

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/02/2015</b>
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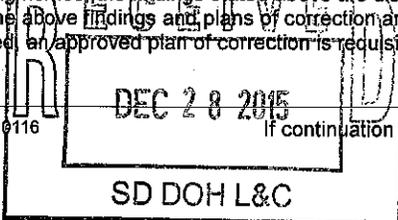
NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</b>
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F 000	INITIAL COMMENTS  Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/30/15 through 12/2/15. South Dakota Human Services Center - Geriatric Program was found not in compliance with the following requirements: F221, F246, F252, F323, F431, and F441.	F 000	* Addendums noted with an asterisk per 1/14/16 per telephone with facility administrator.  JVE/SDDOH/EL	
F 221 SS=E	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: 32335 Based on record review, interview, and policy review, the provider failed to assess three of three sampled residents (1, 3, and 10) for the use of a back closing one-piece outfit. Findings include:  1. Review of resident 3's medical record revealed: *Diagnoses of major neurocognitive disorder (decline in thinking ability) due to Parkinson's disease (progressive disorder affecting movement), post traumatic stress disorder, major depressive disorder, and urinary incontinence (loss of bladder control). *A 10/8/15 physician's order for a one-piece outfit as needed. *His 11/12/15 care plan had an intervention of	F 221	F221: Program Director and Nurse Manager reviewed policy and procedure related to clothing which restricts access to the body. An assessment for the use of clothing which restricts access to the body was created. This form assesses the resident's medical symptoms, potential risks of using restrictive clothing, potential risks of not using clothing, all interventions attempted and their effectiveness prior to use of clothing which restricts access to the body. The assessment also includes a 3 day evaluation of behaviors observed when not using the clothing which restricts access to the body.  In-service training will be provided to all staff regarding the Nursing policy "Clothing Which Restricts Access to the Body" and the Clinical Assessment of Protective Clothing form by 12-31-15.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Jerry Johnson</i>	TITLE  <i>Dir. of Clinical Services</i>	(X6) DATE  <i>12/24/2015</i>
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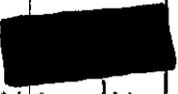
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 221	<p>Continued From page 1</p> <p>"May wear one-piece outfit prn [as needed] due to disrobing and voiding in inappropriate places." *The November personal care record revealed he wore the one-piece outfit twenty-nine out of ninety times. *There was no initial or quarterly assessments for the use of the one-piece outfit.</p> <p>2. Review of resident 10's medical record revealed: *Diagnoses of unspecified neurocognitive disorder and unspecified urinary incontinence. *His 10/20/15 care plan had an intervention of "One piece outfit all shifts. [Resident name] responds better if you call the one-piece outfit a coverall." *The November personal care record revealed he wore the one-piece outfit eighty-nine out of eighty-nine times. *There was no initial or quarterly assessments for the use of the one-piece outfit. Surveyor: 16385</p> <p>3. Review of resident 1's medical record revealed: *A diagnosis of Alzheimer's disease, dementia, and manic depression. *A current signed physician's order dated 11/25/15 for a "One-piece outfit AM and PM for dignity." *Current care plan intervention dated 4/30/15 "May use one-piece outfit for dignity AM and PM shifts. Night shift may put on at 4:30 am." *No initial or quarterly assessments for use of the one-piece outfit for dignity.</p> <p>Interview on 12/2/15 at 1:30 p.m. with registered nurse (RN) J confirmed the night shift staff had dressed resident 1 in the one-piece outfit at 4:30 a.m. during final rounds. Day shift staff had</p>	F 221	<p>F221 continued:</p> <p>The use of clothing which restricts access to the body for residents #1,3, and 10 will be assessed by the unit Charge Nurse using the assessment form noted above and the residents' treatment plan will be updated.</p> <p>Charge Nurses (3) will complete chart audits for all residents who are using clothing that restricts access to the body. These audits will review the completion of the initial and/or quarterly assessments, informed consent, physician's orders, and treatment plan interventions. These audits will be completed monthly for residents using clothing which restricts access and results will be reported to the Nurse Manager. The Nurse Manager will report the findings of these audits to the QAPI committee at the next schedule QAPI meeting and quarterly thereafter until the QAPI committee advises to modify or discontinue.</p>		

