: *There was no mention of her recent fall, broken left arm, or physician's order changes since her return from the hospital on 9/7/15. *There were no updates to the section related to her risk for falls. -That area had been last revised on 4/29/15. *There were no updates to the section related to her need for assistance from staff. -That area had been last revised on 4/27/15.</p> <p>7. Interview on 9/16/15 at 9:30 a.m. with LPN A revealed: *Care plans were done primarily by her and the DON quarterly and as needed. *Charge nurses should have updated care plans related to changes in resident care. *She confirmed care plans should have been</p>	F 280			

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F 280	<p>Continued From page 11 updated related to: -Resident 4's pressure ulcers. -Resident 6's fall, broken arm, and changes in her care related to those areas.</p> <p>Interview on 9/16/15 at 11:00 a.m. with the DON confirmed: *Charge nurses should have updated care plans related to changes in resident care. *Resident 4 and 6's care plans had not been updated appropriately.</p> <p>Surveyor:23059 Interview on 9/16/15 at 10:20 a.m. with the director of nursing revealed she confirmed all of the care plans should have been updated to reflect the resident's current needs. She confirmed all nurses were responsible for keeping the care plans up to date.</p> <p>Review of the provider's revised September 2014 Care Plans policy revealed: *The purpose of the care plan was to provide for continuation of resident-centered care and to provide a means of communication for all of those caring for a resident. *Care plan evaluation was ongoing and care plans were to have been updated with any changes in the resident's status. *Care plans would be developed within fourteen days after admission and every ninety days thereafter. *If there was a significant change in the resident's condition the care plan should have been reviewed and changed. *Any nurse could and was encouraged to contribute to and revise a current care plan. *Updating a care plan should have been done by writing on the existing care plan, initialing, and</p>	F 280			

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F 280	Continued From page 12 dating.	F 280			
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to assess and monitor one of four sampled residents (1) who was on a medication to promote sleep. Findings include:</p>	F 329			

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F 329	<p>Continued From page 13</p> <p>1. Observation on 9/15/15 from 8:15 a.m. to 4:30 p.m. of resident 1 revealed she: *Declined to get up until 9:25 a.m. and stated she was tired. *Was often observed sitting up in her wheelchair with her eyes closed.</p> <p>Review of resident 1's medical record revealed: *A 12/1/14 admission date. *Diagnosis of dementia (memory loss), depression, behavior disorder with aggression, congestive heart failure, and insomnia (difficulty sleeping). *She had been started on Tylenol PM (acetaminophen 500 milligrams [mg] and diphenhydramine [nighttime sleep-aide] 50 mg every bedtime for sleep on 11/15/14 in an acute care hospital swing bed.</p> <p>Review of resident 1's 1/22/15 through 9/11/15 nurse's notes revealed: *1/22/15, "Certified nursing assistant [CNA] reports resident is sitting on the floor between the beds in her room. CNA states she was assisting resident from bed to wheelchair and resident states her legs buckled from under her." *1/25/15, "CNA reports resident is on the floor. CNA and resident state as they were transferring from bed to wheelchair her legs buckled under her and CNA lowered her to the floor. Plan to use two CNA to transfer her now." *2/10/15, "Resident had two falls previous month." 2/24/15, "She is at risk for falls related to weakness in lower extremities [legs] and her legs giving out at times with transfers and not exercising." *3/16/15, "Resident taken to room to change</p>	F 329	<p>F329 – Resident 1's Tylenol PM DC'd and all resident orders reviewed for unnecessary drugs specifically sleep aids and effectiveness. Consultant Pharmacist will review resident 1's chart and all resident charts for hypnotic use, antipsychotics and antidepressants monthly for appropriate use of medications and document. DON or designee will audit five resident medication orders monthly for 6 months or until corrected and report findings to QA committee quarterly.</p> <p><i>for hypnotics, anti-psy chotics, and anti-depressants. NS/SDDOT/EL</i></p>	

