

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

**ORIGINAL**

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/17/2015
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
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F 000	INITIAL COMMENTS  Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/8/15 through 6/11/15 and 6/16/15 through 6/17/15. Southridge Health Care Center was found not in compliance with the following requirement(s): F151, F159, F166, F176, F223, F224, F226, F241, F248, F252, F253, F278, F280, F281, F309, F311, F314, F323, F325, F353, F366, F367, F368, F371, F441, F490, F493, F514, and F520.	F 000	Addendums noted with an asterisk per 7/13/15 telephone to facility administrator and DON. sc15000HJJ	
F 151 SS=F	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488  Surveyor: 32333  Surveyor: 14477  Surveyor: 33265 A. Based on observation, interview, record review, and policy review, the provider failed to consistently identify residents' choice for code status (CPR [cardiopulmonary resuscitation]) for 3 of 16 sampled residents (10, 16, and 22).	F 151	The Code Status was identified and documented in the chart for residents #10 and #22. Resident #16 was discharged on 6-24-15. All residents were audited for their Code Status by the Social Services Department by July 8, 2015 and any conflicting issues were resolved immediately by Social Services. The facility policy and procedure on Code Status (CPR) was revised on 7-09-15. The DON educated all facility staff on the new Code Status policy and procedure on between July 14-15, 2015. The blue band system has been discontinued.	7-16-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jeffrey Mynatt* TITLE Administrator (X6) DATE 7-10-15

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

**RECEIVED**  
JUL 13 2015  
If continuation sheet Page 1 of 158  
SD DOH L&C

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F 151	<p>Continued From page 1</p> <p>Findings include:</p> <p>1. Observation on 6/9/15 at 9:30 a.m. in resident 10's room revealed the resident was not wearing a blue armband on his wrist.</p> <p>Interview on 6/9/15 at 11:20 a.m. with licensed practical nurse (LPN) KK revealed a resident who was a full code (initiate CPR) should have been wearing a blue armband on their wrist.</p> <p>Interview on 6/9/15 at 11:23 a.m. with certified nursing assistant/ medication technician U revealed the way to find the resident's code choice was to look at the page in the medication administration record (MAR) notebook by their photograph, or in the medical record.</p> <p>Review of the resident 10's complete medical record revealed:</p> <p>*There was a "No Code" (CPR) sticker next to his picture on the page in the MAR notebook.</p> <p>*There was no information about code status on the MAR.</p> <p>*There was a physician's order signed on 5/22/15 for the resident to have been a full code.</p> <p>*The 2/23/15 care plan for resident 10 regarding the code status dated 2/23/15 originally had "Do Not Resuscitate" (DNR) identified. That was crossed off and "Full Code" written in without a date or identification of who made the change.</p> <p>2. Observation on 6/16/15 at 8:50 a.m. in East dining room revealed resident 22 did not have a blue armband on either wrist.</p> <p>Review of resident 22's complete medical record revealed:</p> <p>*The admitting orders dated 5/22/15 had not</p>	F 151	<p>The Social Services department audited all current residents to ensure the following match per resident: proper code status, advanced directives, physician order and care plan, Pocket Care Plan. The blue band system is discontinued. Residents with a FULL CODE status will be identified as a red sticker on the outside of their chart spine and a red sheet of card stock on inside of resident chart labeled FULL CODE. All staff will be in-serviced regarding the procedure between July 14-15, 2015. Social Services will audit residents #10, #22 each week for one month and then monthly for 3 months on residents #10, #22 along with 10 random resident charts audits to ensure proper code status is identified. 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. The facility meal/menu policy &amp; procedure was reviewed on July 6, 2015. All facility staff was educated on this new policy/ procedure by the Administrator and DON between July 13-15, 2015.</p>	7-16-15

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F 151	<p>Continued From page 2</p> <p>included any order for code status.</p> <p>*The physician summary sheets for medication and treatment orders for May 2015 and June 2015 both listed the resident as a full code. Neither form was signed by a physician.</p> <p>*The Chart Order form in the front of the medical record has a "No Code" sticker attached to it.</p> <p>*The Pocket care plan sheet for East wing dated 6/15/15 identified her as a "DNR" (do not resuscitate). This sheet was utilized by certified nursing assistants as a quick reference.</p> <p>3. Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator revealed:</p> <p>*The DON stated they would treat residents as a full code until a code status was ordered.</p> <p>*The DON stated she believed the code status should be identified and signed by the physician within the first day after admission.</p> <p>*The administrator requested an audit of code status for all residents be completed that evening.</p> <p>Surveyor 14477</p> <p>4. Random observation on 6/10/15 in the afternoon of resident 16 revealed she had no blue wrist band on either wrist.</p> <p>Review of resident 16's medical record revealed full code status was documented and a full code sticker was on the inside cover of the medical record. Review of the medication administration record (MAR) revealed a no code status sticker on resident's 16's MAR. Interview with registered nurse (RN) D indicated the sticker must have been left over from another resident and she removed it.</p> <p>Interview at the above time with resident 16 and</p>	F 151	<p>A new 16 tray insulated dietary cart was purchased on July 6, 2015 to transport food to Memory Care community.</p> <p>An insulated pan carrier was purchased to transfer food to East Hall and Warren Rehabilitation Hall. The tentative delivery date of both items is 1-2 weeks from the date of purchase.</p> <p>All residents in the facility were interviewed by the Dietary Manager on food preferences. Food preferences will be kept in a binder in the CDM office and on their diet card.</p> <p>Family members were interviewed by the Dietary Manager for residents that are not interviewable to obtain food preferences by July 10, 2015.</p> <p>The Kitchen will ensure that enough food of the posted main entrée and the alternative food list is available for each meal in order to maintain resident choice. Memory Care unit residents and/or their families will be asked to determine food likes or dislikes by July 10, 2015. Alternative menu items will be available if the resident desires a change in the menu item. Dietary cards with resident names will be on the trays and include likes and dislikes.</p>	7-16-15	

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F 151	<p>Continued From page 3</p> <p>RN D in attendance revealed her desire to be a full code status. She stated she did want to wear the blue wrist band to indicate that status. RN D then applied the blue band to resident 16's left wrist.</p> <p>5. Interview on 6/17/15 in the morning with the DON and administrator revealed they confirmed the blue band system to identify full code status was flawed. They agreed some residents wanted to be full code and didn't have the blue wrist band applied in a consistent manner.</p> <p>Surveyor: 33265</p> <p>6. Review of the provider's 10/28/13 Advanced Directives (code status and other resident choices) policy revealed: *Information concerning resident wishes concerning advanced directives would be displayed in plain view in the medical record. *There was no information that a resident wearing a blue armband was to have been considered as a full code.</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to ask residents' preference for meal choice in three of four dining rooms (Memory Lane, Center Wing, and East Wing). Findings include:</p> <p>1. Observation on 6/9/15 at the noon meal in the East Wing dining room revealed: *Those residents' needing assistance with eating were not offered a choice for the meal service. *Dietary Aide F was dishing up food and directing who the plate went to at the assisted tables.</p> <p>Surveyor: 33488 Observation on 6/9/15 during the noon meal</p>	F 151	<p>20 random audits facility wide will be conducted weekly for 1 month and then monthly for 3 months to ensure residents are being offered appropriate meal choices. These audits will be conducted by the Dietary Manager and/or designee who is responsible for overall compliance. The Dietary Manager and/or designee will report the audit findings to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15

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F 151	<p>Continued From page 4 service revealed: *The east dining room dietary aide F ran out of au gratin potatoes to serve. *Cook J entered the East dining room and told dietary aide F "No more au gratin potatoes. Give them mashed."</p> <p>Surveyor: 32333 Observation and interview on 6/9/15 at 11:52 a.m. during the noon meal service in the Center dining room with resident 45 revealed: *Some days they would bring dessert and some days they would not. *The dessert on the menu that day for the noon meal was lime parfait squares. *The dessert served that day was apple sauce. *Some tables were served the apple sauce and some were not.</p> <p>Surveyor: 32335 Observation on 6/9/15 at 11:50 a.m. in the Memory Lane unit revealed: *Food had been brought to the unit in a silver portable enclosed rack on wheels. *The rack had not been insulated. *There were twelve trays in the rack. *There were no diet cards or names on the trays. *Staff passed the trays without asking residents what they wanted. *Certified nursing assistant (CNA) L left the unit to go the Warren dining room to obtain another breaded pork for a resident that required finger foods. -She could not eat the liver and onions. *The dietary manager (DM) and registered dietician (RD) had not been present during any part of the meal observation.</p> <p>Interview on 6/9/15 at 12:00 p.m. with CNA MM</p>	F 151		7-16-15
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F 151	<p>Continued From page 6</p> <p>*The cook would prepare half of the scheduled meal and half of the alternate meal in the kitchen and would send them daily to the Warren and Memory Care units.</p> <p>*She dished up a cold bright green pureed substance.</p> <p>Observation and interview on 6/9/15 at 6:00 p.m. with the DM regarding the bright green pureed food revealed:</p> <p>*That was pureed green bean salad.</p> <p>*It had not been the three bean salad that was on the menu and served to the other residents. It consisted of only green beans.</p> <p>Surveyor: 32335</p> <p>Observation on 6/9/15 at 5:50 p.m. of the meal service in Memory Lane revealed:</p> <p>*There were six trays of hamburger and fries and six trays of soup with a cheese sandwich.</p> <p>*There had been no 3-bean salad as written on the menu to go with the soup and sandwich.</p> <p>*There were no names or diet cards on the trays to know which resident was to get which tray.</p> <p>*Staff passed the trays without asking the residents what they wanted.</p> <p>*Staff had passed the six trays that had the hamburger and fries before realizing the resident with the diet order of finger foods had not received that entree.</p> <p>*Staff cut up the cheese sandwich for her and stated they would have to go find something else as the soup was in a bowl.</p> <p>*The DM and RD had not been present during any part of the meal observation.</p> <p>Review of the dining room audits completed by the RD revealed:</p> <p>*No alternative options had been offered to the</p>	F 151		7-16-15

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F 151	<p>Continued From page 7</p> <p>residents on:</p> <ul style="list-style-type: none"> <li>-10/16/14 in the Center, Memory lane, and Warren dining rooms.</li> <li>-10/21/14 in the Memory Lane dining room.</li> <li>*On 10/31/14 the audit form had changed to include "choices are offered for the meal."</li> <li>*On 11/4/14 choices were not offered in the Warren dining room. For Memory Lane she had checked no and wrote "didn't observe this, staff don't give choice."</li> <li>*On 11/10/14 choices were not offered in the Warren and Memory Lane dining rooms.</li> <li>*On 11/17/14 choices were not offered in the East dining room.</li> <li>*On 11/18/14 choices were not offered in the Center dining room.</li> <li>*On 11/24/14 choices were not offered in the East dining room.</li> <li>*On 11/25/14 choices were not offered in the Memory Lane dining room.</li> <li>*On 12/1/14 choices were not offered in the Memory Lane dining room.</li> <li>*On 12/3/14 choices were not offered in the Warren dining room. She had written "another complaint of residents."</li> <li>*On 12/8/14 choices were not offered in the Memory Lane dining room.</li> <li>*There were no other audits to review past 12/10/14.</li> <li>*There had been no corrective action documented on any of the above audits.</li> </ul> <p>Review of the dietary cards for Warren and Memory Lane revealed there were no resident preferences listed.</p> <p>Interview on 6/10/15 at 9:35 a.m. with the DM and RD revealed:</p> <ul style="list-style-type: none"> <li>*They had not prepared enough of one entree for</li> </ul>	F 151		7-16-15	

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F 151	<p>Continued From page 8</p> <p>all residents to have if that was what they had wanted.</p> <p>*They were comfortable with six trays of each entree being delivered to Memory Lane.</p> <p>*If residents wanted something else staff were to have called the kitchen and requested the item.</p> <p>*They were unaware choices were not being offered to the residents.</p> <p>*Not all of the residents in Memory Lane or the other dining rooms could make a choice but some could and those residents should have had the opportunity to choose.</p> <p>Review of the provider's undated Open Style Dining policy revealed dietary staff were to have offered food and beverage choices to the individual at the point of service.</p>	F 151		
F 159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p>	F 159	<p>This deficient practice could affect all residents. Resident #10 will have another Automatic Payment Authorization Form filled out with the resident and Duly Authorized representative completed if both individuals agree. The facility will reimburse the overdraft charges. The Accounts Receivable employee will audit all current resident financial folders to ensure a current Automatic Payment . Authorization Form is present by July 14, 2015.</p>	7-16-15