  
\*1/21/16  
JVE/SDDO/H/EL

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F 221	Continued From page 2 removed the one-piece outfit on rounds about 6:30 a.m. when he had dressed for the day. The use in the early morning was to maintain his dignity and had kept him from getting bowel movement all over himself and his room.  Surveyor 32335 4. Interview on 12/1/15 at 2:15 p.m. with the director of nursing revealed they had not completed initial or quarterly assessments for the use of the one-piece outfits.  Review of the provider's 6/1/15 Clothing Which Restricts Access to the Body policy revealed: **"Clothing which restricts access to the body may be used if comprehensive individualized assessment determines it is in the patient's best interests and will protect the patient's privacy and dignity." **"A physician or registered nurse (RN) shall conduct a clinical assessment of the patient."	F 221			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, record review, and policy review, the provider failed to ensure	F 246	F246: Resident #10's care plan has been reviewed by the treatment team and updated to ensure proper footwear which accommodates the resident's needs and preferences. All resident treatment plans will be reviewed by the unit Charge Nurse for interventions which ensure the accommodation of the resident's needs/preferences.		

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F 246	<p>Continued From page 3</p> <p>one of one sampled resident (10) had access to proper footwear. Findings include:</p> <p>1. Random observations from 11/30/15 through 12/1/15 regarding resident 10 revealed he was not wearing socks or shoes. In the afternoons he wandered in the hall. The lower half of his legs were red and swollen. His feet were also swollen.</p> <p>Review of resident 10's medical record revealed: *Diagnoses of unspecified neurocognitive disorder (decline in thinking ability), edema (fluid build-up) and unspecified urinary incontinence (loss of bladder control). *He was at high risk for falls. *There was no documentation to reflect his choice of not wearing socks or shoes. *On 10/29/15 the physician's assistant had seen him and tried an oral antibiotic for the weeping in his legs. *On 11/10/15 the physician's assistant had examined his legs. *On 11/20/15 the physician had seen him for the possibility of cellulitis (infection) in his legs and had determined it was not cellulitis.</p> <p>Interview on 11/30/15 at 4:30 p.m. with registered nurse (RN) G regarding resident 10 revealed: *He had worn shoes, but his feet had become so swollen the shoes left imprints on his feet. *His family bought him another pair of shoes, but they were not large enough. *The staff would sometimes put gripper socks on his feet. *She was not sure why he was not wearing them that day. *She thought it had been about a month since his feet had become so swollen his shoes would no longer fit.</p>	F 246	<p>F246 continued:</p> <p>The Geriatric Hourly Patient/Environment Checklist was revised to include a check by each shift for resident dignity including appropriate footwear, clothing, and hygiene. CNA staff will report any issues to the nurse in charge of the unit. All staff will be provided in-service training on resident dignity and respect of the resident's needs and preferences by 12-31-15.</p> <p>Charge Nurses (3) will each complete audits using a random observation form for Homelike Environment/Dignity. These audits will be completed 3 times per week by each Charge Nurse on each unit for one month. After the first month, one audit per unit will be completed weekly by the Charge Nurses. Results of the audits will be reported to the Nurse Manager who will compile the information and report the findings at the next scheduled QAPI Committee Meeting then quarterly thereafter until the QAPI Committee advises to modify or discontinue.</p>	<p>JVE/SD DOW/EL *1/2/16 [REDACTED]</p>	

