...ENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE HEALTH CARE CENTER	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 000	INITIAL COMMENTS *Addendums noted with an asterisk per 1/28/16 per telephone with facility administrator SB/SDDOH/EL Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted from 12/28/15 through 12/30/15. Southridge Health Care Center was found not in compliance with the following requirements: F176, F221, F226, F283, F431, F441, and F516.	F 000		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to: *Appropriately assess for safety of self-administration of nebulizer medication for one of two random residents (19). *Have a care plan in place to specify responsibilities for storage, documentation, and set-up of self-administration of nebulizer medication for one of three sampled (5) and two of three random (19 and 20) residents. Findings include: 1. Observation on 12/29/15 at 8:00 a.m. during a medication pass done by licensed practical nurse (LPN) I with resident 19 revealed: *LPN I removed nebulizer (device to administer medicine as a mist into lungs) medications	F 176	Residents #5, #19 and #20 and all other residents were assessed by 01-29-16 to determine their ability to self-administer nebulizers by the DON and/or designee. DON and/or designee assessed all of the care plans to ensure that each has a care plan in place to specify responsibilities for storage, documentation, and set-up of self-administration of nebulizer medications and a SAM form/TAR is current. All nursing staff was educated on this procedure by the DON by 1-25-16. Self-Administration of Nebulizer Assessment determinations will be documented in each of the resident's EMR and included on each MAR/TAR and care plan after the physician orders are obtained. Self-administration of Nebulizer assessment will be completed quarterly by the charge nurses. The facility policy/procedure on resident self administration of medication was review/revised by 1-25-16 by the DON, interdisciplinary team and the Pharmacy Consultant Kim Roiger. The DON educated all facility staff on the new policy and procedure by 1-25-16.	2-4-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeffrey Bugjak	Administrator	1-20-16

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 176	Continued From page 1 Ipratropium and Albuterol from the medication cart and placed them at his bedside. *She stated the resident: -Had been assessed for medication self-administration. -Was able to self-administer the nebulizer (neb) medication himself. -Was able to set-up the nebulizer medication into the nebulizer chamber himself. *He knew not to mix the medications in the same chamber. *She instructed the resident the medication was at his bedside for his use. *The resident acknowledged he understood. Review of resident 19's medical record revealed: *A 12/15/15 Assessment for Self-Administration of Nebulizer was signed by a nurse and a physician stating the resident could: -State the name of the medications. -Correctly administer the inhaled medication. *Medications for self-administration had included Brovana, Budesonide, Ipratropium-Albuterol, and Proair HRA Inhaler. *The most recent 11/16/15 physician's orders and the December 2015 medication administration record (MAR) had included an order: "SAM (self-administration of medication) assessment OK to leave mask on until med gone." *Neither the physician's orders nor the MAR had indicated which medications the resident had been assessed for. *The 9/23/15 Care Plan had not included the self-administration of medication or the responsibilities for storage, documentation, or set-up of the medications. Upon return to resident 19's room at 10:20 a.m. it was noted his nebulizer medications remained	F 176	Audits will be conducted weekly for 1 month and monthly for the next 3 months on resident #5, #19, #20 and 5 other random residents on a nebulizer treatment to ensure self administration orders are in place [redacted] that nurses and med techs are following the self-administration of medications policy/procedure, current and accurate self administration of nebulizer assessments with signatures are in the chart and a current care plan is in place. The audits will be conducted by the DON and/or designee who will also be responsible for overall compliance. The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.	[redacted]

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F 176	Continued From page 2 unopened sitting on a bedside table. Interview with LPN I at that time revealed: *She agreed resident 19 had not taken his medication. *She would have to wake him up and see that his medications were taken. Interview on 12/29/15 at 1:40 p.m. with resident 19 revealed: *He normally set-up his own medications. *Sometimes he mixed his nebulizer medications together but not always. *He was aware the medications were not as effective when mixed, but he mixed them anyway. *He used only one chamber for his nebulizer medications. *He never rinsed the nebulizer chamber before adding another medication to it. Interview on 12/29/15 at 10:25 a.m. with RN clinical coordinator D revealed: *The floor nurses assessed the residents for self-administration of medications. *Her expectation was the nurse would set-up the nebulizer medication and apply the nebulizer mask. *She agreed the self-administration order had not indicated who would be responsible for setting up the medication. *She would have expected self-administration of medication to have been on the care plan. 2. Observation on 12/29/15 at 12:30 p.m. of resident 20 during a medication pass revealed the December MAR: *Contained an order for Ipratropium and Albuterol nebulizer medication. *Indicated "May self-administer medication	F 176		*SB/SDROH/EL [redacted]