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F 329	Continued From page 14 clothes related to spilling drinks. CNA attempted to use EZ stand [mechanical lift that requires resident to be able to bear some weight on legs] to transfer and resident resistant and will not stand and tries to take arms out of lift." *5/26/15, "Resists care of staff frequently and wanders in halls." *6/23/15, "Behaviors noted to have increased by staff. Repetitive verbalizations and occasional combative behaviors." *7/3/15, "Found sitting on floor beside bed with one hand on bedside rail yelling help me." *7/5/15 at 10:00 p.m., "Yelling and frequently putting on call light. Comprehension and understanding poor no matter how many times you repeat it to her. Since she was not sleeping assisted up in wheelchair and monitor behavior." *7/15/15 at 10:30 p.m., "At this time resident was yelling quite often and frequently. She did not know why restless and insomnia. So up in wheelchair with two assist for transfer. Will also monitor sleep patterns." *8/17/15 at 9:45 p.m., "Has been hollering hey off and on since being assisted to bed per her request at 7:00 p.m. This registered nurse and other staff have been in room numerous times to redirect. Always verbally states she will stop hollering but this only lasts a few minutes." *8/24/15, "Has recently had some change in behavior related to urinary tract infection and not feeling well. Is less argumentative and is slow in her response. Is not as repetitive and verbal, but is slowly returning to her previous behavior of anxious and repetitive statements." *8/25/15, "States she is frequently tired and wants to sleep a lot. Had one non-injury fall this quarter [last three months]. Fall risk related to dementia and behaviors. Pharmacist monitors medications every thirty days and physician every sixty to	F 329		

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F 329	<p>Continued From page 15 ninety days." *8/30/15, "Very quiet today. Difficulty taking her medications. Wants to sleep all the time." *8/31/15, "Spoke with son regarding declining condition. Son states he would like resident to be kept comfortable on comfort cares and only necessary medications." *9/5/15, "Sitting in wheelchair by nurse's station. Calling out hey. Resident called out she was falling. Before the nurse was able to get around the desk the nurse heard a loud bang. Resident was found on the floor face down. Noted to have a large raised area to forehead and abrasion [cut] noted on raised area." *9/6/15 at 11:00 p.m., "Resident hollering all night. When asked unable to communicate wants or needs. Kept hollering hey." *9/7/15 at 4:00 a.m., "Resident hollering hey. Resident not sure what she is wanting. Bruising noted to bilateral [both] eyes. Does complain of headache and acetaminophen given. Wanting to get up." *9/11/15 at 8:00 a.m., "Resident was still sleeping so charge nurse had me hold all her medications."</p> <p>Review of resident 1's 6/20/15 through 8/19/15 CNA notes revealed: *6/20/15, "Resident started yelling to get out of bed at 5:00 a.m. When CNA told resident to wait because it was to early to get up resident kept yelling and was told to quiet down. Resident yelled for two hours." *8/19/15, "She was not as talkative. Blank stare. When being changed only said ouch and no fighting."</p> <p>Review of resident 1's 12/15/14 care plan with a 8/27/15 revision date revealed:</p>	F 329			

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F 329	<p>Continued From page 16</p> <p>*No documentation regarding her insomnia or the nightly use of the Tylenol PM.</p> <p>*No non-pharmalogical interventions to promote sleep.</p> <p>Review of resident 1's January 2015 through September 2015 monthly pharmacy evaluations revealed no documentation regarding the nightly use of Tylenol PM as a hypnotic (sleeping aide).</p> <p>Interview on 9/15/15 at 1:45 p.m. with the director of nursing regarding resident 1 revealed she: *Did not think the use of the Tylenol PM had been effective to help her sleep. *Agreed the physician should have been notified the Tylenol PM had not improved her insomnia. *Was not sure why the pharmacist had not documented on the Tylenol PM in her monthly reviews.</p> <p>Interview on 9/15/15 at 3:15 p.m. with the consultant pharmacist regarding resident 1 revealed she: *Had not been made aware the resident was not sleeping well at night with the use of the Tylenol PM. *Would have recommended the medication should have been discontinued and another medication (preferably short-acting) for sleep should have been tried. *Agreed diphenhydramine (ingredient in Tylenol PM) use in the elderly (age greater than 65) was not recommended due to it's anticholinergic side effects (physical symptoms resulting from medications that counter the action of acetylcholine a neurotransmitter [chemical messages that carry signals to other cells in the body]).</p>	F 329		