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F 246	<p>Continued From page 4</p> <p>*He had a history of open areas on his legs, but there was no open area currently.</p> <p>Interview on 12/2/15 at 1:35 p.m. with RNA regarding resident 10 revealed: *His shoes had become too tight for him to wear due to the swelling in his feet. *The doctor had seen him for the swelling. *The social worker (SW) had contacted his family about getting different shoes, but she was unaware of what had happened with that.</p> <p>Interview and record review on 12/2/15 at 1:35 p.m. with SW B regarding resident 10 revealed: *She had documented on 10/13/15 that his shoes had been washed and dried by the staff. -That had made them unwearable. *She had informed the sister that they would purchase a new pair for him, but the sister stated she would take care of it. *There was no other documentation regarding discussions about his swollen feet and needing different shoes.</p> <p>Interview on 12/2/15 at 2:30 p.m. with the director of nursing regarding resident 10 revealed she thought they had gotten him different shoes and that he chose not to wear them. She was unaware they had not followed up on getting him shoes. She agreed wearing no shoes or socks could increase his risk for falls and increase the potential for open areas. They had not looked into getting him special shoes for the swelling, but they could do that.</p> <p>Review of the provider's undated admission packet information revealed the resident's individual needs and preferences should have been accommodated.</p>	F 246			

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F 252 SS=E	<p>483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b></p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation and interview, the provider failed to ensure glassware was provided for meals in three of three residents' units (Spruce One, Spruce Two, and Willow One). Findings include:</p> <p>1. Observations on 11/30/15 at 5:10 p.m. and again on 12/1/15 at 11:30 a.m. in Spruce One revealed thirteen out of fifteen residents had styrofoam cups for their beverages.</p> <p>Interview on 12/1/15 at 2:15 p.m. with the director of nursing (DON) revealed they should not have been using styrofoam cups for meals. They should have been using glassware.</p> <p>Surveyor: 29354 2. Observations on 11/30/15 on Spruce Two during evening meal, 12/1/15 on Willow One and Spruce Two during noon meal, and on 12/2/15 on Spruce Two during breakfast revealed several residents using styrofoam drinking cups.</p> <p>Interview on 12/2/15 at 8:10 a.m. on Spruce Two with certified nursing assistant (CNA) C and recreational specialist D revealed: *They had used styrofoam drinking cups on</p>	F 252	<p>F252: The Program Director and Nurse Manager reviewed and revised the Meal Service policy to include the use of glassware at meals unless specified in the resident's treatment plan. The Geriatric Hourly Patient/Environment Checklist was revised to include a check by each shift for appropriate glassware/dinnerware at each meal and snack. The amount of glassware/dinnerware provided by the food service contractor was increased to accommodate the units' need for meals and snacks.</p> <p>All staff will be provided in-service training on policy revision and changes to environmental checklist as well as re-education on creating a homelike environment. *by 12/31/15. JVE/SDDD/H/L</p> <p>Charge Nurses will complete 3 audits a week per unit for one month using a random observation form to monitor for appropriate glassware/ dinnerware during meals and snacks. After the first month, Charge Nurses will complete one audit per week. Findings of the audits will be reported to the Nurse Manager who will compile the information and report</p>	
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F 252	Continued From page 6 Spruce Two for all three meals. *They had requested the kitchen "send plastic drinking cups" to their unit.  Interview on 12/2/15 at 9:35 a.m. with interim food service director E and registered dietitian (RD) F revealed: *RD F thought the food service director had ordered more drinking cups about a month ago. *The plastic drinking cups had been sent to the three geriatric units, but they had not always returned to the kitchen. *They both agreed the syrofoam drinking cups were not homelike, and the residents should have had regular drinking cups.  A policy had been requested regarding a homelike environment from the DON but they did not have a policy.  Review of the provider's undated Geriatric Program Guidelines revealed "As a part of the National Nursing Home Advancing Excellence campaign, we are striving to provide as much of a home-like environment as possible."	F 252	F252 continued:  the findings at the next scheduled QAPI Committee Meeting then quarterly thereafter until the QAPI committee advises to modify or discontinue.	[REDACTED] *1/21/16 JVE/STW/HSL	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	F 323			