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F 159	<p>Continued From page 9</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331</p> <p>Surveyor: 33265 Based on interview, and record review, the provider failed to track the management of resident's funds for one of three sampled residents (10). Findings include:</p> <p>Surveyor 32331 1. Interview and observation on 6/10/15 at 3:45</p>	F 159	<p>The facility reported the missing items to the Dept of Health and the Sioux Falls Police Department on 6-16-15. The cell phone was found, is in operable condition and given to the family. Social worker and maintenance searched the room of resident #10 and located the hearing aide, 2 checkbooks and a signature stamper. All items were turned over to the family. Family advised that there was only 1 hearing aide (left ear) so that was given to the charge nurse to place in the locked medication room for Resident #10 to use. The family reported that the debit card was canceled months ago.</p> <p>The Social Services department will ask every resident or resident representative by July 14, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident is missing any stolen property. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria are met.</p> <p>The CFO and or designee provided an in-service on July 13, 2015 regarding the Trust Fund Policy with the Administrator, Accounts Receivable, Accounts Payable and the receptionists present.</p>	7-16-15	

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F 159	Continued From page 10 p.m. with the accounts receivable employee in the finance office regarding resident 10's resident trust account revealed: *He had opened a resident trust account on 5/1/15 with a balance of \$175.00. *He had used the account once since the above time on 5/4/15 for barber services with a withdrawal of \$15.00. *His current resident trust fund balance on 6/10/15 was \$160.00. *She showed this surveyor one legal-sized envelope that had been stored in the business office Sentry safe compartment that contained the following: -One signed check blank by resident 10. *On the outside of that same above envelope there were handwritten notes with the following: -The amount of \$184.00 had been underlined and scribbled out, and the amount of \$175.00 was written next to it. -"2 [two] check blanks." - An asterisk (*) with "took 1 chx (check) blank on 4/3/15" and initials of the accounts receivable employee. -Resident 10's name. -Two more sets of initials. *She stated he had used one of the check blanks for a purchase on 4/3/15. *She stated when the envelope had been given to her to put in the business office's safe it had contained: -Two blank checks. -A total of \$175.00 in cash. *She stated there had not been a debit card in the above envelope when it had been given to her to put in the safe. *That above \$175.00 in cash had been placed in a resident trust account on 5/1/15.	F 159	The facility Trust Fund Policy meets the requirements of F159. The CFO and/or designee will audit 10 random Resident Trust accounts on a monthly basis to ensure that the Trust Fund Policy is being followed. Noticed deviations from the Trust Fund Policy will result in properly correcting the issue and educating the staff member that did not follow the Trust Fund Policy. The CFO and/or designee will report the audit findings to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.	7-16-15	

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

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F 159	<p>Continued From page 11 Surveyor 33265 2. Review of resident 10's complete medical record and financial documentation revealed: *The Inventory of Personal Effects included the following; -One wallet with \$184.00, two blank checks, and a debit card. *One sheet of paper in the medical record had the following written on it: "when [name] discharges - he has money in the finance office." It was signed by social services designee (SSD) T, but there was no date. *Automatic Payment Authorization Form had the following: -The information for one bank account was filled in, then crossed off, and a second bank account information at another bank was filled in. There was no date when the change was made or initials of who made the change. There were no initials or signature by the resident giving permission for that change. -Date for each months invoice with a starting date of 4/5/15. -The only information in the resident section was the resident's signature and 3/30/15 date. -No information the other section for Duly Authorized Representative. It did not state on the form that this was a shared account with the son. -No signature or date in the provider's section at the bottom. *Authorization for provider's trust fund was signed by the resident and dated 4/29/15.</p> <p>Interview on 6/16/15 at 10:55 a.m. with the son of resident 10 revealed: *He believed his father was transferred from the previous facility with the following belongings: -Wallet. -Watch.</p>	F 159		7-16-15

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F 159	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>-Two blank checks.</li> <li>-One cell phone.</li> <li>-One shirt.</li> <li>-One pair of pajamas.</li> </ul> <p>*His father had been moved to this facility while he had been on a two week vacation. Upon his return he brought his father the following items:</p> <ul style="list-style-type: none"> <li>-Two check books from different facilities.</li> <li>-Signature stamper for his use.</li> </ul> <p>Further interview on 6/16/15 at 1:15 p.m. with the son revealed:</p> <ul style="list-style-type: none"> <li>*The next time he had visited his father, he could not find the check books or the stamper.</li> <li>*At that time nothing was missing from either of the accounts.</li> <li>*The provider had used a joint bank account (father and son) to withdraw money from, and the account was overdrawn. He stated that was on 4/7/15.</li> <li>*The provider called him and explained what happened and asked for the routing number for the other bank account.</li> <li>*He stated he had to pay overdraft charges and was not reimbursed by the provider.</li> <li>*He said there could have been a debit card, but he was not sure which financial institution it would have been from.</li> <li>*He had no idea if the provider reported missing items to the State Department of Health.</li> </ul> <p>Interview and record review on 6/16/15 at 2:15 p.m. with social worker designees (SSD) S and T concerning missing items revealed:</p> <ul style="list-style-type: none"> <li>*SSD S had only recently become resident 10's SSD.</li> <li>*SSD S had two cell phones that had been washed in the laundry sitting on his desk. He had no idea who they belonged to.</li> </ul>	F 159		7-16-15	

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F 159	Continued From page 13 *Neither one had known of resident 10's missing items. *SSD T remembered after reviewing records that she had left eight or nine dollars in resident 10's wallet and then put the rest in the safe. She was not sure about the debit card. *Both SSDs agreed when personal property was missing the routine was: -They would write a grievance. -If money was involved the police would have been notified and the State Department of Health would have been notified. -If a cell phone was missing a grievance would have been written and the administrator would have been notified. *There were no grievances written for any missing items for resident 10.  Interview on 6/16/15 at 2:20 p.m. with the accounts receivable employee regarding resident 10's account revealed: *She remembered cash and two blank checks when he was admitted in February 2015. *The cash was left in the safe until 5/1/15 when it was transferred into the resident trust fund. *One check had been used. The one remaining blank check was still in the safe.	F 159		7-16-15	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.  This REQUIREMENT is not met as evidenced by:	F 166	This deficient practice could affect all residents. The Department of Medical Records informs residents and family for regularly scheduled appointments by mail. Charge nurses will notify residents and/or family about upcoming appointments by each Friday for the following week.		

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F 166	<p>Continued From page 14 Surveyor: 33265</p> <p>Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one randomly observed resident (44) and a random group of fifteen residents had been notified of doctors' appointments in a timely manner. Findings include:</p> <p>Surveyor: 33265 1. Observation on 6/9/15 at 12:09 p.m. in the East wing dining room revealed: *Licensed practical nurse (LPN) KK told resident 44 she needed to go to see the physician right away. *The resident stated she knew nothing about having a doctor's appointment. *She had not received her meal. *Her meal was quickly brought to her, and she was told to hurry and eat. *She finished most of her meal and was wheeled out before dessert was served.</p> <p>Surveyor: 32333 2. Group interview on 6/9/15 at 3:15 p.m. with fifteen residents in attendance revealed it was the group consensus: *They were not being notified of doctor's appointments in a timely manner. *A staff member would notify them of a doctor's appointment minutes before they were scheduled. *They had brought that to the provider's attention several times in the past. *That grievance was not being followed-up on nor resolved.</p>	F 166	<p>The charge nurse will enter an IPN (Interdisciplinary Progress Note) note in the EMR about the notification of the upcoming medical appointment. The Social Services department will ask every resident or resident representative by July 13, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident is receiving enough notice for their medical appointments. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria are met. All staff will be inserviced between July 13-15, 2015 about the medical appointment process. The charge nurses will review the transportation log daily to review if there are medical appointments for the day and remind the resident of the appointment 1/2 sheet of paper. All grievances mentioned in the Resident Council will be entered in a Resident Grievance Complaint Log by the Activities Director and the Grievance given to the appropriate department in accordance with the Grievance Policy and Procedure. The Clinical Coordinators will choose 5 random residents that had medical appointments for the calendar month.</p>	7-16-15	

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F 166	Continued From page 15 Review of the resident council meeting minutes from January 2015 through June 2015 revealed: *1/5/15 New business "Some residents expressed concern in not receiving appointment reminder sheets. *2/2/15 Old business "Residents are not getting their announcements of doctor's appointments." *3/2/15 Old business "Residents are not getting their announcements of doctor's appointments." *4/13/15 There was no follow-up mentioned for the above stated concerns. *5/13/15 There was no follow-up mentioned for the above stated concerns. *6/1/15 New business "[Resident name] said they are not being notified about appointments."  Interview on 6/16/15 at 2:25 p.m. with the administrator and director of nursing revealed they would have expected follow-up and resolution with resident council grievances.  Surveyor: 33265 Review of provider's 11/8/12 Grievance/Complaints Policy and Procedure revealed anyone who complained had a right to request and receive a written response to the complaint within a reasonable period of time.	F 166	The Clinical Coordinators will ask the resident or Responsible party if they were notified timely of the appointment. The Social Services Department will follow-up with all grievances brought forth in resident council using the grievance procedure. The Clinical Coordinators will report the findings of the Medical Appointment audit and Social Workers will report results of any grievances for the month to the QAPI committee for a period of 1 year and then as deemed necessary by the QAPI committee.	7-16-15	
F 176 SS=D	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:	F 176	The facility policy and procedure on self-administration of medications was revised on 7-08-15. All nursing staff will be educated on this procedure by the DON on July 13-15 2015. . Resident #10 and all other residents in the facility were assessed on 7-08-15 to determine their ability to self-administer drugs by the DON and/or designee.		

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F 176	<p>Continued From page 16 Surveyor: 34030</p> <p>Surveyor: 33265 Based on observation, interview, record review, and guideline review, the provider failed to appropriately assess one of one sampled residents (10) on nebulizer (machine that turns liquid medication into aerosol that is inhaled) treatment for self-administration of medication after set-up. Findings include:</p> <p>Surveyor: 34030 1. Observation and interview on 6/9/15 at 11:30 a.m. of a nebulizer treatment for resident 10 by medication aide U revealed: *She stayed with the resident during the entire treatment. *She stated "I need to stay with him as he can't do this [nebulizer] on his own."</p> <p>Surveyor 33265 Review of resident 10's complete medical record revealed: *Nurses notes from 3/28/15 by licensed practical nurse (LPN) QQ stated "does neb [nebulizer] after set up well." *The resident had an Assessment for Self-Administration of Medications completed on 5/7/15. -The assessment stated the resident was fully capable of administering inhaled medications after it was set-up. -Two nurses: LPN KK and registered nurse (RN) RR had signed under the interdisciplinary team section. -There was no physician's signature.</p> <p>Review of the provider's 12/08/08 Assessment for Self-Administration of Medications form revealed</p>	F 176	<p>Assessment determinations will be documented in each of the resident's EMR and included on each MAR/TAR after the physician orders are obtained. Self-administration of medication assessment will occur quarterly. Audits will be conducted weekly for 1 month and monthly for the next 3 months on resident #10 and five other residents on a nebulizer treatment to ensure self administration orders are in place or that trained nurses or med techs are assisting the residents without self administration of drug orders with their nebulizer treatments. The audits will be conducted by the DON and/or designee who will also be responsible for overall compliance. Audit findings will be reported to the monthly QAPI meetings for 1 year by the DON and/or designee and then as deemed necessary by the QAPI committee.</p>	7-16-15	

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F 176	Continued From page 17 an evaluation was required before self-administration of medications and at least every three months thereafter.  Review of the provider's undated Self-Administration of Drugs guidelines revealed residents were not permitted to administer any medication in their rooms unless the attending physician had written an order for the self-administration of the medication.  Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing and administrator revealed the DON was not aware resident 10 was self-administering the nebulizer after set-up.	F 176			
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION  The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.  The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.  This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure freedom of movement for one of one sampled residents (10). Findings include:  1. Observation and interview on 6/10/15 from 12:40 p.m. to 1:00 p.m. in the East wing, far East	F 223	The door of resident #10 was adjusted and operates properly. Maintenance audited all doors of the facility on July 10, 2015 to ensure proper operation and ensure that the door doesn't stick to the frame. All doors are now open and close properly.  Involuntary seclusion could affect all residents. All staff will be educated on the facility's abuse and neglect policy including the different types of abuse including involuntary seclusion between July 14-15, 2015. The Social Services department will ask every resident or resident representative by July 13, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident has ever experienced involuntary seclusion.	7-16-15	

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F 223	<p>Continued From page 18 hallway revealed: *At 12:40 p.m. resident 10 was seated in his wheelchair, his knees were up against the bed, his head was down. *At 12:45 p.m. resident 10 put his call light on. It stayed on for several minutes, and then went into a faster beeping and flashing mode. The resident made his way into the hall with his wheelchair and stayed just outside of his doorway. *At 12:53 p.m. three certified nursing assistants (CNA) came to answer the call light. The resident was pushed back into his room, the television was turned on, and one CNA asked him if the channel was okay. I heard no response from the resident. *At 12:55 p.m. the resident turned his light on again and went out into the hallway in his wheelchair. *Two of the above three CNAs returned to his room, CNAs II and JJ pushed him backwards into his room. CNA II told him he needed to wait ten more minutes then they would move him into his recliner, then they closed the door to his room. *When the two CNAs were asked why the resident had to wait ten minutes. CNA II responded he wanted to know his weight, and they had not had time to get it.</p> <p>*This surveyor had previously identified the door to his room stuck and was difficult to open. *On previous random observations when the resident had been in his recliner and watching television, the door had been left open a few inches and the resident could have been seen in the recliner.</p> <p>After the CNAs had closed the resident's door and left the following occurred: *The resident was heard trying to open the door.</p>	F 223	<p>Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria are met. The social services department will audit 10 random residents per month and ask if a staff member has involuntarily secluded them. Audit findings will be reported to the monthly QAPI meeting for 1 year by the Social Work Department and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7-16-15	