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F 329	Continued From page 17 Review of Todd Semela, et al., Geriatric Dosage Handbook, 16th ED., pp. 494-497, revealed: *Beers criteria (guideline for healthcare professionals to help improve the safety of prescribing medications for the elderly) stated "This drug may be inappropriate for the elderly." **"May cause sedation [sleepiness]." **"Should not be used as a hypnotic in the elderly, may cause excessive sedation and confusion [memory loss]." **"Has high anticholinergic properties [confusion and disorientation (memory loss)], agitation, memory problems, increased risk for falls, incoherent [unable to understand] speech, irritability, and poor coordination [body movements]." **"It's use as a sleep-aide is discouraged due to its anticholinergic effects." **"Interpretive guidelines from Centers for Medicare and Medicaid Services [CMS] discourage the use of diphenhydramine as a sedative in long-term care facilities." Review of the provider's January 2006 Pharmaceutical Services policy revealed "The consulting pharmacist shall review monthly each resident's drug regimen and document."	F 329			
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.	F 368			

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F 368	<p>Continued From page 18</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, record review, and policy review revealed bedtime snacks had not been offered to nine of nine sampled residents (1, 2, 3, 4, 5, 6, 7, 8, and 9) and five randomly interviewed residents every night. Findings include:</p> <p>1. Interview on 9/15/15 at 10:30 a.m. with five random residents who attended the group interview revealed: *They stated they were rarely if ever offered a bedtime snack. *The snack cart was wheeled into the employee break room, and they thought the employees had eaten them.</p> <p>Review of the medical records of all sampled residents 1, 2, 3, 4, 5, 6, 7, 8, and 9 revealed there was no documentation to confirm snacks had been offered, eaten, or refused.</p> <p>Interview on 9/15/15 at 2:10 p.m. with the dietary manager revealed: *Dietary staff placed residents' snacks in the employee break room for the staff to distribute</p>	F 368	<p>F368 – Residents 1, 2, 3, 4, 5, 6, 7, 8, and 9 and all residents will be offered HS snacks daily by the nurse or UAP (Medication aide) on duty. A daily record will be kept in a three ring binder to document acceptance or refusal of snacks. DON or designee will monitor snack records ^{#1} monthly for 6 months or until corrected and report findings to QA committee quarterly.</p> <p><i>Weekly times one month and the monthly for 6 months. NS/SDDcttel</i></p>		

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F 368	<p>Continued From page 19 every evening. *Those snacks consisted of a variety of yogurts, crackers, cookies, cheese, sandwiches, pudding, and milk. *The certified nursing assistants and nursing staff were responsible for offering those snacks to residents each evening. *She was aware the staff had been eating some of those snacks. *She was unsure if residents had been offered snacks but knew they should have been.</p> <p>Observation on 9/15/15 at 4:15 p.m. revealed a tray of snacks for the residents had been stored in the employee break room refrigerator. There was also a bucket of wrapped snacks on top of the refrigerator.</p> <p>Interview on 9/15/15 at 4:15 p.m. with licensed practical nurse A revealed she was aware the residents' snacks had been kept in the employee break room. She was aware not all residents had been offered bedtime snacks each evening. She confirmed employees did sometimes eat some of those snacks.</p> <p>Surveyor: 35237 Interview on 9/16/15 at 11:15 a.m. with resident 6 regarding bedtime snacks revealed: *Staff rarely offered her them. *She thought they brought bedtime snacks around about once every two weeks.</p> <p>Interview on 9/16/15 at 11:25 a.m. of resident 4 regarding bedtime snacks revealed she: *Had not received a snack at bedtime in a long time. *Was unsure when the snacks had stopped being</p>	F 368			

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F 368	Continued From page 20 offered. *Would like to have a bedtime snack sometimes. Surveyor: 23059 Review of the provider's Dietary Snacks policy revealed: *Snacks would be stocked in the nursing home refrigerator. *Snacks would have been stocked by the cooks in the dietary department. *The nursing refrigerator would have been stocked with: -Three sandwiches. -Yogurt. -Milk. -Pudding. -Cheese sticks. -Assortment of packaged snacks. Interview on 9/16/15 at 10:20 a.m. with the director of nursing revealed: *All nursing staff was to have offered snacks to all residents every evening. *She confirmed employees might have been eating the residents' bedtime snacks. *There was no documentation to confirm if residents had been offered snacks, eaten, or refused them.	F 368			
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Surveyor: 35237	F 372			