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F 323	Continued From page 7 by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate falls that had resulted in injuries for two of two sampled residents (3 and 6). Findings include:  1. Review of resident 3's medical record revealed: *Diagnoses of major neurocognitive disorder (decline in thinking ability) due to Parkinson's disease (progressive disorder affecting movement), post traumatic stress disorder, major depressive disorder, and urinary incontinence (loss of bladder control). *He was at high risk for falls. *He had an unwitnessed fall on 10/14/15. -He had hit his head and was bleeding. *The registered nurse (RN) on duty had documented the fall in the progress notes. *She had not documented the time of the fall, what had been occurring at the time of the fall, who had been working with him, when he had been assisted to the bathroom last, or if the care plan had been followed. *A certified nursing assistant (CNA) had documented the fall in the progress notes. *She had not documented what had been occurring at the time of the fall, who had been working with him, when he had been assisted to the bathroom last, or if the care plan had been followed. *He had falls after that date on 10/23/15, 11/10/15, and 11/22/15.  Review of resident 3's 10/14/15 occurrence report revealed there had been no other documentation to support an investigation had been conducted	F 323	F323: An Occupational Therapy referral was made and completed for an assessment of Resident s #3 and 6's living environment for potential fall risks. The treatment plans for residents #3 and 6 were updated by the treatment team.  A template for a fall progress note was created and implemented into the electronic medical record to assess, investigate, and document findings of falls for all residents.  All RN staff will be in serviced on investigation and documentation of a resident fall and the template in the EMR *by 12/31/15. <i>JVE/SDDOHCL</i> Charge Nurses will complete audits of all falls occurring on their unit for one month. After one month, Charge Nurses will complete audits on 5 falls on each unit (if less than 5 falls have occurred the total number of falls will be audited).  Findings of the audits will be reported to the Nurse Manager who will compile the information and report the findings at the next scheduled		

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F 323	<p>Continued From page 8 regarding the above fall.</p> <p>2. Review of resident 6's medical record revealed: *Diagnoses of major neurocognitive disorder with behavioral disturbances, Lewy body type dementia, and generalized anxiety disorder. *He was at risk for falls. *He had an unwitnessed fall on 9/22/15. -He hit his head. *The RN on duty had documented the fall in the progress notes. *During the assessments his head, arms, and legs began to jerk and twitch. *She had not documented the time of the fall, what had been occurring at the time of the fall, who had been working with him, when he had been assisted to the bathroom last, or if the care plan had been followed.</p> <p>3. Interview on 12/2/15 at 10:45 a.m. with the director of nursing, RN K, RN L, and the Minimum Data Set (MDS) coordinator regarding the falls for residents 3 and 6 revealed: *They had not thoroughly investigated the above mentioned falls. *Without a thorough investigation they were unable to identify, evaluate, and analyze the hazard and risk; implement interventions to reduce the hazard and risk; monitor for effectiveness and modify the interventions.</p> <p>Review of the provider's 6/1/15 Fall Assessment and Prevention Protocol policy revealed: *With a fall occurrence the RN should have documented the following: -Location of the fall. -Behavior prior to the fall. -Observations related to the fall.</p>	F 323	<p>F323 Continued:</p> <p>QAPI Committee Meeting then quarterly thereafter until the QAPI committee advises to modify or discontinue.</p>	<p>[REDACTED]</p> <p>*1/21/16 JVE/SDD/HIC</p>	