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F 223	Continued From page 19 *The door knob was moving, but it was not opening. *After knocking on the door, this surveyor opened it slowly to find the resident was right in front of the door. *He motioned with his hands he wanted to move to the recliner. -His call light was not seen. *At 1:00 p.m. the resident's light was back on. *The two CNAs returned with an EZ Stand (device to assist in lifting a person into the standing position) to move the resident.  Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator, revealed they were: *Unaware of the event. *Wanting to know if the event needed to be reported to the Department of Health office in Pierre at this time.  Review of the provider's June 2014 Reporting Abuse to Facility Management policy revealed: *Involuntary seclusion was listed as a type of abuse. *The definition for involuntary seclusion included a resident being confined to his room against his will. *Employees, facility consultants, and or attending physicians were to report abuse or suspected abuse to the administrator or DON.	F 223			
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 224		7-16-15	

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F 224	<p>Continued From page 20 and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331</p> <p>Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to identify, track, and investigate the loss of one of one sampled resident's (10) personal property. Findings include:</p> <p>1. Observation on 6/9/15 at 12:00 noon meal and at the evening meal on east wing in the dining room revealed resident 10 had not worn his dentures or hearing aides for either meal.</p> <p>Review of resident 10's complete medical record revealed: *The Inventory of Personal Effects form listed the following: -One pair of dentures, upper, and lower. -One pair of glasses - gold framed/brown in color. -One cell phone, black Samsung flip type. -One wallet with \$184.00, two blank checks, and a debit card. -One gold Timex watch.</p> <p>The Activities Evaluation form dated 2/12/15 revealed: **"Hearing aides needed from." *The check box for hearing aides was checked. -Further clarification of which side or sides the</p>	F 224	<p>The facility reported the missing items for resident #10 to the Dept of Health and the Sioux Falls Police Department on 6-16-15. The cell phone was found, is in operable condition and given to the family. Social worker and maintenance searched the room of resident #10 and located the hearing aide, 2 checkbooks and a signature stamper. All items were turned over to the family. Family advised that there was only 1 hearing aide (left ear) so that was given to the charge nurse to place in the locked medication room for resident #10 to use. The family reported that the debit card was canceled months ago. Social Services asked the resident and his son if any other items are missing on July 9, 2015. The Social Services department will ask every resident or resident representative by July 13, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident has any missing property. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria is met. The social services department will continue to maintain a Grievance Log in the Social Work office and follow the facility Grievance Policy and Procedure. All staff will be in-serviced on the Grievance Policy Procedure between July 14-15, 2015.</p>	7-15-15	

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F 224	<p>Continued From page 21</p> <p>hearing aides were for was not checked. *Under adaptive equipment nothing was checked: no hearing aides, no glasses, and no dentures.</p> <p>The 2/12/15 Oral/Dental Status form stated "left dentures at (former facility)."</p> <p>The 5/6/15 Oral/Dental Status form had "dentures" written in.</p> <p>Interview on 6/10/15 at 8:15 a.m. with certified nursing assistant (CNA) LL regarding resident 10 revealed: *She did not know about the resident's hearing aides. *She thought one had worked. *She usually worked evenings and had never seen a hearing aide belonging to him. *She searched for his dentures and located both upper and lower dentures in a dry cup without a lid. *When she offered him his dentures he declined.</p> <p>Further interview on 6/10/15 at 8:30 a.m. with CNA LL regarding resident 10's hearing aide revealed she had asked her colleagues and they said there had been one hearing aide for the left ear.</p> <p>Further interview on 6/10/15 at 9:15 a.m. with CNA LL regarding resident 10's hearing aide revealed she: *Had asked other staff members about the hearing aide. *Was told the hearing aide was not working and had been given to the family to take home. That date was not known.</p> <p>Interview on 6/16/15 at 1:15 p.m. with the son of</p>	F 224	<p>The social services department will list all outstanding grievances during the daily stand-up meeting. The Administrator will audit each grievance on the Grievance Log on a weekly basis to ensure timely follow-up on grievances.</p> <p>The Administrator will bring the results of the Grievance Log audit to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7-16-15	

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F 224	<p>Continued From page 22</p> <p>resident 10 revealed:</p> <ul style="list-style-type: none"> <li>*He had not been given the hearing aide to take home.</li> <li>*He had no idea where the hearing aide was and it had rarely been in his dad's ear.</li> <li>*It was very hard to communicate with his father without the hearing aide.</li> <li>*He understood the physician had written a notation to put his father's hearing aide in his ear every day.</li> <li>*He had no idea if the missing hearing aide had been reported to the State Department of Health.</li> </ul> <p>Surveyor 32331</p> <p>2. Interview and observation on 6/10/15 at 3:45 p.m. with the accounts receivable employee in the finance office regarding resident 10's resident trust account revealed:</p> <ul style="list-style-type: none"> <li>*He had opened a resident trust account on 5/1/15 with a balance of \$175.00.</li> <li>*He had used the account once since the above time on 5/4/15 for barber services with a withdrawal of \$15.00.</li> <li>*His current resident trust fund balance on 6/10/15 was \$160.00.</li> <li>*She showed this surveyor one legal-sized envelope that had been stored in the business office Sentry safe compartment that contained the following: <ul style="list-style-type: none"> <li>-One signed check blank by resident 10.</li> <li>*On the outside of that same above envelope there were handwritten notes with the following: <ul style="list-style-type: none"> <li>-The amount of \$184.00 had been underlined and scribbled out, and the amount of \$175.00 was written next to it.</li> <li>-"2 [two] check blanks."</li> <li>- An asterisk (*) with "took 1 chx (check) blank on 4/3/15" and initials of the accounts receivable employee.</li> </ul> </li> </ul> </li> </ul>	F 224		7-16-15

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F 224	<p>Continued From page 23</p> <ul style="list-style-type: none"> <li>-Resident 10's name.</li> <li>-Two more sets of initials.</li> <li>*She stated he had used one of the check blanks for a purchase on 4/3/15.</li> <li>*She stated when the envelope had been given to her to put in the business office's safe it had contained:                             <ul style="list-style-type: none"> <li>-Two blank checks.</li> <li>-A total of \$175.00 in cash.</li> </ul> </li> <li>*She stated there had not been a debit card in the above envelope when it had been given to her to put in the safe.</li> <li>*That above \$175.00 in cash had been placed in a resident trust account on 5/1/15.</li> </ul> <p>Surveyor 33265 Review of resident 10's financial records revealed: *The resident trust fund account for resident 10 showed: -Deposit of \$175.00 on 5/1/15. -Withdrawal of \$15.00 for barber on 5/4/15.</p> <p>Interview on 6/16/15 at 10:55 a.m. with the son of resident 10 revealed: *He believed his father was transferred from the previous facility with the following belongings: -Wallet. -Watch. -Two blank checks. -One cell phone. -One shirt. -One pair of pajamas. *His father had been moved to this facility while he had been on a two week vacation. He brought his father the following items: -Two check books from different facilities. -Signature stamper for his use.</p>	F 224		7-16-15	

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F 224	<p>Continued From page 24</p> <p>Further interview on 6/16/15 at 1:15 p.m. with the son revealed that:</p> <ul style="list-style-type: none"> <li>*The next time he visited his father he could not find the check books or the stamper.</li> <li>*At that time nothing was missing from either of the accounts.</li> <li>*He said there could have been a debit card, but he was not sure which financial institution it would have been from.</li> <li>*He had no idea if the provider reported missing items to the State Department of Health.</li> </ul> <p>Interview on 6/16/15 at 2:20 p.m. with the accounts receivable employee regarding resident 10's account revealed:</p> <ul style="list-style-type: none"> <li>*She remembered cash and two blank checks when he was admitted in February 2015.</li> <li>*The cash was left in the safe until 5/1/15 when it was transferred into the resident trust fund.</li> <li>*One check had been used. The one remaining blank check was still in the safe.</li> </ul> <p>3..Random observations between 6/9/15 and 6/11/15 in resident 10's room revealed no cell phone within site in his room.</p> <p>Interviews on 6/16/15 at 10:55 a.m. and 1:15 p.m. with resident 10's son revealed:</p> <ul style="list-style-type: none"> <li>*His father had brought a cell phone with him from the previous facility.</li> <li>*The cell phone had been washed in the provider's laundry multiple times, and then went missing so was replaced by the son.</li> <li>*The second cell phone was reported as washed by the provider's laundry within three days of being delivered to his father. That too went on to be washed multiple times, then went missing, and was replaced by the son.</li> <li>*The third cell phone had also gone missing. He</li> </ul>	F 224		7-16-15	

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F 224	<p>Continued From page 25</p> <p>had canceled the service between the first and second interviews today.</p> <p>*He had no idea if the provider had reported the missing items to the State Department of Health.</p> <p>4. Interview and record review on 6/16/15 at 2:15 p.m. with social worker designees (SSD) S and T concerning missing items revealed:</p> <p>*SSD S had only recently become resident 10's SSD.</p> <p>*SSD S had two cell phones that had been washed in the laundry sitting on his desk. He had no idea who they belonged to.</p> <p>*Neither one had known of resident 10's missing items.</p> <p>*SSD T remembered after reviewing records she had left eight or nine dollars in resident 10's wallet, and then put the rest in the safe. She was not sure about the debit card.</p> <p>*Both SSDs agreed when personal property was missing the routine was:</p> <p>-They would write a grievance .</p> <p>-if money was involved the police would be called and the State Department of Health would be notified.</p> <p>*If a cell phones was missing a grievance would be written and the administrator was notified.</p> <p>*There were no grievances written for any missing items for resident 10.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the DON and the administrator regarding the multiple missing items of resident 10 revealed:</p> <p>*Neither were aware of the personal items of his that were missing.</p> <p>*The administrator wanted to know if a report needed to be filed with the State Department of Health at this time.</p>	F 224		7-16-15	

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F 224	Continued From page 26	F 224			
F 226 SS=F	<p>Review of provider's June 2014 Personal Property Policy revealed: *Residents were encouraged to retain and use personal possessions as space permits. *The residents' personal belongings and clothing would be inventoried and documented upon admission and as items are added. *The facility would promptly investigate any complaints of misappropriation or mistreatment of resident property.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 A. Based on interview, record review, and policy review, the provider failed to ensure one of one suspected drug diversion with eight identified residents (6, 8, 47, 48, 49, 50, 51, 52) was reported and investigated in a timely manner. Findings include:</p> <p>1. Review of the provider's twenty-four hour initial event report required by the South Dakota Department of Health received on 5/31/15 revealed on 5/27/15 it was discovered there was a possible diversion of controlled substances on the Warren rehabilitation wing.</p>	F 226	<p>Resident #11 resides in the facility. Employee QQ was terminated for neglect resulting from the interview and direct admission of the neglect action to the Administrator and DON. The incident was reported to the State Board of Nursing. There was no documented or suspected harm to these residents (6,8,47,48,49,50,51,52). After review of pain assessments, there was also no documented increased pain or complaints of not receiving appropriate medications requested for pain of these residents. Residents # 47,48,49,50 have discharged. Residents #6,8,51,52 have no further reports of drug diversion.</p>	7/16-15	