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F 176	Continued From page 3 treatments. May leave mask on until neb gone." *Had not indicated which medications she was able to self-administer. Review of resident 20's medical record revealed: *A 10/24/15 Assessment for Self-Administration of nebulizer signed by the nurse and physician. *The assessment indicated she was able to state the name of the medication and could correctly administer inhaled medication. *The medications assessed were Budesonide and Ipratroprium/Albuterol. *The most recent 11/2/15 physician's orders had not included orders for self-administration. *Review of the updated 7/8/15 care plan revealed: -"If you leave/set-up my neb for me I will leave the mask on till my med is gone-I passed the assessment." -No documentation regarding the responsibilities for storage or documentation of the medication. 3. Review of resident 5's medical record revealed: *A 10/13/15 Assessment for Self-Administration of Nebulizer had not been signed by a nurse. *The assessment indicated he was able to state the name of the medication and could correctly administer inhaled medication. *The medications assessed were Ipratropium bromide/albuterol sulfate. *The most recent 12/28/15 physician's orders had not included orders for self-administration. *The December 2015 MAR indicated, "SAM assessment completed. May leave on until med is gone. May self-administer medication treatments." *The MAR had not included which medication treatments the resident was allowed to	F 176		[redacted] *SB/SDDOH/EL

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F 176	Continued From page 4 self-administer. *The 10/22/15 care plan had not included anything about self-administration of medications. 4. Interview on 12/30/15 at 1:30 p.m. with the director on nursing regarding residents 5, 19, and 20 revealed: *Her expectation was the nurse would set-up medications and apply the nebulizer mask for each resident who self-administered the nebulizer medications. *The MAR should have specified what medications each resident self-administered. *Medications should not have been left at the residents' bedside. *Nebulizer chambers should have been rinsed out prior to using a different medication. *Residents were not supposed to mix any medications themselves. *Self-administration of medication should have been documented in the residents' care plans. Review of Todd P. Semla et al., Geriatric Dosage Handbook, 16th ed., Hudson, Ohio, 2011, revealed: *Page 131, regarding Brovana, "Do not mix with other medications in nebulizer." *Page 205, regarding Budesonide, "Do not mix with other medications in nebulizer." Review of the provider's July 2015 Self-Administration of Medications policy revealed: *The staff and practitioner would perform a skill assessment including the ability to recognize risks and major adverse consequences of the medications. *If the staff determined a resident could not safely self-administer medications the nursing staff	F 176		*SB/DDOH/EL [redacted]

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F 176	Continued From page 5 would administer the resident's medications. *Self-administered medications were to have been stored in a safe place away from other residents. *Residents who self-administered medications were responsible for informing the charge nurse or medication aide, so that information could have been documented.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, record review, interview, and policy review, the provider failed to ensure restraint assessments had been completed for two of two sampled residents (6 and 18) with side rails. Findings include: 1. Observation from 12/28/15 through 12/30/15 in resident 6's room revealed he had two half-side rails in the up position at the top of the bed. Review of resident 6's medical record revealed: *He had been admitted on 12/11/15. *A 12/22/15 physician's order for "Therapy currently recommends top bed rails to res [resident] bed to help with positioning and transfers, is this ok with you?" Physician's was response "yes." *The 12/17/15 Minimum Data Set admission	F 221	Residents #6 and #18 and all other residents were assessed for the documentation of a repositioning bar assessment. After a physician order is received for a repositioning bar for a new resident a Comprehensive Mobility Assessment will be completed by the charge nurse with signature and date. All Residents care plans will be updated by 1-29-16 who utilize repositioning bars for mobility. The Comprehensive Mobility Assessment policy was reviewed by the interdisciplinary team on 1-20-16. The nurses were educated on the policy by 1-29-16 by DON and/or designee. The DON and/or designee will audit weekly for 3 months and then monthly for one year on residents #6 and #18 along with 5 random residents that utilize repositioning bars to ensure the policy is being followed, Comprehensive Mobility Assessment is completed and the care plan is updated and current.	2-4-16