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F 323	Continued From page 9 -Physical assessment of resident's condition. -Interventions/precautions taken to care for the resident and prevent further falls.	F 323	F431: Program Director, Nurse Manager, and Pharmacist reviewed policy and procedure regarding medication disposal.		
F 431 SS=F	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 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.	F 431	A chemical disposal system for medications was acquired for each of the medication rooms. The policies regarding disposal of medications were revised to include a charcoal activated medication disposal system for all residents using Fentanyl patches or wasted narcotic pain medications.  Education for all RN staff on the chemical disposal system and the changes to policy and procedure will be provided by 12-31-15.  Charge Nurses will review MAR of all patients receiving Fentanyl patches and narcotic pain medications to ensure that the nurse disposing of the medication and the nurse observing the disposal have both documented.  Charge Nurses will complete audits for all disposed fentanyl patches and wasted narcotic pain medications to assess proper documentation and signature of two nurses at the time of disposal.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A067</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/02/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</b>		
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F 431	Continued From page 10  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on interview, observation, and policy review, the provider failed to maintain limited access to used Fentanyl (narcotic pain medicine) patch destruction and wasted narcotic pain medication in three of three geriatric (elderly) resident units (Spruce One, Spruce Two, and Willow One). Findings include:  1. Observation and Interview on 12/1/15 at 10:51 a.m. with registered nurse (RN) A in the Spruce One geriatric unit medication room regarding used Fentanyl patch destruction revealed: *The on-campus pharmacy gave the option to either place the patches in a locked box to be returned to pharmacy for destruction, or they could place them in the sharp's box (used to put needles and syringes in). *Those sharp's containers were taken to the admissions department by the unit secretary or the nurse. *Any other narcotic medications that would need to be wasted, for example, if it had been dropped on the floor it would also be placed into the sharps box.  Observation and interview on 12/1/15 at 11:10 a.m. with patient services representative M revealed: *Sharps boxes were brought from the units to the admissions office. *There, they were stored under the counter in an unlocked cupboard labeled "sharps" until they were picked up weekly and taken to the chicken coop (an old chicken coop converted into storage	F 431	F431 continued:  Audits will be completed on all residents with disposed Fentanyl patches and wasted narcotic medications weekly for one month.  After one month, audits will be completed on all Fentanyl patches and wasted narcotic pain medications monthly.*by the charge nurse.  Findings of the audits will be reported*by the charge nurse. to the Nurse Manager who will compile the information and report the findings to the QAPI Committee at the next scheduled QAPI Meeting then quarterly thereafter until the QAPI committee advises to modify or discontinue.	*by the charge nurse JVE/SDDOH/EL  *by the charge nurse. JVE/SDDOH/EL  *1/21/14 JVE/SDDOH/EL	

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F 431	<p>Continued From page 11 on the property). *To the best of her knowledge that building was not locked or secured.</p> <p>Observation and interview on 12/1/15 at 11:15 a.m. with RN N in the Willow One geriatric unit revealed: *They used the black pharmacy tackle box to return medications back to the pharmacy. *When a used Fentanyl patch was discarded they would place it in that box. *That box was supposed to be returned to the pharmacy that same day if a narcotic medication was known to be in it. *One used Fentanyl patch with a placed-on date of 11/25 was found inside. *That medication was to have been removed after seventy-two hours, so it would have been placed there on 11/28/15. It had not been taken to pharmacy according to their policy.</p> <p>Interview on 12/1/15 at 1:30 p.m. with the on-campus pharmacist O revealed she: *Had been aware the pharmacy gave nursing staff both of the above options to dispose of used or wasted medication. *Was unsure where the full sharps containers were stored off the unit. *Was unsure what the nursing protocol was for the storage of used sharps containers.</p> <p>Interview on 12/1/15 at 2:23 p.m. with RN P regarding narcotic drug disposal on Spruce Two geriatric unit revealed: *The nurses on that unit placed the used Fentanyl patches in the black pharmacy box, and wasted medications in the sharps box. *She agreed the medications would not be secured if they were not taken to pharmacy right</p>	F 431			

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F 431	Continued From page 12 away in the pharmacy box or taken to the admission office in the sharps container.  Interview on 12/1/15 at 5:15 p.m. with the director of nursing regarding the above narcotic medication disposal revealed she agreed the Fentanyl patches and other wasted narcotic medication were not secured from unauthorized individuals.  Review of the provider's 6/1/15 Returning Medication policy revealed: *Controlled (narcotic) medication might have been disposed of in the sharps box but must have been witnessed by another nurse. *Fentanyl patches were to be placed in the pharmacy box and locked, and returned to pharmacy.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (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	F 441		