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F 226	<p>Continued From page 27</p> <p>Interview on 6/1/15 at 4:55 p.m. with the administrator and registered nurse (RN) C revealed:</p> <ul style="list-style-type: none"> <li>*Medications were found to have disappeared on 5/12/15.</li> <li>*Sixty hydrocodone (controlled narcotic) were delivered from the pharmacy.</li> <li>*Thirty of those hydrocodone were missing.</li> <li>*Nursing staff discovered they were short twenty-two tramadol (controlled narcotic).</li> <li>*There were multiple other controlled medications missing.</li> <li>*They were in the process of their investigation.</li> <li>*They were unsure of the exact number of residents and medications the suspected diversion involved at this time.</li> <li>*They had not notified law enforcement until 5/31/15.</li> <li>*At the time they notified law enforcement they reported thirty missing hydrocodone tablets.</li> <li>*They had not reported any of the other missing medications.</li> <li>*They had not reported the suspected drug diversion, because they were unsure if it was a diversion.</li> </ul> <p>Review of the provider's final five-working day investigation report received on 6/5/15 into the South Dakota Department of Health revealed:</p> <ul style="list-style-type: none"> <li>*They determined eight residents had missing medications.</li> <li>*All medication documentation records, pain assessments, and controlled substances in the facility were reviewed.</li> <li>*The medications were found to have disappeared from 5/12/15 through 5/15/15 along with the sealed packaging they had arrived in or were kept in.</li> <li>*They were continuing to investigate.</li> </ul>	F 226	<p>Administrator now understands that drug diversions are required to be reported to the Department of Health and law enforcement immediately within twenty-four hours of the missing medications being noticed and will follow the provider's Resident Abuse/Neglect Policy and Procedure. The consultant pharmacist explained to the Administrator that the diversion needed to be reported immediately. The Administrator did report the diversion on 5-31-15 after an email from with the consultant pharmacist. The Administrator and nursing team (DON was on vacation) did have a teleconference about the possible diversion with Pharmacy (consultant pharmacist not present) on the afternoon of 5-27-15 to come up with a plan to prevent further issues and to define if the diversion was actually a diversion. The drug diversion incident is still being investigated in cooperation with, Special Assistant Attorney General, Diversion Unit. The DON and/or designee will observe 5 random medication passes per month to ensure the six "Rs" are being conducted for medication administration. Resident #41 discharged from the facility on 2-20-15. Resident #42 discharged from the facility on 2-28-15.</p>	7-16-15	

to include all shifts sc/soo/nlj

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F 226	Continued From page 28  Review of the undated amendment to the drug diversion report revealed: *Resident 47 had lorazepam 1 milligram (mg), two tablets missing. *Resident 48 had oxycodone 5 mg 4 tablets missing; hydrocodone/Tylenol (APAP) 5/325 mg 4 tablets missing; Tramadol 50 mg 30 tablets missing. *Resident 49 had morphine sulfate immediate release 15 mg 24 tablets missing. *Resident 50 had Tramadol 50 mg 29 tablets missing. *Resident 51 had hydrocodone/APAP 5/325 mg 4 tablets missing; Oxycodone 5 mg 30 tablets missing *Resident 6 had oxycodone/APAP 5/325 mg 3 tablets missing; tramadol 50 mg 2 tablets missing. *Resident 8 had hydrocodone/APAP 5/325 mg 3 tablets; tramadol 50 mg 2 tablets. *Resident 52 had Tramadol 50 mg 21 tablets missing.  Interview on 6/16/15 at 2:25 p.m. with the director of nursing and the administrator revealed: *The administrator said he: -Had never had a drug diversion before. -Was unsure if the medications were misplaced or diverted. -The consultant pharmacist told him he needed to report the suspected drug diversion. -Should have notified the South Dakota Department of Health immediately within twenty-four hours of the missing medications being noticed. -Should have notified the police immediately within the same above stated time-frame.	F 226	The Controlled Substance Policy and Procedure was reviewed on July 10, 2015 and will be included on the all staff in-service on July 14-15, 2015. All staff will be in-serviced on the facility abuse and neglect policy/procedure, Department of Health abuse/neglect reporting requirements and timelines, and the Controlled Substance Policy and Procedure by July 14-15, 2015. The facility now utilizes a Controlled Substances Record Binder Book provided by Pharmacy to control and reduce the opportunities for a drug diversion to occur. The social services department developed a Resident Property Log on July 8, 2015 that will be used to log the resident name, room number, current date, type of item, final status, and date item given back to resident or resident representative. DON and/or designee will randomly audit 10 random residents in the facility each month that are listed in the Controlled Substances Record Book for 4 months to look for signs of possible drug diversion. The DON will in-service the Medication Aides and Nurses regarding the drug diversion and measures that the facility takes to reduce the opportunities for drug diversions between July 14-15, 2015.	7-16-15	

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F 226	<p>Continued From page 29</p> <p>Review of the provider's revised June 2014 Resident Abuse/Neglect Policy and Procedure revealed "The administrator or designee will notify the Department of Social Services, the ombudsman, Department of Health and the residents attending physician immediately after being informed of the incident. (Immediately as defined as not longer than twenty-four (24) hours after being informed of the incident."</p> <p>Surveyor: 32335</p> <p>Surveyor: 35625</p> <p>B. Based on record review, interview, and policy review, the provider failed to thoroughly investigate four of four sampled incident reports (11, 41, 42) to determine no abuse or neglect had occurred. Findings include:</p> <p>1a. Review of a grievance report dated 2/3/15 regarding resident 41 revealed:</p> <ul style="list-style-type: none"> <li>*The incident occurred on 1/30/15.</li> <li>*Her call light had been on for over an hour.</li> <li>*Social services designee S had been rude and disrespectful.</li> <li>*The facility ran a call light report for resident 41's room with a response time of no longer than twelve minutes for that date.</li> <li>*The resident was switched to social worker designee T.</li> <li>*There was no documentation interviews had been conducted or that a thorough investigation had been completed.</li> <li>*There was no documentation the provider had followed up with resident 41 regarding the grievance.</li> </ul>	F 226	<p>The Social Services department will ask a random sample of 10 residents or resident representatives each month for 4 months if the resident has any property that is missing. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria is met. The Social Services Department will audit the Resident Property Log each month to ensure timely follow-up on all entries during the month.</p> <p>The results of the Controlled Substances Record Binder Book audit will be brought to the monthly QAPI meeting by the Director of Nursing and/or designee for 4 months and then for 1 years until deemed necessary by the QAPI committee if no further patterns persist. The Social Services Department audits of the Quality of Care tool and Resident Property Log will be given to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7-16-15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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F 226	Continued From page 30  b. Review of a grievance report dated 1/31/15 regarding resident 42 revealed: *A certified nursing assistant (CNA) had been rude and disrespectful during the previous night. *The resident and spouse were very upset regarding the matter. *An apology was offered to resident 42 and his spouse. *The CNA no longer worked at the facility. *The name of the CNA was not documented in the report. *No documentation was provided regarding the reason the CNA no longer worked at the facility. *No documentation was available regarding investigation of the CNA's behavior.  c. Review of an event form submitted to the Department of Health (DOH) dated 5/7/15 for resident 11 revealed: *She had sustained a fall while attempting to transfer herself in the bathroom. *It had occurred on 4/30/15 at 4:00 a.m. *The CNA notified the nurse of the incident. *The nurse had left the building for a cigarette break and had not immediately assessed resident 11. *The nurse was terminated for neglect. *There was no documentation interviews had been conducted or that a thorough investigation had been completed.  d. Interview on 6/1/15 at 9:30 a.m. with the local ombudsman prior to entering the facility regarding resident 11 revealed: *She had given the hearing aids to social services designee S to have repaired. *The hearing aids were not delivered in a timely manner to the repair shop.	F 226		7-16-15	

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F 226	<p>Continued From page 31</p> <p>*Social services designee S had them in his car for an undetermined length of time.</p> <p>*The repair shop had not received payment for the repair of the hearing aids.</p> <p>*No dates were provided in regards to the event.</p> <p>Review of a grievance report dated 6/5/15 for resident 11 revealed:</p> <p>*The facility had paid for the damaged hearing aids for resident 11 on 6/5/15.</p> <p>*A copy of the invoice and check was attached in the report.</p> <p>*No additional documentation was provided in the report.</p> <p>Interview on 6/16/15 at 10:00 a.m. with social services designee S revealed he:</p> <p>*Acknowledged the hearing aids were left in his car for an extended period of time.</p> <p>*Was not able to provide a date the hearing aids were given to him or when it was turned in to the repair shop.</p> <p>*Acknowledged he had no system in place for the documentation of items given to him by residents.</p> <p>e. Interview on 6/16/15 at 10:45 a.m. with the director of nursing and the administrator revealed:</p> <p>*Several staff members had visited with resident 41, but those interviews were not documented.</p> <p>*Acknowledged the report for resident 42 should have contained the name of the CNA involved in the incident and the reason she was no longer employed at the facility.</p> <p>*They were unable to provide documentation the nurse involved in the fall regarding resident 11 was reported to the South Dakota Board of Nursing.</p> <p>*Acknowledged the hearing aids for resident 11 had been left in social services designee S's car.</p>	F 226		7-16-15	

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F 226	<p>Continued From page 32</p> <p>-The administrator referred to that as an "outlying situation."</p> <p>-Was not aware social service designee S did not document receipt of items for the residents.</p> <p>*Acknowledged the reviewed incidents did not contain thorough documentation of the evidence to determine if abuse, neglect, or misappropriation of property had occurred.</p> <p>Review of the provider's June 2014 Resident Abuse/Neglect Policy and Procedures revealed:</p> <p>*The completed report should have contained as many details as possible.</p> <p>*All occurrences should have been reported to the administrator immediately.</p> <p>*Social services personnel and nursing manager/designee were responsible for interviews of witnesses.</p> <p>*Witness reports would be in writing with a signature and date</p> <p>*The administrator or designee would notify the Department of Social Services, the ombudsman, Department of Health, and attending physician immediately after being informed of the incident.</p>	F 226		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure</p>	F 241	<p>The facility dignity policy and procedure was reviewed and revised to include direction of the resident chooses to use their own clothing protector. The DON will educate the nursing staff on the new dignity policy and procedure on July 14-15, 2015. Resident #10's careplan was updated on July 6, 2015 to include his personal preference to wear his personal clothing protectors.</p>	7-16-15

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F 241	<p>Continued From page 33</p> <p>resident dignity was maintained by:</p> <p>*Transporting one of one sampled residents (10) through the halls while wearing a clothing protector for three of three observed meal services.</p> <p>*Requiring one of five interviewed residents (29) to wear a blue armband identifying the resident as requesting a full code (emergency treatment if heart or lungs fail).</p> <p>*Serving only a part of a meal, without the main protein portion (meat) to one of one randomly observed resident (43) for one of three (noon meal) observed meal services.</p> <p>*Serving food on plates that remained wet after washing them to residents who ate in the Warren and Memory Care unit dining rooms during one of two (evening meal) observed meal services.</p> <p>Findings include:</p> <p>1. Observation on 6/9/15 at 11:50 a.m. in the East wing dining room regarding resident 10 revealed the resident was wheeled into the dining room with a clothing protector already in place around his neck.</p> <p>Observation on 6/9/15 at 5:34 p.m. in the East wing dining room regarding resident 10 revealed the resident wheeled into the dining room with a clothing protector already in place around his neck</p> <p>Observation and interview on 6/10/15 at 8:15 a.m. outside of resident 10's room with certified nursing assistant (CNA) LL revealed:</p> <p>*The resident had a clothing protector on as he was being wheeled to the dining room for breakfast.</p> <p>*The CNA usually worked evenings and was not sure of the day shift routines.</p>	F 241	<p>All other residents in the facility that choose to wear their own personal clothing protectors were assessed to ensure their care plan has been updated to include instructions for wearing their personal clothing protectors. These assessments will be conducted by the DON and/or designee.</p> <p>Weekly audits will be conducted for the 1st month and then monthly for 3 months on resident #10 and all other residents who choose to wear their own personal clothing protectors to ensure the appropriate care plan and daily use of such protectors are in place. These audits will be conducted by the DON and or designee who will also be responsible for overall compliance.</p> <p>The audit findings will be reported by the DON and/or designee to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7-16-15	

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F 241	<p>Continued From page 34</p> <p>Interview on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator revealed the DON would expect if clothing protectors were needed they would be put on and taken off in the dining room.</p> <p>2. Interview on 6/9/15 at 11:20 a.m. with licensed practical nurse (LPN) KK revealed a resident who was a full code should be wearing a blue armband on their wrist.</p> <p>Observation and interview on 6/11/15 at 9:00 a.m. with resident 29 revealed she: *Was wearing a medium blue colored arm band on her left wrist. *Had to wear the armband in order to get emergency help if her heart quit. *Stated the armbands had just started within the last few months and were a "pain." *"Felt like a prisoner" having to wear it all the time.</p> <p>Interview on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator revealed the DON was not aware of resident 29's feelings towards wearing the blue armband.</p> <p>Surveyor: 33488</p> <p>3. Observation and interview on 6/10/15 at 12:25 p.m. in the East dining hall with dietary aide F as she served the noon meal revealed: *A container of pureed meat that was not set down in the steam table but was above it off to the side. *Dietary aide F proceeded to dish up the pureed meat. *She had not checked the temperature of the</p>	F 241	<p>The blue band system is discontinued. Residents with a FULL CODE status will be identified as a red sticker on the outside of their chart spine and a red sheet of card stock on inside of resident chart labeled FULL CODE. All staff will be in-serviced regarding the procedure between July 13-15, 2015.</p> <p>Dietary Aide F was educated by the CDM on 6/10/15 on facility policy for food temperature procedures at meal time with regards to resident #43 and all residents throughout the facility. The CDM or designee will randomly monitor Dietary Staff F weekly x 4 weeks for compliance. A directed in-service was completed by the RD on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on proper food temperature ranges and the need to temp all foods prior to meal service. The South Dakota Food Code, specifically SDCL 44:02:07:31 states hot food must be maintained at 140 degrees F or above, so staff was educated on this more restrictive rule than the Federal Food Code (3-501.16). Also included was serving the resident all food at the same time. Protein is a very important component of the residents' diets, and should be served so they are not full of eating other foods while</p>	7-16-15	