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F 221	Continued From page 6 assessment coded bed rails as not being used. *The 12/11/15 care plan with an estimated date of 12/22/15: "Bilateral siderails to bed to aid with transfers and respositioning." *There was no documentation a side rail assessment had been completed prior to placement of the half-side rails. Interview on 12/29/15 at 11:50 a.m. with the infection control nurse confirmed side rail assessments had been completed as comprehensive mobility assessments. Interview on 12/30/15 at 8:20 a.m. with the director of nursing (DON) regarding resident 6's side rail assessment revealed: *Side rail assessments were completed as comprehensive mobility assessments. *The comprehensive mobility assessment had not been completed prior to placement of the side rails. *The nurse who had been responsible to complete the comprehensive mobility assessment had told her she had not received that as part of her training. *Her expectations were: -For new nurses to receive training on completion of comprehensive mobility assessment prior to placement of side rails. -The comprehensive mobility assessment should have been completed prior to placement of side rails. *The nurse had completed the comprehensive mobility assessment after she had told her to do it. Review of resident 6's medical record and interview with the DON on 12/30/15 at 9:30 a.m. revealed:	F 221	The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee. [redacted] *SBS DDCH/EL	

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F 221	Continued From page 7 *Resident 6's Comprehensive Mobility Assessment dated 12/29/15 had not been signed or dated by the person completing the assessment. *Interview at the above time with the DON confirmed her expectations were for the person completing the assessment to have signed and dated it. Surveyor: 32331 2. Observation on 12/28/15 at 4:00 p.m. and on 12/30/15 at 9:15 a.m. in resident 18's room revealed she had one side rail in the up position at the top of the bed. Review of resident 18's medical record revealed: *She had been admitted on 2/8/11. *Her diagnoses had included fall, bipolar (a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out daily tasks), and weakness. *The 10/12/15 quarterly MDS assessment coded bed rails as not being used. *The 10/12/15 revised care plan had no information regarding a side rail on her bed. *There was no signature and date on her Comprehensive Mobility Assessment for the use of a side rail on the assessments done on the following dates: -4/14/15. -7/15/15. -10/11/15. Interview on 12/30/15 at 9:35 a.m. with clinical coordinator D revealed: *The side rail assessments had been completed as comprehensive mobility assessments. *She agreed the side rail needed to have been on the care plan.	F 221		

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F 221	Continued From page 8 *She confirmed the last three quarterly comprehensive mobility assessments had not been signed or dated by the person completing the assessment. Interview on 12/30/15 at 1:15 p.m. with the DON regarding resident 18's side rail assessment revealed: *The comprehensive mobility assessment needed to have been signed and dated by the person completing the assessment. *Her expectations were for the person completing the assessment to have signed and dated it. Surveyor: 29354 3. Review of the provider's undated Bed Safety policy revealed: *"If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the attending physician, and input from the resident and/or legal representative. *The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. *Side rails may be used if assessment and consultation with the attending physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer. *Before using side rails the staff shall inform the resident and family."	F 221	*SB/SDDOH/EC [redacted]	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226		

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F 226	Continued From page 9 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure they investigated and reported to the South Dakota Department of Health (SD DOH) as required for one of one sampled resident (7) with a fall resulting in major injury. Findings include: 1. Review of resident 7's medical record revealed she: *Had a history of falls. *Had diagnoses that had included dementia (mental illness losing touch with reality), anxiety, depression, schizophrenia (a disorder that affects how a person thinks, feels, and acts), a history of falls, and agitation. Review of resident 7's 10/1/15 Minimum Data Set (MDS) quarterly assessment, section C revealed: *She had a Brief Interview for Mental Status (testing of thought processes) score of four. *A score of four indicated severe impairment or loss. Review of resident 7's revised 12/22/15 care plan revealed she had: *A history of numerous falls. *Took antipsychotic medication (mood altering mental illness medication) that increased the risk of falls. *Been unaware of her safety needs. Review of resident 7's 6/26/15 Post Fall Risk	F 226	Resident #7 has had no further incidents. The Accidents and Incidents – Investigating and Reporting policy was reviewed by the interdisciplinary team on 1-22-16 and will be included on the all staff in-service on 1-22-16. The in-service will include the time limits that all staff has to report any grievance or allegation of abuse/neglect that meets the state reportable definitions. All staff will be in-serviced on the facility abuse and neglect policy/procedure, Department of Health abuse/neglect reporting requirements and timelines by the DON and/or designee on 1-22-16. The Administrator and/or designee will audit all grievances/allegations of abuse/neglect each week for a year to ensure that the event was reported timely to the Department of Health/appropriate agencies. The results of the audit will be brought to the monthly QAPI meeting by the Administrator and/or designee on a monthly basis for one year and then as deemed necessary by the QAPI committee if no further patterns persist.	2-4-16