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F 441	<p>Continued From page 13</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to use appropriate infection control technique during one of two bathroom observations while toileting one of two residents (16) on contact isolation (specific precautions used when providing care). Findings include:</p> <p>1. Observation and interview on 11/30/15 during initial tour at the nurses station with registered nurse P confirmed resident 16 was known to have a bacterial infection called ESBL( a bacteria resistant to most antibiotics ) found in his urine. That information had been posted in the nursing station on a whiteboard.</p>	F 441	<p>F441:</p> <p>Nurse Manager, Program Director, and Infection Control RN reviewed and revised protocol for Donning, Doffing, and Handwashing to include creating and maintaining a clean field during personal cares for all residents.</p> <p>In-service training for all staff on the appropriate infection control technique for caring/ toileting a resident using transmission- based precautions, policy, and procedures will be provided by 12-31-15.</p>	

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F 441	<p>Continued From page 14</p> <p>Observation on 11/30/15 at 3:10 p.m. of certified nursing assistants (CNA) H and I toileting resident 16 revealed:</p> <p>*Both CNAs had gowned and gloved after sanitizing their hands and proceeded to change resident 16's disposable brief that had become soiled with urine and bowel movement.</p> <p>*CNA I assisted the resident to a standing position from his wheelchair.</p> <p>*CNA H placed a disposable pad on the bed beside the resident, removed his soiled brief, and placed it on that pad.</p> <p>*She got a package of disposable wipes from the cupboard and cleaned his bottom with them.</p> <p>*Her gloves were soiled with bowel movement and urine.</p> <p>*She repeatedly reached into the wipes package and touched the outside of the package each time.</p> <p>*After cleaning the resident she:</p> <ul style="list-style-type: none"> <li>-Removed her gloves and she:</li> <li>-Reached underneath her protective gown and got the hand sanitizer from her pocket.</li> <li>-Used the hand sanitizer and touched her gown with her hands and placed it back into her pocket.</li> <li>-Put on clean gloves and pulled the resident's pants back up.</li> </ul> <p>*With her bare hands she removed her soiled gloves and gown and she:</p> <ul style="list-style-type: none"> <li>-Washed her hands in the sink, walked to the bed, picking up the soiled brief and pad with her bare hands and placed it in the garbage.</li> </ul> <p>*She turned the soiled disposable wipe container to the cupboard.</p> <p>*She reached into her uniform pocket, retrieved her hand sanitizer, used it on her hands and placed it back into her pocket and left the room.</p> <p>Interview with CNA H immediately after the above</p>	F 441	<p>F441 continued:</p> <p>Charge Nurses will complete 3 audits a week per unit for one month using a random observation form to monitor staffs' use of appropriate infection control precaution techniques for care/toileting of residents with and without transmission based precautions. After the first month, Charge Nurses will complete one audit per unit weekly. Findings of the audits will be reported to the Nurse Manager who will compile the information and report the findings at the next scheduled QAPI Committee Meeting then quarterly thereafter until the QAPI committee advises to modify or discontinue.</p>	<p></p> <p>*12/1/16</p> <p>JVE/SDCH/EL</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</b>		
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F 441	<p>Continued From page 15</p> <p>observation revealed she agreed she should not have:</p> <ul style="list-style-type: none"> <li>*Reached into her pocket for her hand sanitizer while wearing a protective gown.</li> <li>*Removed her gown before disposing of the soiled brief.</li> <li>*Touched the soiled brief with her bare hands.</li> <li>*Touched the disposable wipes with her soiled gloves and later her bare hands.</li> </ul> <p>Interview on 12/2/15 at 1:30 with the director of nursing revealed she agreed appropriate infection control technique had not been maintained by CNA H.</p> <p>Review of the provider's 10/26/15 Transmission-Based Precautions policy revealed: *"Change gloves after having contact with infective material..." *"After glove removal and handwashing, ensure hands do not touch potentially contaminated environmental surfaces or item's in the patient's [resident] room..."</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</b>	
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/2/15. South Dakota Human Services Center - Geriatric Program (Building 01, Spruce I and II) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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