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F 372	<p>Continued From page 21</p> <p>Based on observation, interview, and policy review, the provider failed to maintain the outside garbage container in a sanitary manner. Findings include:</p> <p>1. Random observations throughout the survey from 9/14/15 through 9/16/15 of the garbage container located behind the outside of the building revealed:</p> <ul style="list-style-type: none"> *It was overflowing with garbage. *The lids had been open. *At one point a bag of garbage was on the ground beside the container. <p>Interview on 9/15/15 at 3:50 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *Usually the lids to the garbage container were closed. *They were probably open because it was full. *She thought garbage was picked up once a week. <p>Observation and interview on 9/15/15 at 4:30 p.m. with housekeeper D who was outside at that time revealed:</p> <ul style="list-style-type: none"> *Garbage was picked up twice a week. *The lids were open, and the garbage was overflowing. *Normally the lids were closed. <p>Interview on 9/16/15 at 8:30 a.m. with the maintenance supervisor revealed:</p> <ul style="list-style-type: none"> *The garbage was picked up twice a week. *It had been overflowing the container frequently lately. *Nothing had been agreed on to address the problem. *He agreed it was a sanitation issue and had the potential to draw pests. 	F 372	<p>F372</p> <p>Additional dumpster will be added to increase capacity of the garbage container area to enable proper sanitary storage of refuse/ garbage. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.</p> <p><i>Audits will be conducted weekly for one month and monthly for 5 months.</i></p> <p><i>NS/SDDOtt/EL</i></p>	<p><i>11/5/2015</i></p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2015
NAME OF PROVIDER OR SUPPLIER PHILIP NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 503 WEST PINE POST OFFICE BOX 790 PHILIP, SD 57567		
(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 372	Continued From page 22	F 372			
F 520 SS=D	<p>Review of the provider's 6/15/10 Infection Control for Maintenance policy revealed "7. Waste disposal shall be done in compliance with Federal and State regulations."</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on interview, record review, and policy</p>	F 520	F520 – A physician will attend each quarterly QA meeting. If they are unable to attend, the QA Coordinator will present a QA report at the quarterly Medical Staff Meeting to all medical providers in attendance and have the QA report documented in the Med Staff meeting notes. The DON will monitor QA meetings quarterly and/or Medical Staff Meetings for physician attendance and report findings to QA committee quarterly.		

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F 520	<p>Continued From page 23</p> <p>review, the provider failed to ensure a physician or the medical director had attended the quality assurance (QA) meetings on a quarterly basis for the past year. Findings include:</p> <p>1. Interview and record review on 9/16/15 at 10:20 a.m. with the director of nursing confirmed the medical director or a physician had not come to every QA meeting. They had met on a quarterly basis. She stated he had only attended one meeting in the past twelve months.</p> <p>Review of the provider's undated Quality Improvement policy revealed the medical director was one of the members of that program. It had stated the meetings would be quarterly or more frequent if a need had arisen sooner.</p>	F 520			

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/15/15. Philip Nursing Home was found not 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 upon correction of deficiencies identified at K052, K062, K069, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 052 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the fire alarm system was continuously maintained in reliable operating condition, was inspected, and was tested</p>	K 052	<p>K052</p> <p>Annual fire alarm inspection will be conducted by <u>Western States Fire Protection</u>, a new vendor. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.</p>	<p>11/5/2015</p> <p><i>(Signature)</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>(Signature)</i>	TITLE CEO / ADMINISTRATOR	(X6) DATE 10/7/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 052	Continued From page 1 periodically in accordance with NFPA 72 National Fire Alarm and Signaling Code (annual fire alarm inspection). Findings include: 1. Document review at 9:45 a.m. on 9/15/15 of the provider's fire alarm inspection report prepared by Simplex Grinnell revealed no documentation of the required annual fire alarm inspection report for the past year. The last inspection report available was from August 5, 2014. At the time of survey, approximately one and a half months had lapsed since the last annual inspection should have been completed. Interview with the facility manager at the time of the record review confirmed that condition. He indicated he was unaware of the annual fire alarm inspection requirement. He indicated he was in the process of finding a new service company to conduct the inspections.	K 052			
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition, was inspected, and was tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and	K 062	K062 Quarterly flow tests for the automatic fire sprinkler system will be conducted by <u>Western States Fire Protection</u> , a new vendor. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.	11/5/2015 	