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F 226	Continued From page 10 Assessment revealed: *She had been found on the floor in her room after attempting to sit on the floor. *She had fallen on her left side. *The above fall had not been witnessed. *After that fall she had complained of pain in the left thigh/hip area. Review of resident 7's nurses progress notes revealed: *On 6/26/15 at 3:03 p.m. she had: -Been attempting to sit on the floor and fell on her left side. -Complained of left thigh and hip pain. *On 6/26/15 at 3:10 p.m.: -Her daughter and physician had been contacted regarding the fall. *On 6/26/15 at 5:17 p.m.: -Her physician ordered to have her sent to the emergency room (ER) if she complained of pain with ambulation (to move from one place to another). *On 6/26/15 at 6:51 p.m. she: -Had complained of left thigh pain when ambulating. -Was transferred to the ER. *On 6/27/15 at 12:10 a.m. she: -Had been admitted to the hospital with a hip fracture. Review of the provider's incident report for resident 7 revealed: *On 6/28/15 at 12:15 p.m. the administrator had notified the SD DOH regarding the fall that had occurred on 6/26/15 at 3:03 p.m. -In that report the administrator had been first aware of the fall with fracture "on 6/28/15 around 9:30 a.m." *The SD DOH had been notified approximately	F 226		*SB/SDDOH/EL [redacted]

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F 226	Continued From page 11 two days after the fall with major injury had occurred. Interview on 12/29/15 at 4:20 p.m. with the licensed social services director regarding resident 7's fall on 6/26/15 revealed: *The fall had not been investigated and reported to the SD DOH in a timely fashion. *That fall had been unwitnessed. *She had decreased cognition (thinking). *She had received a major injury with that fall. *He stated that a fall with major injury needed to have been reported within two hours. Interview on 12/30/15 at 1:15 p.m. with the director of nursing regarding resident 7's fall on 6/26/15 revealed: *The fall had not been investigated and reported to the SD DOH in a timely fashion. *That fall had been unwitnessed. *She had considered her fall to have been one of serious injury. *She expected that fall to have been reported within two hours or as soon as possible to the SD DOH. *She, the administrator, or the manager on duty was responsible for investigating and reporting to the SD DOH. *She stated the provider's system for reporting to the SD DOH in a timely fashion needed to have been improved. Review of the provider's 7/7/15 Accidents and Incidents-Investigating and Reporting policy revealed: *If a fall involved a serious bodily injury: -The nurse supervisor/charge nurse and/or department director or supervisor must have notified the administrator and/or the DON	F 226		*SD DOH/EL [redacted]

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SOUTHRIDGE HEALTH CARE CENTER	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 226	Continued From page 12 immediately. - The appropriate agencies were to have been notified. *Any serious bodily injury incident must have been documented on the required "Nursing Facility Event Reporting" form and reported to the SD DOH.	F 226		
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on record review and interview, the provider failed to ensure: *Three of three discharged residents (14, 15, and 16) had a recapitulation (recap) (summary) of their stay. *One of one discharged resident (15) had a completed transfer form. Findings include: 1. Review of resident 16's closed record revealed: *He had been discharged to his own home on 9/30/15. *His discharge instructions had been completed on 9/30/15. *There was no documentation a recap of his stay	F 283	Residents #14, #15, #16 have been discharged and their records are closed so they will not have a discharge summary completed. All potential discharges are reviewed by DON and/or designee for discharge summary completion. Discharge summary sheet and policy/procedures reviewed/revised by interdisciplinary team on 1-20-16 and nursing staff will be in-serviced on 1-20-16 regarding recap of stay information, discharging Residents, and policy/procedure. All resident discharges are reviewed by DON and/or designee for discharge summary completion. Discharge summary sheet and policy/procedures reviewed/revised by interdisciplinary team on 1-20-16 and nursing staff in-serviced on 1-20-16 regarding recap of stay information, discharged residents and policy/procedure.	2-4-16