TITLE

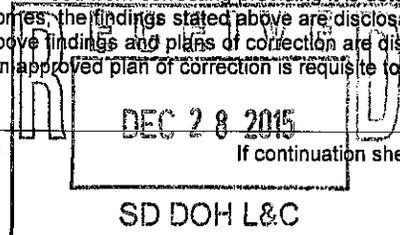
(X6) DATE

*[Signature]*

*Dir of Clinical Services*

*12/24/2015*

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 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/2/15. South Dakota Human Services Center - Geriatric Program (Building 02, Willow I) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

TITLE

(X6) DATE

*[Signature]*

*Dir. of Clinical Services*

*12/24/2015*

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10719SD</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/02/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC F</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</b>
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S 000	Compliance/Noncompliance Statement  Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 11/30/15 through 12/2/15. South Dakota Human Services Center - Geriatric Program was found not in compliance with the following requirement: S296.	S 000	*Addendums noted with an asterisk per 1/14/16 per telephone with facility administrator.  JVE / SPDOH/EL	
S 296	44:73:07:11 Director of Dietetic Services  A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits.	S 296		

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

*[Signature]*

STATE FORM

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CC4711

Dir. of Physical Services

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SD DOH L&C

(X6) DATE 12/24/2015

If continuation sheet 1 of 3

South Dakota Department of Health

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S 296	<p>Continued From page 1</p> <p>Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29354 Based on interview, record review, and policy review, the provider failed to ensure the director of food services had: *Enrolled in an approved dietary manager's course within ninety days of being hired. *Completed the course within eighteen months of being hired. Findings include:</p> <p>1. Interview and personnel record review on 12/2/15 at 9:30 a.m. with interim food services director E regarding the director of food services revealed: *The dietary department was a contracted company. *She had been employed with the company and had been filling in for a few weeks while the food services director was on vacation. *She had been the interim food services director while he had been gone. *She confirmed the food services director had not been a certified dietary manager. *She confirmed the food service director had been hired on 11/11/13. *The food services director had been in that position since that date.</p> <p>Interview and personnel record review on 12/2/15 at 11:30 a.m. with interim food services director E confirmed: *She had spoken with the director of dietary services on the telephone and he stated he had</p>	S 296	<p>S296: The food service contractor reports their Dietetic Technician has completed the coursework and received the certification of a Certified Dietary Manager. This is a full time member of the management team that monitors the dietary and nutritional needs for all residents.</p> <p>The Food Service Director remains enrolled in a dietary manager's course. His expected completion date is June 2016.</p> <p>The Food Service Director will report progress on the course work in the dietary manager's coursework monthly to the Program Director. The Program Director will report the progress to the QAPI Committee at the next scheduled QAPI Meeting then quarterly thereafter until the QAPI committee advises to modify or discontinue.</p>	<p><i>*1/21/16</i> <i>JVE/SDR/TEC</i></p>
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10719SD</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/02/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SD HUMAN SERVICES CENTER - GERIATRIC F</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3515 BROADWAY AVE POST OFFICE BOX 7600 YANKTON, SD 57078</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 296	<p>Continued From page 2</p> <p>been enrolled in a dietary manager's course. He had not started any of the course work yet. *Review of the notification of payment revealed the director of dietary services had enrolled in the dietary manager's course on 3/16/15. *The food services director had not enrolled in the dietary manager's course until 3/16/15. *Her expectations would have been for the food services director to have completed the dietary manager's course within eighteen months of having been hired.</p> <p>Review of the provider's undated contracted Food Services Supervision policy revealed "The Food Service Director meets all state specific qualifications for Food Services Director, including education level and training."</p>	S 296		