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F 241	<p>Continued From page 35</p> <p>meat prior to attempting to dish the meat onto a plate.</p> <p>*Upon asking her to perform a temperature check the meat was found to be at 90 degrees. Safe holding temperatures on a steam table should have been above 135 degrees.</p> <p>*When asked what the safe holding temperature would be she replied 160 degrees.</p> <p>*She had not understood the above temperature fell far below the safe holding temperature. She was asked by this surveyor to call her cook and request a new serving of the pureed meat.</p> <p>*She continued to dish up the remainder of the resident's pureed food. She then gave the food to the CNA who served the food to the resident. No effort was made to contact the cook for more pureed meat.</p> <p>*The unidentified CNA told dietary aide F she had to call the cook and get more food. Dietary aide F had not acknowledged that request.</p> <p>*The CNA began to feed the resident who was identified as resident 43 without the pureed meat.</p> <p>*At 12:35 p.m. the dietary aide left the dining room and returned ten minutes later with pureed meat for the resident.</p> <p>4. Observation and interview on 6/9/15 at 5:25 p.m. in the Warren dining room with dietary aide H who was dishing up residents' food onto plates revealed:</p> <p>*Dishes were visibly wet.</p> <p>*As she dished up the plates to be served occasionally she would shake the water off the plate.</p> <p>*She had not dried the plates prior to serving.</p> <p>*She agreed she would not want to be served food with water remaining on the plates.</p> <p>Review of the provider's April 2013 Quality of Life</p>	F 241	<p>waiting for the protein, as in this example. A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.</p> <p>The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 1 year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then as deemed necessary by the QAPI committee.</p> <p>Dietary Aide H was educated by the CDM on 6/10/15 on facility policy on clean dishes procedures. The CDM or designee will randomly monitor Dietary Staff H weekly x 4 weeks for compliance.</p> <p>A directed inservice was completed by the RD on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on proper dish handling, including fan usage in the dish rooms, air drying of all dishes, not drying any dishes with a towel, or shaking dishes off, and the need to store dishes, cups, and silverware upside down so water could drain from them and not leave any room for bacteria to grow on any amount of standing water. A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff.</p>	7-16-15	

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F 241	Continued From page 36 - Dignity policy revealed residents "shall be treated with dignity and respect at all times."	F 241	Records to be kept in the CDM office. The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 1 year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then as deemed necessary by the QAPI committee. Review of the clinical records for Resident's 2 & 3 were reviewed on 7/6/15 and those residents were determined to have no negative outcomes related to F Tag 248. Reviewed resident's 2 & 3 along with all residents with activity staff. The Activity Director or designee will provide one on one's per what Individual Activities & Room Visits Program policy states. The Activity Staff will chart whether the resident was unavailable, out of building or refused if they could not or did not want to attend the activity. Review of the clinical records for Resident 18 was reviewed on 7/6/15 and that resident was determined to have no negative outcomes related to F Tag 248. Resident 18 review of the activity participation log shows that resident 18 attended activities 64% of the time from 10/7/14 till his discharge. The Activity Staff will chart whether the resident was unavailable, out of building or refused if they could not or did not want to attend the activity.	7-16-15	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on interview, record review, policy review, the provider failed to maintain an effective one-to-one activity program for 3 of 3 sampled residents (2, 3, and 18) that were unable to plan or attend activities on their own. Findings include:  1. Review of resident 2's activities with the Staff Detail report from 5/1/15 through 6/8/15 revealed: *No activities were documented on 5/1/15. *There were two one-to-one activities documented. *There was one one-to-one activity documented as attempted. *No other documentation of one-to-one activities were documented during that time frame.  Review of resident 2's 9/1/14 care plan for activities revealed no mention of how many times a week she would have been offered one-to-one activities by the staff.  2. Review of resident 3's activities with the Staff Detail report form from 5/1/15 through 6/8/15	F 248			

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F 248	<p>Continued From page 37 revealed: *No activities were documented from 5/1/15 through 5/3/15. *There were two one-to-one activities documented. *There was one one-to-one activity documented as attempted. *No other documentation of one-to-one activities were documented during that time frame.</p> <p>Review of resident 3's May 2015 care plan for activities revealed: *"Provide one-to-one services in my room . You can hold my hand, sensory, read to me and visit with me." *No mention of how many times a week one-to-one activities should have been offered per week.</p> <p>3. Review of the provider's list of residents that were on a one-to-one activity program revealed eighteen residents including resident 2 and 3.</p> <p>Interview on 6/16/15 at 1:15 p.m. with the activity director revealed: *They had 18 residents that were on a one-to-one activity program. *She would have liked each resident to at least have had three one-to-one activities a week. *They do not always have enough staff to work in activities. *The one-to-one activity program has not been developed as much as she would like it to be.</p> <p>Surveyor: 14477 4. Review of discharged resident 18's 7/14/14 care plan notes revealed he had wanted assistance to attend special music, watch TV, visit with people, participate in Bingo, and to help</p>	F 248	<p>Activity Staff will also chart how many attempts were made by the staff. Individual Activities &amp; Room Visit Program Policy was revised and changes were made to reflect current activities. In-service was held on 7/8/15 to go over new policies and new systems in place. The Activity Director or designee will randomly audit the participation records for 8 residents per week for 12 weeks and then 8 residents per month for 3 months, then quarterly on going. The audit reports on activity participation will be presented at the monthly QAPI committee by the Activity Director for 1 year and then the QAPI committee will determines otherwise.</p>	7-16-15	

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F 248	<p>Continued From page 38</p> <p>him outside when the weather was between 70-80 degrees. He also had wanted help turning on his room TV, and wanted to sit by the nurses station to visit with people who walked by.</p> <p>Review of resident 18's 10/7/14 care conference notes revealed his sister who had Durable Power of Attorney (DPOA) for him was upset he had been removed from activities because he was too loud. The provider had stated he was to have had more one-to-one activities and someone would have had to sit with him during a movie activity.</p> <p>Review of the 3/5/15 interview with the DPOA revealed the provider had been keeping resident 18 in his room and had not been offering or taking him to activities. The DPOA felt the lack of participation in activities had undone years of behavior modification resident 18 had previously received.</p> <p>Review of the closed medical record for resident 18 revealed there was no documentation of one-to-one activities or any other activity attendance.</p> <p>Surveyor: 32333 Review of the provider's undated Individual Activities and Room visit program revealed "It is recommended that residents on a full room visit program receive, at a minimum, three room visits per week. Typically a room visit is ten to fifteen minutes in length."</p>	F 248		7-16-15
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252		

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F 252	<p>Continued From page 39</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: 33265</p> <p>Surveyor: 16385 Based on observation and interview, the provider failed to maintain a homelike environment for all residents residing in the facility for the following: *The memory care unit (Memory Lane) dining/common area laminate floor was visibly scratched and worn. *Four doors were hard to open and/or close (room 317, center tub room, center soiled utility room, and east shower room). *Plates, cups, and silverware were left on trays instead of being placed on the table for two of two meals observed in Memory Lane. Findings include:</p> <p>1. Random observations from 6/8/15 through 6/11/15 revealed the memory lane dining/common area laminate floor had large areas where the finish was scratched or worn off. That created an uncleanable surface.</p> <p>Interview on 6/11/15 at 8:30 a.m. with the administrator confirmed he was aware of the worn laminate floors in Memory Lane. He revealed he and the owner had toured the area and noted the floor was worn. No immediate plans were in place to replace the floor.</p>	F 252	<p>The scratched flooring is estimated to be replaced around September 22, 2015 when the flooring arrives. The flooring has been ordered. The four doors (room 317, center tub room, center soiled utility room, and east shower room) were adjusted and operate correctly.</p> <p>The Memory Care tables have new tablecloths and napkins. All staff will be in-serviced on July 14-15, 2015 to make sure that all items are removed off the tray while serving the meal to the residents on all halls and no soft plastic cups are to be used during mealtime. The Director of Environmental Services tested all doors on July 10, 2015 to ensure proper operation. All doors now operate correctly. The Director of Environmental Services audited all common area flooring on July 10, 2015 and all common area flooring is now in compliance.</p> <p>The Homelike Environment policy and procedure was reviewed and updated on 7-07-15. All staff will be in serviced on the Homelike Environmental policy and procedure between July 14-15, 2015.</p> <p>Checking the flooring and proper door function has been added to the Monthly Preventative Maintenance checklist. A work order will be created for any issues. The Preventative Maintenance checklist will be given to the Administrator on a monthly basis.</p>	7-16-15
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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F 252	<p>Continued From page 40</p> <p>Surveyor: 33265</p> <p>2. Random observations throughout 6/9/15 and 6/10/15 revealed:</p> <p>*The center wing tub room door was difficult to open and would not close completely. It would not lock as it should when closed.</p> <p>*The center soiled utility room door was difficult to open.</p> <p>*The east shower room door would stick and was difficult to get into and out of.</p> <p>*Resident room 317 door would stick and was hard to move or close.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing and the administrator revealed they:</p> <p>*Were not aware resident room 317's door was sticking and difficult to open and close.</p> <p>*Wanted a list of the doors not working properly.</p> <p>Surveyor: 32335</p> <p>3. Observation on 6/9/15 at 11:50 a.m. and at 5:50 p.m. of the meal service in Memory Lane revealed the staff left the plates, cups, and silverware on the trays when they served the residents.</p> <p>Interview on 6/10/15 at 1:30 p.m. with certified nursing assistant MM revealed she was not sure if they were supposed to leave the trays on the table or not during meals.</p> <p>4. Interview on 6/10/15 at 9:35 a.m. with the dietary manager and registered dietitian revealed staff should not have left the plates, cups, and silverware on the trays when serving meals. They should have taken those items off and set them on the table. Staff should have used regular cups not the soft plastic ones for snacks and all meals.</p>	F 252	<p>The Dietary Manager and/or designee will ensure that all dietary items are removed off the tray while serving the residents during mealtime on the Memory Care Community. The Dietary Manager and/or designee will randomly audit 3 times a week per month during mealtime to ensure all dietary items are removed off the tray while serving the residents during mealtime on the Memory Care Community.</p> <p>The Director of Environmental Services will audit 10 random rooms per month to ensure that the doors close properly and audit all resident common area locations for floor condition. The Director of Environmental Services will bring the door and floor audit to the Monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.</p> <p>The Dietary Manager and/or designee will bring the results of the mealtime audits to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7-16-15	

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F 252	Continued From page 41	F 252			
F 253 SS=D	<p>A homelike environment policy had been requested but had not been provided before the team exited the facility on 6/17/15.</p> <p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, and interview, the provider failed to properly maintain equipment including one of one wall mounted fan in the center wing tub room, two of two randomly observed wheelchairs, and one of one randomly observed EZ stand, in a clean and hazard free manner. Findings include:</p> <p>1. Observation on 6/9/15 at 11:10 a.m. in the center wing tub room revealed a functioning wall mounted fan that had dirty clumps of unidentifiable material hanging throughout the grid on the front of the fan. Some clumps were an inch long.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing and administrator revealed that the fan had been replaced with a new fan.</p> <p>A policy on the maintenance and/or the cleaning of fans was requested. Two policies were received. These were the June 2014 Cleaning and Disinfection of the Resident-Care Items and</p>	F 253	<p>The center wing tub fan was replaced on 6-17-15. All other fans have been cleaned and are on the weekly housekeeping cleaning schedule. The left wheelchair arm for resident #35 was replaced. All other wheelchairs have been inspected, work orders issued and parts ordered on 7-08-15. The Director of Environmental services and/or designee will randomly audit 10 wheelchairs per month for overall condition.</p> <p>All EZ stands were cleaned on July 9, 2015. This is a responsibility of the night shift and was added to the night shift list of responsibilities on 7-09-15.</p> <p>Cleaning the fans is part of the weekly housekeeping checklist. The Director of Environmental services will audit the condition of each fan once a week and the wheelchair condition audit results of the audit to the monthly QAPI meeting for a period of 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15	