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F 283	Continued From page 13 had been completed. Interview on 12/30/15 at 8:30 a.m. with the director of nursing confirmed the discharge instructions were not a recap of a resident's stay. A recap of stay should have been completed prior to discharging a resident. Surveyor: 32332 Review of resident 15's closed record revealed: *A 10/28/15 physician's order indicated it was alright for her to discharge to another nursing facility on 10/29/15 with her medication. *No recap of her stay had been located in the closed record. *No transfer form had been located in the closed record. *The last written documentation in the interdisciplinary notes had been on 10/28/15. *There was no documentation to have indicated when she had been discharged. Interview on 12/30/15 at 1:30 p.m. with the director of nursing revealed her expectation had been the medical record should have included: *A recap of her stay in the facility. *A copy of the transfer form that had been sent to the facility she was transferred to. *Documentation in the interdisciplinary notes at the time of her discharge. Surveyor: 35625 3. Review of resident 14's closed record revealed: *She had been discharged to her home on 11/6/15 with home health services. *A copy of the discharge instructions that was	F 283	Upon receiving discharge orders the nurse will inform the DON and/or designee of discharge who then will ensure the nurse starts the discharge summary. Medical records will audit each discharged/transferred Resident's information to ensure recap of stay/discharge summary/transfer form are completed, and give the information to the DON. Medical Records will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.	

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F 283	Continued From page 14 given to the resident was in the closed record. *There was no recap of her stay in the electronic or paper medical record. Interview on 12/30/15 at 1:55 p.m. with the director of nursing revealed: *There was no recap present in the medical record for resident 14. *A recap was to have been completed at the conclusion of the resident's stay.	F 283		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	Fentanyl patches are now destroyed with a chemical called RX destroyer effective 1-20-16. A used fentanyl patch will be placed in the chemical and the patch will be dissolved making the old patch useless. The RX destroyer will be available at each nurse station medication room. The pharmacy services policy/procedure was updated to reflect this disposal method of used fentanyl patches by the interdisciplinary team on 1-20-16. All nurses will be in-serviced by the DON and/or designee on the new procedure on 1-20-16.	2-4-16

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F 431	Continued From page 15 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, and policy review, the provider failed to appropriately dispose of Fentanyl patches (controlled pain medication delivered through the skin) awaiting destruction in three of three medication rooms where medications awaiting destruction were stored. Findings include: 1. Medication cart observation and interview on 12/29/15 at 4:30 p.m. with the director of nursing (DON) revealed: *Used Fentanyl patches were folded and placed in the sharps container on the medication cart. -The wasting of the patches was witnessed by two licensed nurses. -The sharps container was located on the side of each medication cart. *The sharps container was removed from the cart when it was full and was locked. -It was to be placed in a locked hazardous waste room as it awaited pick-up for final destruction. -It was her understanding that nursing and maintenance personnel had keys to the hazardous waste room. Interview on 12/30/15 at 1:05 p.m. with registered nurse (RN) A revealed:	F 431	The DON and/or designee will audit each medication room on a weekly basis for three months and then monthly to ensure that used fentanyl patches are being destroyed per policy and that there is ample amount of RX Destroyer. The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.	[redacted] *SB/SDDOH/EL

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F 431	Continued From page 16 *Used Fentanyl patches were to be folded and placed in the sharps container on the medication cart. *She was not able to state what to do with the sharps container when it was full, as she had only worked at the facility for several months. Interview on 12/30/15 at 1:35 p.m. with RN B revealed: *Used Fentanyl patches were folded, witnessed, and placed in the sharps container. *A full sharps container would be locked and placed in the medication room until it was picked up. Interview on 12/30/15 at 1:55 p.m. with the DON revealed: *Full sharps containers were placed in the medication room before they were taken to the hazardous waste room. *Nursing staff had keys to the medication rooms. *She acknowledged it was possible that a sharps container could be removed from the medication room before it was taken to the hazardous waste room. *The keys to the hazardous waste room were held by the center station charge nurse. Review of the provider's undated Discarding and Destroying Medications policy revealed it did not address the discarding and destruction of Fentanyl patches.	F 431		[redacted] *SB/DDCH/EL
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		