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K 062	Continued From page 2 Maintenance of Water-Based Fire Protection Systems (quarterly flow test). Findings include: 1. Document review at 10:10 a.m. on 9/15/15 of the provider's automatic sprinkler system inspection report prepared by Simplex Grinnell revealed missing documentation of the required quarterly flow test for the automatic fire sprinkler system. Quarterly flow testing reports were not available for the third quarter of 2015 and the second and fourth quarters of 2014. Interview with the facility manager at the time of the record review confirmed that condition. He indicated he was unaware of the quarterly flow testing requirement. He believed that Simplex Grinnell was conducting all the testing and inspection required by NFPA 25.	K 062			
K 069 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review, observation, and interview, the provider failed to ensure the commercial kitchen hood was continuously maintained in reliable operating condition, was inspected, and was tested periodically in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (bi-annual inspection). Findings include: 1. Document review at 10:15 a.m. on 9/15/15 of the provider's commercial kitchen hood	K 069	K069 Kitchen hood semi-annual inspection report has been obtained from Armstrong Extinguisher Service, Inc. to properly document the inspection. Report dated April 15, 2015. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.	11/5/2015 	

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K 069	Continued From page 3 inspection reports prepared by Armstrong Extinguisher Service Inc. revealed missing documentation for the required bi-annual commercial kitchen hood inspections. The last report available was for April 8, 2014. Bi-annual reports were not available for April 2015 and October 2014. Interview with the facility manager at the time of the above record review confirmed that condition. He indicated he was unaware of the bi-annual inspection requirements. 2. Observation at 12:15 p.m. on 9/15/15 in the kitchen area revealed an inspection tag on the commercial kitchen hood fire suppression release pull station. That tag was dated April 2015 by Armstrong Fire Extinguisher Service Inc. Interview with the facility manager at the time of the above observation confirmed that condition. He indicated he was unsure where the inspection report dated April 2015 was at.	K 069		
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the electrical system in accordance with the National Fire Protection Association (NFPA 70), National Electrical Code (NEC) article 408.4(A) Field Identification in one randomly observed location (electrical equipment	K 147	K147 Circuit directory for emergency life safety panel board will be completed in a legible manner to enable clear identification of all electrical circuits. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.	11/5/2015 

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K 147	Continued From page 4 room). Findings include: 1. Observation at 11:45 a.m. on 9/15/15 revealed an electrical equipment room near the laundry department. Further observation revealed an emergency life safety panel board that was part of the essential electric service. The circuit directory of that panel board had not been filled in. Circuits shall be legibly identified as to its clear, evident, and specific purpose or use. Interview with the maintenance manager at the time of the above observation revealed he confirmed that condition. He revealed he was unaware of that condition but confirmed the necessity of having the circuit directory available.	K 147			

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S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/14/15 through 9/16/15. Philip Nursing Home was found not in compliance with the following requirements: S180 and S326.	S 000		
S 180	44:04:02:18 AREA REQUIREMENTS Each currently licensed...resident room must have at least 75 square feet (6.98 square meters) of floor space per bed, with at least 3 feet (0.91 meters) between beds in multi-bed rooms exclusive of closets and wardrobes; and 95 square feet (8.83 square meters) in single rooms, exclusive of closets and wardrobes. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 35237 Based on observation, measurement, and interview, resident's beds were not maintained at least three feet apart in 5 of 13 double resident rooms (102, 104, 114, 116, and 120). Findings include: 1. Observation and measurement on 9/15/15 from 2:00 p.m. through 2:30 p.m. of the distance in inches (in.) between the resident's beds in their rooms revealed: *Room 102 was 21 in. *Room 104 was 12 in. *Room 114 was 21 in. *Room 116 was 15 in. *Room 120 was 19 in.	S 180	S180 – The distance between beds in rooms 102, 104, 114, 116, and 120 and all semi-private resident rooms have been arranged at least three feet apart. The DON or designee will monitor all resident rooms three times weekly for one month, then once weekly for one month, then monthly for four months or until corrected. DON will report findings to QA committee quarterly.	<i>[Signature]</i> 11/5/15

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

[Signature]

TITLE

[Signature]
ADMINISTRATOR

(X6) DATE

10/07/15

037 0 0 2005

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S 180	<p>Continued From page 1</p> <p>*Those rooms had the beds positioned in the middle of the room with the head of the beds against the wall.</p> <p>Interview of the residents in Room 102 at the time of the above observation revealed they felt the beds were "too close." They were unsure if the room could have been rearranged.</p> <p>Interview on 9/15/15 at 4:10 p.m. with the director of nursing revealed: *She had known the beds in some resident rooms were too close together. *She was aware of the regulation for the beds to be at least three feet apart. *She agreed there was an infection control risk when the beds were less than three feet apart. *They could have rearranged those rooms, so the beds were not that close together. *They did not have a policy specific to the bed spacing.</p> <p>Interview on 9/16/15 at 9:45 a.m. of certified nursing assistants (CNA) B and C revealed: *They felt the beds were too close in some resident's rooms. *They were unsure why some rooms were arranged with the beds in the middle versus against the walls. *CNA B thought the beds were supposed to be at least three "blocks" (floor tiles) away from each other. -That distance would have been about three feet. *Because of education they recognized there may be an infection control risk for those residents when the beds were closer than three feet apart.</p>	S 180		
S 326	44:04:08:05 ADMINISTRATION OF MEDICATIONS AND DRUGS	S 326		