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F 253	Continued From page 42 Equipment and the undated Maintenance policy. Neither discussed the cleaning of fans other than "exhaust fans." No other policies were found regarding maintenance and cleaning of fans.  Surveyor: 14477 2. Observation on 6/8/15 at 7:00 p.m. of resident 35's left wheelchair arm revealed the covering was torn and had exposed padding. That made it an uncleanable service and a potential skin tear hazard.  3. Random observation on 6/17/15 in the afternoon of an unidentified resident sitting in her electric wheelchair outside the administrator's office revealed a torn arm rest with exposed padding. The administrator was present at that time when this surveyor pointed it out to him. He immediately requested a staff person make sure a replacement wheelchair arm rest replacement had been ordered.  4. Observation on 6/8/15 at 7:07 p.m. revealed an EZ stand lift with an accumulation of dirt and debris on the foot stand was in the hall by room 212.  Surveyor: 16385 5. Interview on 6/10/15 at 4:15 p.m. with the maintenance supervisor revealed the dirty fans in the center tub room and east shower room were supposed to have been cleaned by the evening nursing staff. Further interview revealed the night shift certified nursing assistants (CNA) were responsible to wash the wheelchairs and EZ lift stand aids.	F 253		7-16-15	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278			

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F 278	<p>Continued From page 43</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure the gerobics (geriatric aerobics) restorative program was coded accurately for 13 of 13 sampled residents (2, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, and 40) who participated in the</p>	F 278	<p>The facility will not utilize gerobics as a restorative option and only as an activity function. The facility will maintain a one to four instructor to resident ratio for other restorative programs. All-staff will be in-serviced on the MDS assessment restorative program regarding the ratios on July 14-15, 2015.</p> <p>The MDS Coordinator will pick 5 random residents on Restorative per week to audit for ensuring that the conditions for restorative program are being met.</p> <p>The MDS Coordinator will bring the results of the audit to the monthly QAPI meeting for a period of 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15
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F 278	Continued From page 44 program. Findings include:  1. Interview on 6/10/15 at 3:05 p.m. and on 6/16/15 at 1:15 p.m. with the activities director revealed: *There had been more than four residents in the gerobic program. *They had not maintained a one-to-four instructor to resident ratio. *They coded residents that were in there Minimum Data Set assessment look back period as being in a restorative program. *She was only able to code four residents in attendance each session of that restorative program. *She was not sure why she was only able to code four residents at a time. Refer to F311.	F 278			
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	The facility care plan policy was updated on July 8, 2015, which includes direction to ensure that care plans are updated regularly to ensure accurate and current information is available for staff to follow through with resident cares. Resident 19 was discharged from our facility. Care plans for residents #11, 2, 10 and 12 have been updated to include current and accurate information. Care plans for all other residents in the facility have been assessed to ensure they include accurate information as well.	7-16-15	

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F 280	<p>Continued From page 45 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans had been updated and revised to reflect the residents current needs for 5 of 16 sampled residents (2, 10, 11, 12, and 19). Findings include:</p> <p>1. Review of resident 11's complete medical record revealed: *She was admitted on 4/22/14. *Her 4/8/15 Minimum Data Set (MDS) assessment revealed: -A Brief Interview for Mental Status assessment that showed her to be aware and able to make decisions. -She needed extensive assistance of one staff member to transfer out of bed and to the bathroom. *Her 4/12/15 comprehensive care plan stated she was unsteady, needed assistance with transfers and activities of daily living.</p> <p>Interview on 6/9/15 at 10:30 a.m. with certified nursing assistant (CNA)/ medication aide W revealed resident 11 transferred into the bathroom by herself. Staff did not assist her.</p> <p>Interview on 6/9/15 at 3:30 p.m. with resident 11 revealed she usually transferred herself to the bathroom.</p>	F 280	<p>Education for all nursing staff on the revised care plan policy and procedure will be conducted by the DON and/or designee on July 14-15, 2015.</p> <p>Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that care plans for residents #11, 2, 10 and 12 include current and accurate information.</p> <p>Five (5) random care plan audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that care plans are updated as needed to ensure they include current and accurate information for 5 random residents as well.</p> <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings to QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15

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F 280	<p>Continued From page 46</p> <p>Review of the undated CNA pocket care plan for resident 11 revealed she needed the assistance of two staff to transfer her.</p> <p>Interview on 6/16/15 at 10:45 a.m. with MDS case manager X regarding resident 11 revealed: *She decided how to code resident care needs based on discussion with staff and reviewing Care Tracker (where the CNAs charted their care for a resident). *She coded based on how the activity was done the majority of time. *"Sometimes the resident transferred herself and sometimes she needed help." *She agreed the comprehensive care plan for resident 11 had not been updated to show she frequently transferred herself to the bathroom nor did the pocket care plan reflect that.</p> <p>Interview on 6/16/15 at 3:30 p.m. with the director of nursing (DON) and the administrator regarding resident 11 revealed they agreed her care plan had not been updated to reflect her current care.</p> <p>Surveyor: 33265 2a. Interviews with CNA LL on 6/10/15 and with resident 10's son on 6/16/15 identified the resident had some lost personal items. Refer to F224 findings 1, 2, 3, and 4.</p> <p>b. Review of resident 10's complete medical record revealed: *He had been admitted on 2/12/15. *He weighed 205.6 pounds (lbs) on admission. *He weighed 177 lbs on 5/19/15, which was a loss of 28 lbs. *He had upper and lower dentures. *He was hard of hearing and used hearing aides. On 3/13/15 a hearing aide was documented as</p>	F 280		7-16-15
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F 280	<p>Continued From page 47 having been in his left ear. *He had a cell phone when he was admitted. The cell phone had gone through the washing machine in the laundry. *He wanted to be a full code (wanted CPR [cardiopulmonary resuscitation]), but was also listed as a "do not resuscitate" (DNR [do not do CPR]). *He was on honey thickened liquids (all liquids to drink were thickened to be like honey) since 6/4/15. *The undated care plan had documented: -He used a hearing aid in his left ear and still had difficulty hearing. Resident 10 had not worn a hearing aide in either ear during the survey. Refer to F 224, Findings 1 and 4. -He needed nectar thickened liquids. That had not been updated to the change to honey thickened liquids. -Stated he wanted to be a full code and a DNR. -Had not included any update on weight loss. -Had not included when the resident was to be weighed. -Had not included the resident had not been using his dentures to eat. -Had not included any update as to the repeated washing and loss of three cell phones. Refer to F224, Findings 1, 3, and 4.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator revealed the DON: *Thought the daily weights had been discontinued. *Would expect the care plan to be updated when changes occurred.</p>	F 280		7-16-15
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IDENTIFICATION NUMBER:  
  
435039

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_  
B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED  
  
06/17/2015

NAME OF PROVIDER OR SUPPLIER  
  
SOUTHRIDGE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE  
3600 SOUTH NORTON AVENUE  
SIOUX FALLS, SD 57105

(X4) ID  
PREFIX  
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(EACH CORRECTIVE ACTION SHOULD BE  
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DEFICIENCY)

(X5)  
COMPLETION  
DATE

F 280

Continued From page 48

F 280

Surveyor: 33488  
3. Review of the medical record for resident 12  
revealed:  
\*He had a tunneled catheter (a special type of  
intravenous line that is placed into a large vein,  
the flexible line is placed under the skin and then  
into the vein) placed on 3/22/15.  
\*His care plan documentation showed "Monitor  
my shunt dialysis fistula [surgically created  
access for dialysis, placed in arm or leg] for signs  
and symptoms of infection, and bruit [sound  
heard when assessing a dialysis fistula] for  
patency."

Interview on 6/11/15 at 9:30 a.m. with MDS case  
manager X regarding resident 12's care plan  
documentation listed above revealed she:  
\*Stated the resident had a fistula in his arm.  
\*Was unaware of where the floor nursing staff  
documented on the assessment for the resident.

Interview on 6/11/15 at 10:00 a.m. with the  
director of nursing regarding resident 12  
revealed:  
\*Nursing staff had not routinely documented bruit  
and thrill. They would only document if something  
was wrong or abnormal.  
\*She was unsure where the fistula was located on  
the resident.  
\*An unidentified staff nurse who was nearby  
remarked the resident had not had a fistula but  
had a tunneled catheter for dialysis access.

Interview on 6/11/15 at 10:30 a.m. with resident  
12 revealed he did not have a fistula. He had a  
tunneled catheter in his right upper chest.

A tunneled catheter would be monitored for signs

7-16-15

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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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F 280	<p>Continued From page 49 and symptoms of infection and whether or not the dressing was intact. The care plan was incorrect for resident 12 at the time of the survey.</p> <p>Surveyor: 32333 4. Review of resident 2's care plan revealed: *Two focus areas documented as pressure ulcers (injury to the skin from prolonged pressure). a. *One of the pressure ulcer focus areas updated on 3/12/15 included the following: -She was at risk for pressure ulcers, because she was frequently incontinent (loss of bladder control) of urine and she had edema (swelling). -During care they were to observe her skin and notify the nurse if there were any areas of concern. -Notify the nurse, family and doctor with any areas that are reddened, opened, or with any unexplained bruising. -Remind the resident to reposition when sitting or lying in one place. -On 3/12/15 her care plan was updated "Area to buttock [bottom] crease open again." -3/12/15 was the last time her care plan had been updated for that focus area. b. *The other focus area documented as pressure ulcers updated on May 2015 included the following: -"I have a pressure ulcer." -Progress toward the healing of the resident's pressure ulcer. -If there were no changes to wound in two weeks seek a different treatment. -If there were no changes in four weeks, seek a consultation to the wound clinic. c. *She had a focus area for pain with the following interventions: -Nursing should assess pain and document it.</p>	F 280		7-16-15
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F 280	<p>Continued From page 50</p> <p>-Encourage the resident to change positions if she was in the same position for more than two hours.</p> <p>*Review of her care plan on 6/16/15 revealed it had not been updated to include her new skin concern noted on 6/10/15. Refer to F314.</p> <p>Review of resident 2's complete medical record revealed:</p> <p>*A 3/12/15 skin assessment report that stated she had a stage II pressure ulcer (open sore) to her buttock crease (no documentation as to the exact location).</p> <p>*A 3/12/15 fax to the physician with the concern of a new stage II pressure ulcer.</p> <p>*On 5/21/15 at 10:30 p.m. a nursing note:</p> <p>-Her coccyx open to air.</p> <p>-DuoDerm (Type of wound dressing) discontinued and area healed.</p> <p>-No areas of concerns.</p> <p>*There was no mention of her pressure ulcer as being healed on her care plan.</p> <p>5. Review of resident 19's fall risk assessment revealed he scored a sixteen which indicated he was at high risk for falls.</p> <p>Review of resident 19's 2/16/15 nursing Kardex (temporary care plan) revealed no mention or interventions for falls.</p> <p>Review of resident 19's nursing notes revealed he had a fall resulting in a left hip fracture on 2/17/15. Refer to F323.</p> <p>6. Interview on 6/16/15 at 2:25 p.m. with the administrator and director of nursing revealed they would have expected care plans to have been complete and updated to reflect the</p>	F 280		7-15-15	

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F 280	Continued From page 51 residents' current status.  Surveyor 33265 Review of the provider's January 2009 Care Plans-Preliminary Policy and Procedure revealed a preliminary care plan was developed on admission to assure the resident's immediate care needs are met and maintained.  Review of the provider's January 2009 Care Plans - Comprehensive Policy and Procedure revealed the comprehensive care plan: *Was to be developed within seven days of the completion of the resident's assessment or within twenty-one days after the resident's admission, whichever came first. *Was to include measurable goals and time tables to meet the resident's medical, nursing, and psychological needs. *Was to be revised as changes in the resident's condition occurred. *Had been designed to: -Identify problem areas. -Identify risk factors associated with the identified problem areas. -Build on resident's strengths. -Identify treatment goals in measurable terms. -Prevent decline in the resident's abilities. -Increase the resident's abilities to function by focusing on a rehabilitation program.	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced	F 281		7-16-15	

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F 281	<p>Continued From page 52</p> <p>by: Surveyor: 14477</p> <p>Based on observation, record review, interview, and policy review, the provider failed to compare medication administration records (MARS) against current physician's orders for route of medication, medication parameters, and monitoring for side effects for antipsychotic (mood altering) medications. Findings include:</p> <p>1. Review of resident 1's medical record revealed he had been admitted on 5/19/15 on tube feedings (nutrition provided through a tube inserted directly into the stomach) and had a physician's order for nothing by mouth (NPO). Review of the June 2015 MAR revealed a 5/19/15 physician's order for "Aspirin EC (enteric coated) 325 milligram (mg) tablet - give 1 tablet by mouth two times daily (0800-1800)."</p> <p>Observation on 6/9/15 in the morning of registered nurse (RN) D revealed she was preparing to crush the Aspirin EC 325 mg to give to resident 1 via his feeding tube. Interview at that time revealed RN D was not aware of a "Do Not Crush List" on the medication cart or in the medication room.</p> <p>Further interview on 6/9/15 at 12:20 PM with RN D revealed she had received a copy of the "Do Not Crush List" from the director of nursing (DON). She confirmed the Aspirin EC should not have been crushed as it was on the list. She confirmed no one had clarified the physician's order to give it by mouth when the resident had a physician's order to be NPO since his 5/19/15 admission.</p>	F 281	<p>The following facility policies: "Writing Orders – General Principles", "Physician Services", "Administering Medications", and "Charting and Documentation Policy" were revised on 7-8-2015 and will be reviewed with facility nurses on July 14-15 2015 to ensure they will be followed appropriately.</p> <p>Audits conducted on numbers F-281 -1, 2 and 3 below will be reviewed as stated to ensure compliance. The DON and/or designee will be responsible for audits and overall compliance. The DON and/or designee will report audit findings at monthly QAPI meetings for 3 months.</p> <p>The physician's order for resident #1's Aspirin EC 325mg tablet BID – give 1 tablet by mouth bid was verified changed to regular Aspirin 325 on 6-09-15 and all medications were changed to PO on 6-11-15. Resident #10's order for metoprolol tartrate 25mg bid which included parameters to check heart rate and blood pressure was verified on 7/10/15. Resident #6's physician order for side effect follow up on prescribed Seroquel medication was verified on 7/10/15. Physician's orders for all other residents receiving medication per tube feeding were reviewed to ensure they were accurate and medications were given as ordered.</p>	7-16-15