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F 441	Continued From page 17 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, product information review, and policy review, the	F 441	Resident #1 has been relocated to a private room on the East Hall. He remains on contact precautions. Resident #17 is no longer on contact/droplet precautions. Employees #F and #G have been individually inserviced on the hand washing policy and both employees have demonstrated correct hand washing technique to the infection control nurse on 12-30-15. Employee #E was individually in-serviced along with director of rehabilitation department about the proper disinfecting time of multi-use equipment on 12-30-15 by the infection control nurse. Policy and procedure for cleaning equipment reviewed on 1-20-16. Employee #H was individually in-serviced by the dietary manager on policy/procedure of isolation rooms on 12-30-15. In-service for all dietary staff will be conducted by 1-22-16 on policy/procedure of isolation precautions, and hand hygiene.	2-4-16

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F 441	Continued From page 18 provider failed to: *Properly clean resident use equipment for one of one sampled resident (1) who was on contact precautions (special precautions for residents known or suspected to be infected that can be transmitted to another person by direct contact). *Perform hand hygiene during resident's personal care for one of one observed resident (6) by two of two observed staff (F and G). *Follow isolation precautions for one of one resident (17) who was on droplet precautions (infection that can be transmitted by coughing, sneezing, or talking) by one of one dietary staff (H). *Clean and store nebulizer equipment between use for one of one randomly observed resident (21). Findings include: 1. Observation on 12/28/15 at 2:45 p.m. outside of resident 1's room with occupational therapist (OT) E revealed: *She stood between the doorway of the resident's room and the hallway. *She took a container marked Sani wipes from the top of a container in the hallway. *She wiped off seven hand cones (used for therapy) with seven wet wipes, and then stacked the cones on top of the pull out stand container. Review of product information and interview on 12/29/15 at 10:15 a.m. with OT E regarding the above revealed: *The label on the back of the Super Sani-Cloth Germicidal Disposable wipes revealed "To disinfect and deodorize: To disinfect nonfood contact surfaces only. Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two [2] minutes. Let air dry."	F 441	Employee #C was individually in-serviced on proper way to clean and store nebulizer equipment by DON on 1-20-16. Policy/procedure revised on 1-6-16 and all nurses and med-techs in-serviced by 1-20-16 on policy/procedure of nebulizer cleaning and storing by DON and/or designee. Employees #F and #G have been individually inserviced on the hand washing policy and have demonstrated correct hand washing technique to the infection control nurse on 12-30-15. Employee #E was individually in-serviced along with director of rehabilitation department about the proper disinfecting time of multi-use equipment on 12-30-15 by infection control nurse. Policy and procedure for cleaning equipment reviewed on 1-20-16. Employee #H was individually in-serviced by the dietary manager on policy/procedure of isolation rooms on 12-30-15. In-service for all dietary staff to be conducted by 1-22-16 on policy/procedure of isolation precautions, and hand hygiene by infection control nurse.	*SB/SDDOH/EC [redacted]

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F 441	Continued From page 19 *She confirmed she had: -Wiped the hand cones with the Sani-Cloths and let it air dry. *Always cleaned equipment that way. *Not been aware the surface of the equipment was to remain wet for two minutes. Interview on 12/29/15 at 10:40 a.m. with the director of rehabilitation department revealed: *Sani-Cloths were used to clean equipment between each resident use. *They wiped the equipment off and let it air dry. *Had been unaware of the two minute contact time. *Had been instructed to clean the equipment that way. *Was not aware if they had a policy for cleaning the equipment. Interview on 12/29/15 at 10:50 a.m. with the director of nursing (DON) revealed: *Resident 1 was on contact precautions. *Her expectations would be for the staff to clean equipment per manufacturers' instructions. Interview on 12/30/15 at 9:10 a.m. with the infection control nurse and the DON revealed: *The infection control nurse agreed the equipment had been cleaned incorrectly. *The policy was written "off of the product" for cleaning equipment. Review of the provider's revised 7/8/15 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed "Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions."	F 441	Employee #C individually in-serviced on proper way to clean and store nebulizer equipment by 1-20-16 by DON and/or designee. Policy/procedure revised on 1-7-16 and all nurses and med-techs in-serviced by 1-20-16 on policy/procedure of nebulizer cleaning and storing by DON and/or designee. DON and/or designee will audit nebulizer cleaning and storage on a weekly basis for Resident #21 and 5 random residents on nebulizers weekly times 3 months and then monthly times 1 year. The DON will bring audits monthly to QAPI for 1 year and then as deemed necessary by the QAPI committee. Dietary manager will audit dietary staff passing room trays weekly times 3 months then monthly times 1 year. The dietary manager will bring audits monthly to QAPI for 1 year and then as deemed necessary by the QAPI committee.	