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S 326	<p>Continued From page 2</p> <p>Each medication administered must be recorded in the...resident's medical record and signed by the individual responsible. Medication errors and drug reactions must be reported to the...resident's physician and an entry made in the...resident's medical record. Orders involving abbreviations and chemical symbols may be carried out only if the facility has a standard list of abbreviations and symbols approved by the medical staff or, in the absence of an organized medical staff, by the medical director and the list is available to the nursing staff. In...nursing facilities all medications must be administered to patients by personnel acting under delegation of a licensed nurse, or licensed to administer medications...</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure medications errors were reported to four of five sampled residents' (1, 2, 3, and 5) physicians. Findings include:</p> <p>1. Review of resident 1's 7/15/15 and 8/10/15 medication variance forms revealed: *7/15/15, Tramadol (pain) 50 milligrams (mg) and Zolpidem Tartrate (sleep) 2.5 mg had not been given. *8/10/15, Tramadol 50 mg had not been given. *There was no documentation either medication omission had been reported to the physician.</p> <p>2. Review of resident 2's 4/9/15 medication variance form revealed Fentanyl (narcotic pain patch) 25 micrograms (mcg) had been borrowed</p>	S 326	<p>S326 – The Medication Variance policy and Variance Form has been reviewed and revised to reflect that all medication variances are to be reported to the physician. The updated policy and variance form will be reviewed at the next nurses' meeting on October 7th. DON or designee will monitor all Medication Variances for proper notification of physician monthly for 6 months or until corrected and findings will be reported to the QA committee quarterly.</p> <p>1. Resident 1's Medication Variance's from 7/15/15 and 8/10/15 has been reported to the physician. Nurse and UAP staff educated on notifying physician whenever a Medication Variance has occurred. DON or designee will monitor all Medication Variances monthly for 6 months or until corrected for physician notification and report findings to QA committee quarterly.</p> <p>2. Resident 2's Medication Variance from 4/9/15 was reported to the physician. Nurse and UAP staff educated on notifying physician whenever a Medication Variance</p>	
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S 326	<p>Continued From page 3</p> <p>from another resident's box. "Order overlooked."</p> <p>3. Review of resident 3's 4/22/15 medication variance report revealed: *Fentanyl patch 25 mcg "Old patch not taken off when a new one was put on. Patch removal overlooked." *There was no documentation the physician had been informed.</p> <p>4. Review of resident 5's 5/4/15 and 8/11/15 medication variance forms revealed: *5/4/15, Morphine sulfate (narcotic for pain) 15 mg had been omitted and KCL (potassium) 20 meq only one KCL given due to misreading dose. *8/11/15, Morphine sulfate 15 mg had been omitted. *There was no documentation either medication omission had been reported to the physician.</p> <p>5. Interview on 9/16/15 at 10:00 a.m. with the director of nursing regarding the above residents revealed they only informed the physician of medication errors if they were significant.</p> <p>Review of the provider's January 2006 Medication Variance policy revealed: *"The nurse is responsible for notifying the physician if deemed clinically significant and carrying out resident/patient care instructions as ordered." *"A variance that does not reach the resident/patient does not require physician notification, but does require a medication variance form." *"Physicians must be notified of medication errors that have reached the resident/patient when involve medications that are not administered as ordered. Examples include wrong dose, wrong route, omitted dose, extra dose, medications</p>	S 326	<p>has occurred. DON or designee will monitor all Medication Variances monthly for 6 months or until corrected for physician notification and report findings to QA committee quarterly.</p> <p>3. Resident 3 is deceased therefore this Medication Variance will not be reported.</p> <p>4. Resident 5 is deceased therefore this Medication Variance will not be reported.</p>	<p><i>Handwritten initials and date: 11/8/15</i></p>

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S 326	Continued From page 4 ordered STAT/NOW that are given late, or scheduled medications given late."	S 326			