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F 281	Continued From page 53  Surveyor: 33265 Review of resident 10's complete medical record revealed: *A physician's order written on 2/12/15 for metoprolol tartrate (medication for high blood pressure) 25 mg to be given twice a day. The physician's order included parameters (directions on what resident conditions were to have been checked) for giving the medication. These were: -Do not give medication if heart rate (HR) was less than sixty beats per minute. -Do not give medication if systolic blood pressure (upper number of blood pressure [B/P] reading) was less than one hundred. *The April 2015 pharmacy consultation report, signed by the pharmacist on 4/9/15, and by the registered nurse X on 4/24/15 revealed the pharmacist was unable to locate documentation that a B/P and HR were recorded before each dose to determine if the medication should have been given or not given. *The MAR revealed: -During February and March 2015 there was no documentation of B/P or HR recorded before the medication was given. -During April 2015, from the first through twenty-third, there was no documentation for the B/P or HR. -On 4/24/15 the physician's order was noted to have been rewritten. -The rewritten physician's order had identified spaces for the B/P and HR to be written in for both doses of the medication. The B/P was not filled in for April 24, 25, and 26, 2015. -During May 2015 there was a space for the B/P for the morning dose, and places for both the B/P and HR for the afternoon dose. There was no	F 281	Physician's orders for all other residents on medications that need side effect follow up were assessed to ensure the proper side effect follow-up stickers are in place. The facility policies listed above were all revised as listed above. The DON will provide education on all of the above policies to all nursing staff on July 14-15 2015. Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that residents #1 and 6 and on five random residents with tube feeding medications and on five random residents receiving medication that need side-effect follow up to ensure that the physician's orders are being followed appropriately for each. The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings to QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.	7-16-15	

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F 281	<p>Continued From page 54</p> <p>space for the heart rate to have been checked and documented before the morning dose was given.</p> <p>-During June 2015 there were spaces for both the B/P and HR to have been written in for each dose of the medication.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator revealed the DON would expect the physician ordered parameters for when to give or not give a medication would have been measured and recorded before the medication was given.</p> <p>Review of the provider's 10/28/13 Medication Orders policy revealed physicians could specify actions that were to have been taken prior to administering a medication.</p> <p>Review of Patricia A Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, pp. 305 revealed: "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients." "The nurse is responsible for transcribing written orders correctly."</p> <p>Surveyor: 35625 3. Review of resident 6's medical record revealed: *His physician had prescribed Seroquel (an antipsychotic medication used to clear thoughts) 25 mg on 5/4/15 to have been taken three times a day. *The medication administration record (MAR) for May 2015 contained documentation that the</p>	F 281		7-16-15	

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F 281	<p>Continued From page 55</p> <p>provider monitored for side effects from the medication on each shift while the resident was in the facility.</p> <p>*In reviewing the June 2015 MAR, there was no documentation for the presence of side effects for Seroquel from June 1 through June 10, 2015.</p> <p>*Side effects being monitored for the use of the Seroquel were:</p> <ul style="list-style-type: none"> <li>-Sedation.</li> <li>-Dry mouth.</li> <li>-Constipation.</li> <li>-Blurred vision.</li> <li>-Weight gain.</li> <li>-Extrapyramidal effects (abnormal body movements).</li> <li>-Postural hypotension (drop in blood pressure when standing up).</li> <li>-Decreased appetite.</li> <li>-Urinary retention.</li> </ul> <p>*Stickers were used to monitor for side effects.</p> <p>-These stickers include the potential side effects for specific types of medication.</p> <p>Interview on 6/16/15 at at 9:15 a.m. with registered nurse (RN) M regarding the placing of the stickers on the MAR revealed:</p> <p>*The monitoring stickers for psychoactive medications were to have been placed on the chart by overnight nursing staff prior to the start of a new MAR at the beginning of each month.</p> <p>*All medications on the MAR should have been reviewed by the nursing staff to verify the resident continues to be prescribed the medication.</p> <p>*She could offer no explanation as to why the monitoring stickers had not been placed on the June 2015 MAR.</p> <p>Interview on 6/16/15 at 2:40 p.m. with the DON regarding the process for monitoring of side</p>	F 281		7-16-15	

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F 281	Continued From page 56 effects revealed she: *Acknowledged the process was for the overnight nurses to review and prepare the MARs for the start of the month. -That included placing the monitoring stickers on each MAR when the resident was prescribed an antipsychotic *Verified there was no monitoring sticker placed on the June 2015 MAR for the side effects of Seroquel for resident 6. *Acknowledged the staff had not been monitoring for side effects for June 2015.	F 281			
F 309 SS=H	Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 350, revealed, "Common charting mistakes include...failing to record pertinent health and drug information." <b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 A. Based on observation, record review, interview, and policy review, the provider failed to perform tasks of daily living (toileting), implement individualized interventions, and appropriately assess and document skin breakdown for three	F 309	The facility Pressure Ulcer/Skin Breakdown protocol was revised on 7-06-15. The new protocol will be implemented on residents #10 and #25 on 7-13-15. All other residents in the facility were assessed on 7-06-15 to ensure skin was intact and to begin the revised protocol on 7-13-15. All nursing staff will be inserviced on the revised Pressure Ulcer/Skin Breakdown protocol on July 14-15, 2015. The facility is actively setting up an outside wound care specialist to in-service the nursing staff regarding pressure ulcer/skin breakdown prevention within the next 30 days.	7-16-15	

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F 309	<p>Continued From page 57 of three sampled residents (10, 18, and 25) who needed assistance with toileting resulting in skin breakdown. Findings include:</p> <p>1. Interview on 6/10/15 between the timeframe of 2:30 p.m. and 3:30 p.m. with resident 25's daughter revealed she:</p> <ul style="list-style-type: none"> <li>*Visited almost everyday.</li> <li>*Felt her mother was taken to the bathroom too late sometimes.</li> <li>*Purposely did her mother's laundry to see how wet her clothes were from being incontinent.</li> <li>*Had a system where staff were to put wet clothes into one laundry bag and dry clothes into the other but staff had not followed it.</li> <li>*Stated the clothes were consistently very wet.</li> <li>*Stated her mother had skin breakdown on her bottom which healed about one month ago.</li> </ul> <p>Review of resident 25's skin assessment report revealed on 2/18/15 she had developed a superficial skin abrasion to her bottom. The contributing factor was incontinence.</p> <p>Review of resident 25's 4/30/15 Minimum Data Set (MDS) assessment revealed she was frequently incontinent of bladder (urine). She needed extensive assistance of two plus staff members for toileting. Her mental status score (thinking ability) was 0 meaning her thinking was severely impaired.</p> <p>Review of resident 25's 2/11/15 care plan revealed:</p> <ul style="list-style-type: none"> <li>*Urinary incontinence had been identified as a focus area on 8/26/14.</li> <li>*Interventions included:</li> <li>- "Assist me to the toilet before and after meals, at bedtime, and every couple of hours at night."</li> </ul>	F 309	<p>Audits will be conducted weekly for 1 month and then monthly for 3 months on residents #10 and #25 and on all residents found to have skin issues on the facility wide assessment process to ensure skin protocol is being followed appropriately. A new skin integrity team has been created and meet weekly to assess, monitor and document all pressure related skin concerns.</p> <p>The DON and/or designee will be responsible for ensuring compliance and audit findings will be reported by the DON at the monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p> <p>The facility bathing policy and procedure was reviewed on 7-06-15. All nursing staff will be educated by the DON on the new bathing policy and procedure on July 14-15, 2015. Residents #3,29,36,38,53,54,55,56,57 and 58 records and all other residents in the facility were reviewed on July 9, 2015 to ensure that they had received a bath during the week. A daily bathing record was implemented to assist the assigned bath aide with documenting baths or showers appropriately. Caretracker charting has been modified to include scheduled baths.</p> <p><i>[Redacted]</i></p> <p><i>[Redacted]</i> The Unit Coordinators and/or designee will be responsible for ensuring the or shower given as well as not given. If the residents preference for a bath or shower is not honored, the reason will be indicated and documented on the Care-tracker.</p> <p><i>sc/soan/jt</i></p>	7/16/15
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F 309	<p>Continued From page 58</p> <p>"If I am anxious, ask me if I need to use the toilet."</p> <p>-On 11/16/14 toilet every two hours while awake, at 12:01 a.m. and between 5:00 a.m. and 6:00 a.m. had been added.</p> <p>-On 11/19/14 "I want to be kept clean and dry throughout our next meeting" had been added.</p> <p>*There were no other interventions added for urinary incontinence after 11/19/14.</p> <p>*There had been no documentation on the care plan regarding the documented 2/18/15 skin abrasion.</p> <p>Interview on 6/10/15 between the timeframe of 2:30 p.m. and 3:30 p.m. with certified nursing assistant (CNA) II revealed some residents who needed assistance with toileting are "soaked" in the morning when she gets to work. She defined "soaked" as meaning the bed and her clothes had been wet. She stated the overnight staff did not always toilet residents, especially those that may have behaviors or are more difficult.</p> <p>Interview on 6/16/15 at 2:30 p.m. with CNA NN regarding resident 25 revealed:</p> <p>*The resident was dependent on staff for most care.</p> <p>*She was to have assistance from one staff person for toileting.</p> <p>*Sometimes when she arrived at work in the morning the resident was "really wet."</p> <p>-When asked to explain what really wet meant she replied, "The bed, her clothes, and everything."</p> <p>*She did not think the overnight staff always toileted her.</p> <p>*She felt they did not change her because they were short staffed or because sometimes the resident would fight with staff.</p>	F 309	<p>bath aides get their daily baths completed and documented. Weekly audits will be conducted by the Unit Coordinators and/or designee weekly for one month and then monthly for 3 months on the residents listed above as being deficient during the survey and on 10 random residents in the facility to ensure compliance. The DON and/or designee will be responsible for overall compliance and will present audit findings at the monthly QAPI meeting for 1 year.</p> <p>The facility hospice policy and procedure was revised on 7-06-15 to include how to incorporate the hospice agency care plans into the facility's care plans. All facility nursing and social service staff will be educated on this new policy and procedures on July 14-15, 2015 by the DON.</p> <p>Resident # 14 and 15 care plans have been updated to ensure they have been updated per the new facility policy. Care plans for all other residents in the facility on hospice have been updated to ensure they are in compliance with the new policy as well. Audits will be conducted weekly for 1 month and then monthly for 3 months on the hospice care plans for residents #14 and 15 and on five random hospice residents.</p>	7-16-15	

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F 309	<p>Continued From page 59</p> <p>Interview on 6/16/15 at 2:15 p.m. with the director of nursing revealed: *CNAs did not document every time they assisted the resident with toileting. They would document one time during their shift. *There was no documentation to verify staff had been toileting her "before and after meals, at bedtime, every couple of hours at night" or "every two hours while awake, at 12:01 a.m., and between 5:00 a.m. and 6:00 a.m." *There had been no updated interventions on the care plan.</p> <p>A toileting policy had been requested on 6/11/15 but had not been received by the time the survey team had exited on 6/17/15.</p> <p>Review of the provider's 11/13/14 Bowel and Bladder Assessment Policy revealed: *Residents would achieve their highest possible level of bowel and bladder function. *Each resident would be assessed for bowel and bladder incontinence upon admission, re-admission, annual review, and with significant changes. *The bladder screening sheet should have been completed by staff for three days to provide information on potential patterns of incontinence. *The nurse was to implement an individualized toileting plan based on the information obtained. *The care plan should have included goals and interventions.</p> <p>Surveyor: 33265 2. Observation and interview on 6/10/15 at 1:00 p.m. with CNA II during resident 10's care after toileting with assistance from CNAs II and JJ revealed:</p>	F 309	<p>These audits will be conducted by the DON and/or designee who will also be responsible for overall compliance. Audit findings will be reported at the monthly QAPI meetings by the DON and/or designee for 1 year.</p>	7-16-15