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F 441	Continued From page 20 2. Observation on 12/28/15 at 1:56 p.m. in resident 6's room with OT F and certified nursing assistant (CNA) G revealed: *OT F had pushed resident 6 into his room. *CNA G had then entered the room. *Without performing hand hygiene they both put on a pair of gloves. *They assisted the resident to a standing position. *OT F: -Removed the soiled brief and discarded it into the trash can. -Then handed a wet wipe to CNA G. *CNA G wiped the resident's perineal area and coccyx area, discarded the soiled wipe, removed her gloves, and put on a new pair of gloves. *With the same gloved hands OT F: -Removed her name badge and placed it on the sink. -Put the arm rest back on the wheel chair. -Put a gait belt on the resident. -Scratched the side of her face. -Pulled up the resident's pants. -Had the resident wash his hands. -Put her name badge back on her shirt. -Removed her gloves and put on a new pair of gloves. Interview on 12/29/15 at 10:50 a.m. with the DON revealed her expectations would be for staff to wash their hands after changing a soiled brief and assisting with personal care. Interview on 12/30/15 at 9:10 a.m. with the DON and infection control nurse revealed they both agreed hand hygiene should have been performed after removing a soiled brief and assisting with personal care. 3. Observation on 12/29/15 at 9:15 a.m. on the	F 441	DON and/or designee will audit therapy weekly times 3 months then monthly times 1 year for proper disinfecting of equipment between residents. The DON and/or designee will bring audits monthly to QAPI for 1 year and then as deemed necessary by the QAPI committee. The DON, dietary manager and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report all above audit findings at the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.	[redacted]

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F 441	Continued From page 21 Warren Wing revealed dietary aide (DA) H pushed a cart containing five resident meal trays. During the above time DA H: *Without performing hand hygiene or applying a face mask picked up a meal tray and entered resident 17's room. She then placed the meal tray down onto the overbed table and left the room. *Without performing hand hygiene continued to deliver meal trays to other residents'. Review of resident 17's medical record revealed he was on droplet precautions (infection transmitted by droplets that can be generated by the individual coughing, sneezing or talking). Interview on 12/29/15 at 10:50 a.m. with the DON regarding the above revealed: *Her expectations would have been for the dietary aide: -To wear a face mask when entering a resident's room on droplet precautions. -To perform hand hygiene after leaving the room. *All staff should wash their hands or perform hand hygiene before entering another resident's room and after leaving a resident's room. Review of the provider's undated Handwashing/Hand Hygiene policy revealed: *"Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: -Before and after direct resident contact. -Before and after entering isolation precaution settings. -Before and after eating or handling food. -Before and after assisting a resident with toileting (hand washing with soap and water). -After removing gloves."	F 441		[redacted] *SB/DDOH/EL

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F 441	Continued From page 22 Surveyor: 35625 4. Observation on 12/28/15 at 4:45 p.m. of registered nurse (RN) C following a nebulizer treatment (medication delivered as a mist into lungs) for randomly observed resident 21 revealed she: *Removed the mask from his face and took apart the mask and cup. *Rinsed the pieces and placed them on a clean paper towel on each side of the faucet handles in the resident's bathroom. Interview on 12/28/15 at 6:15 p.m. with RN C regarding resident 21's nebulizer equipment revealed: *It was her usual practice to take apart the nebulizer parts, wash, and place them on a clean paper towel. *The location of the cleaned nebulizer parts varied in each room and was dependent on available space. 5. Observation on 12/29/15 at 7:55 a.m. of RN B following a nebulizer treatment for resident 21 revealed: *She took off the nebulizer mask from the resident and placed it next to the nebulizer machine. *The mask and cup were not taken apart or cleaned following the medication delivery. Interview on 12/29/15 at 8:20 a.m. with RN B regarding nebulizer cleaning revealed she: *Would usually take apart the nebulizer pieces and wash them. *Offered no explanation for not completing it during the observation.	F 441	[redacted] *SB6DDOH1EL	

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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
F 441	Continued From page 23 6. Interview on 12/30/15 at 10:45 a.m. with the director of nursing (DON) regarding the cleaning of the nebulizer revealed: *Education was provided to all nursing staff in the fall of 2015 regarding nebulizer cleaning and care. *It was her expectation the nebulizer cup and mask would be taken apart and cleaned after each use. *Acknowledged the placement of the clean nebulizer parts on the back of the sink would be an infection control concern. Review of the provider's 7/8/15 Nebulizer Cleaning and Care Policy and Procedure revealed: *"Nebulizer components (mask, mouthpiece, and tubing) will be taken apart after each use. *The medication pouch will be rinsed out with tap water and placed on a clean paper towel to air dry after each treatment."	F 441		
F 516 SS=D	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use.	F 516	The door leading to the basement is only accessible by key. The Medical Records room in the basement had a lock installed on December 31, 2015 and only 3 keys were made: DON, Administrator, and the Director of Medical Records have access to the medical records. The Medical Record Policy was reviewed and updated on January 22, 2016 by the interdisciplinary team. Only those with the 3 keys will be able to access the Medical Records located in the basement.	2-4-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435039		12/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE HEALTH CARE CENTER	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 516	Continued From page 24 This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to store residents' medical records in a secured location. Findings include: 1. Observation and interview on 12/29/15 at 8:10 a.m. with the environmental services director revealed: *He unlocked a door leading to the basement. *In the basement was an opened, unlocked door with a sign "Medical Records." *Inside the opened, unlocked door were several boxes and file cabinets. The outside of the boxes and file cabinets were dated with different years. *He confirmed: -The old medical records were kept in the basement. -Two other maintenance staff, the medical records director, and himself had a key to unlock the basement doors. -There were two doors leading to the basement. -He had worked at the facility for four years. The old medical records had "always been stored like that." Interview on 12/29/15 at 10:55 a.m. with the director of nursing revealed she agreed: *The medical records were not secured. *The maintenance staff should not have had access to the medical records. Interview on 12/29/15 at 11:00 a.m. with the medical records coordinator revealed: *Current medical records were stored in two locked rooms on the main floor of the facility.	F 516	The Administrator will audit the medical records room in the basement on a monthly basis to ensure it is locked for a period of one year. The Administrator will be responsible for conducting audits and for overall compliance. The Administrator will report audit findings at the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee. [redacted] *SB/DDH/EL	

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SOUTHRIDGE HEALTH CARE CENTER	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 516	Continued From page 25 *Old medical records were kept for ten years and stored in the basement. *Did not know why maintenance would need access to the old medical records. Review of the provider's reviewed April 2011 Medical Record policy revealed: *"Purpose: To outline correct handling of resident's medical record. *Policy: To maintain constant and consistent control of all parts of the resident's medical record. *Procedure: -Residents discharged more than a year ago are kept in the locked medical records storage area in the basement. -Medical records are available to authorized personnel on a "need to know" basis. Authorized personnel include, but are not limited to: Nursing, physicians, consultants, support services, administration, government agenies, resident or his or her representative, others designated by the resident."	F 516		[redacted]

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

ORIGINAL

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435039		12/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE HEALTH CARE CENTER	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(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	K 000		
	Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/29/15. Southridge Health Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 12/29/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.			F
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain a one hour fire resistive path of egress from one of three	K 033		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey Bujnak
TITLE: Administrator
(X6) DATE: 1-20-16

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	435039		**12/29/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHRIDGE HEALTH CARE CENTER	**3600 SOUTH NORTON AVENUE** **SIOUX FALLS, SD 57105**

(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 basements (center wing) to the exterior of the building. The center wing basement stairways discharged into the corridor system on the main level. Findings include: 1. Observation at 10:00 a.m. on 12/29/15 revealed the center basement wing contained two remote exits. One of the exits discharged directly to the exterior with the second discharging into the corridor system. Review of previous survey data confirmed that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column (x5) to indicate correction of the deficiencies identified in K000.	K 033		F

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PRINTED: 01/12/2016
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	10682		12/30/2015

NAME OF PROVIDER OR SUPPLIER

SOUTHRIDGE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3900S NORTON AVENUE
SIOUX FALLS, SD 57105

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S 000	Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/28/15 through 12/30/15. Southridge Health Care Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeffrey Bergh

TITLE: Administrator

(X6) DATE: 1-20-16

STATE FORM 6899 PUH611 If continuation sheet 1 of 1

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