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F 309	<p>Continued From page 60</p> <p>*Both sides of his buttocks were bright pink and dry with cracks in the skin at the outer edges of the bright pink area.</p> <p>*There was a small open area (top layer of skin was gone) on the upper right buttock.</p> <p>*There was an area the size of a quarter on the back side of the upper left thigh with small dark brown scabbed areas throughout.</p> <p>-CNA II stated she had not known of the scabbed area on the upper left thigh.</p> <p>*There were several small open areas on the back side of the scrotum. Those areas were open, red inside, and about half the size of a pencil eraser.</p> <p>-CNA II stated these were from his constant dribbling of urine.</p> <p>-He had dribbling of urine during the time of the assessment.</p> <p>*When asked how those areas were being cared for CNA II replied they were to use a cream on the scrotum and buttocks.</p> <p>-The Calmoseptine cream (a moisture barrier) that had been in the resident's room was applied in a thick layer over both sides of the buttocks, the back side of the upper left thigh, and the back side of the scrotum.</p> <p>Review of resident 10's complete medical record revealed:</p> <p>*From 2/28/15 to 4/11/15 the skin was documented as intact with no areas of concern.</p> <p>*On 4/13/15 the groin area was pink.</p> <p>*On 4/14/15 there was an open area on the right upper buttocks and the family and the physician were notified.</p> <p>-"Moisture cream applied to area."</p> <p>-No time was documented.</p> <p>*On 4/14/15 the Skin Assessment Report had documented an open area on the upper right</p>	F 309		7-16-15	

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F 309	<p>Continued From page 61</p> <p>buttocks with "sitting in urine" listed as a causal or contributing factor.</p> <p>-The diagram to identify the location of the skin concern had an "X" over the left groin.</p> <p>*On multiple dates the wound was tracked on a Non-Pressure Skin Condition Report form and was identified as a "skin tear".</p> <p>-The intervention started was listed as a "moisture barrier."</p> <p>*On 4/27/15 the left ischial crease (skin fold at bottom of buttocks and top part of thigh) was documented as a new area of concern.</p> <p>*On 4/27/15 the Skin Assessment Report identified friction from briefs as a causal or contributing factor.</p> <p>-Skin was described as sheared.</p> <p>*On 5/4/15 there were no new areas of concern noted; wounds to buttocks "not improving much".</p> <p>*No physician's order or nursing order for the use of the Calmoseptine cream was found.</p> <p>*Calmoseptine cream was not documented on the treatment administration record.</p> <p>Review of the undated manufacturer's instructions stated to apply Calmoseptine in a thin layer.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator revealed the DON:</p> <p>*Had not seen resident 10's open skin area.</p> <p>*Was not aware a barrier cream was being used on resident 10's open skin areas.</p> <p>Surveyor: 14477</p> <p>3. Review of resident 18's closed medical record revealed an admission skin assessment had been completed on 7/3/14 with no skin concerns</p>	F 309		7-16-15

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F 309	Continued From page 62 noted on buttocks, coccyx, or heels. Review of his 7/4/14 nursing note revealed he had been a total assist for all ADLs (activities of daily living), was incontinent of both bladder and bowel, and wore incontinent products. Further review of the Interdisciplinary Progress Notes revealed on: *7/11/14 - Admission MDS (Minimum Data Set is an assessment tool) revealed a: -Braden (a skin assessment tool) score of 13 (at risk for skin breakdown). -Pressure reducing mattress was to have been on his bed at all times. -Pressure reducing cushion was to have been in the wheelchair when he was in it. *9/9/14- At 11:15 a.m. the nutrition documentation revealed "a Braden score of 13 and coccyx may be red." A nursing note on that same day at 5:16 p.m. stated a half-dollar size red area was noted on the lower coccyx, but was not open. *9/24/14 - A nutrition note indicated his skin did not have a pressure ulcer per nurse and the skin team notes had been reviewed. *10/7/14 - The care plan conference record revealed the family was concerned the resident was not getting a bath 3 times a week as expected. *11/6/14 - A new skin concern of an open area 1 centimeter (cm) x 1 cm on the inner aspect of butt cheek had been documented. The physician was notified and an order received for Calmoseptine (moisture barrier ointment). The area was also documented on a non-pressure skin condition report and was noted as incontinence skin break down. *11/7/14 - On a weekly pressure ulcer record the coccyx was noted to have been a stage II ulcer (an open sore in the top layer of the skin) measuring 1.0 cm x 1.0 cm. Risk factors/cause were noted to have been diabetes and	F 309		7-16-15	

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F 309	Continued From page 63 incontinence. *11/14/14 - On the weekly pressure ulcer record the coccyx was noted to be a stage 1 (reddened area without being open) and was 0.5 cm x 0.5 cm. *11/21/14 - The weekly pressure ulcer record stated the coccyx area was healed but a new area was observed. The non-pressure skin condition report stated the inner buttocks cheek area was healed. *11/21/14 - The skin assessment revealed a new open area on the inner lower aspect of buttocks cheek measuring 2 cm x 2 cm. Incontinence had been listed as a causal or contributing factor. *11/29/14 - The nutrition notes indicated nursing assessments had documented an open area from incontinence; the nutrition team discussed it was a closed area; but a voice mail message left for dietary by nursing stated it was an open area. There was no change regarding extra protein until clarification of the skin condition had been received. The resident's family had been made aware of the open areas. *12/8/14 -Licensed Nurses Notes stated the DuoDerm (type of wound dressing) had been replaced on the coccyx when there was no documentation of a start date for the DuoDerm. *12/21/14- Licensed Nurses Notes stated the DuoDerm dressing had been reapplied to the reddened coccyx. *12/23/14 - The nutrition notes indicated the pressure area was healed. *1/5/14 (should have been 2015) - Licensed Nurses Notes stated the coccyx area was pink and intact and DuoDerm had been used for protection of fragile skin.  Surveyor: 32333 B. Based on observation, interview, record	F 309			7-16-15

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F 309	<p>Continued From page 64</p> <p>review, and policy review, the provider failed to ensure one of one sampled resident (3), 1 randomly interviewed resident (29), and 8 randomly reviewed residents (36, 38, 53, 54, 55, 56, 57, and 58) that resided in Center hall had received scheduled baths/showers and accurate documentation of when baths/showers were given had been kept.</p> <p>1. Review on 6/10/15 of resident 3's Bath Type Detail Report revealed she had not had a bath since 5/31/15.</p> <p>Review of resident 3's May 2015 care plan for activities of daily living function/incontinence revealed: *She is always incontinent of bowel and bladder. *She would like to be kept clean and dry.</p> <p>Interview on 6/10/15 at 9:45 a.m. with CNA OO who is also a full-time bath-aide revealed: *There were usually three CNA's including the bath-aide that worked on Center Hall. *She would get pulled from giving baths to help the other CNA's. *3 CNA's were not enough for this many residents. *There were more than forty residents on Center hall. *Sometimes there was only one CNA on night shift. *Baths do not get done everyday. *Some of yesterdays baths had been done. *Last nights scheduled baths had not been done. *There were a lot of wet beds and urine soaked residents in the mornings.</p> <p>Interview on 6/9/15 at 11:40 a.m. with CNA EE revealed there were two to three CNA's during</p>	F 309		7-16-15

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F 309	<p>Continued From page 65</p> <p>the day to approximately forty-seven residents. Sometimes baths did not get done and they were moved to the next day. They usually had nine baths on Mondays, and about twelve to thirteen on Wednesdays and Thursdays. Sometimes they would have to change three to four urine soaked beds in the mornings when they got to work.</p> <p>Interview on 6/10/15 at 1:55 p.m. with CNA EE revealed the bath logs that were kept in the bath house were inaccurate. The bath log in the computer should have been more accurate. When a resident was given a bath even if it was after their scheduled bath day, they would still document that the bath was given on their scheduled day. Sometimes they would put the correct date of the bath behind the residents names on the bath logs that were kept in the bath house. There was not consistent documentation.</p> <p>Review of the Center bathing log from 6/8/15 through 6/11/15 revealed: *On 6/9/15 resident 53 was scheduled for bath. *Resident 53 was moved to the next day on 6/10/15. *On 6/9/15 resident 54 was scheduled for a bath. *There was no documentation for resident 54 on 6/9/15 they had received a bath. *On 6/10/15 resident 36 was moved to 6/11/15.</p> <p>Review of the Bath Detail Report from 6/8/15 through 6/11/15 revealed: -Resident 53: -On 6/9/15 at 10:16 a.m. it was documented she received a shower. -On 6/10/15 at 2:27 p.m. it was documented she received a whirlpool bath. *Resident 54: -On 6/10/15 at 8:27 a.m. it was documented she</p>	F 309		7-16-15	

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F 309	<p>Continued From page 66</p> <p>received a shower.</p> <p>-On 6/11/15 at 9:51 a.m. it was documented she received a whirlpool bath.</p> <p>-On 6/11/15 at 10:28 a.m. it was documented she received a shower.</p> <p>*Resident 55:</p> <p>-On 6/11/15 at 10:01 a.m. it was documented he received a shower.</p> <p>-On 6/11/15 at 11:18 a.m. it was documented he received a whirlpool bath.</p> <p>*Resident 38:</p> <p>-On 6/8/15 at 5:49 a.m. it was document he received a whirlpool bath.</p> <p>-On 6/8/15 at 6:50 a.m. it was documented he received a shower.</p> <p>*Resident 56:</p> <p>-On 6/9/15 at 10:10 a.m. it was document he received a shower.</p> <p>-On 6/10/15 at 2:27 p.m. it was documented he received a whirlpool bath.</p> <p>*Resident 57:</p> <p>-On 6/11/15 at was documented she received a shower at 9:06 a.m. and 9:46 a.m.</p> <p>*Resident 58:</p> <p>-On 6/9/15 at 10:15 a.m. it was documented she received a shower.</p> <p>-On 6/10/15 at 2:27 p.m. it was documented she received a shower.</p> <p>Surveyor: 33265 Interview on 6/11/15 at 9:00 a.m. with resident 29 revealed "there was no time for my shower this morning. Maybe I will get it this afternoon. Otherwise I will have to wait until tomorrow. That happens all the time."</p> <p>Surveyor: 32333 Interview on 6/16/15 at 9:05 a.m. with CNA OO who was also a full-time bath aide revealed:</p>	F 309		7-16-15

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F 309	<p>Continued From page 67</p> <ul style="list-style-type: none"> <li>*The Bath Detail Reports were not accurate.</li> <li>*Instead of just the bath-aide documenting that a resident would get a bath or shower all the CNA's would document it.</li> <li>*The charting would be inaccurate.</li> <li>*There was no way to know from their documentation if or when a resident received a shower or whirlpool bath.</li> <li>*There was just not enough staff to get all the cares done.</li> </ul> <p>Interview on 6/16/15 at 2:25 p.m. with the director of nursing and administrator revealed:</p> <ul style="list-style-type: none"> <li>*They would have expected baths and showers to have been completed the day they were scheduled.</li> <li>*They would have expected documentation to have been accurate and timely.</li> </ul> <p>Review of the revised October 2010 Shower/Tub policy/procedure revealed:</p> <ul style="list-style-type: none"> <li>*"The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the residents skin."</li> <li>*The following information should have been recorded on the residents activities of daily living and/or in the medical record: <ul style="list-style-type: none"> <li>-The date and time the shower/tub bath was performed.</li> <li>-The name and title of the individual who assisted the resident with the shower/tub bath.</li> <li>-All assessment data obtained during the shower/tub bath.</li> <li>-How the resident tolerated the shower/tub bath.</li> <li>-If the resident refused the shower/tub bath, the reason why, and the intervention taken.</li> <li>-The signature and title of the person recording the data.</li> <li>-Notify the supervisor if the resident refuses the</li> </ul> </li> </ul>	F 309			7-16-15

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F 309	<p>Continued From page 68 shower/tub bath.</p> <p>Surveyor: 34030 C. Based on record review, interview, and policy review, the provider failed to combine the hospice plan of care with the provider's plan of care to specify who was responsible for care for two of three sampled hospice residents (14 and 15). Findings include:</p> <p>1. Review of resident 14's medical record revealed an admission on 8/9/14. Hospice care had started 5/22/15.</p> <p>Review of resident 14's current 2/12/15 provider's care plan revealed: *It was located in a Care Plan binder with the hospice agency's care plan placed behind it. *No mention was made on the provider's care plan to show who was responsible for what care the resident was to receive.</p> <p>Interview on 6/16/15 at 3:30 p.m. with the DON and administrator revealed they were unaware of the need to specify provider and hospice care for residents. No hospice specific policy on resident care plans existed.</p> <p>Surveyor: 32331 2. Review of resident 15's medical record revealed: *She had been admitted on 6/4/15. *She was currently on hospice care and had been receiving hospice services at another facility. *A 6/3/15 physician's order for hospice care for "No change in level of care at this time only change of location."</p> <p>Review of resident 15's undated care plan</p>	F 309		7-16-15	

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F 309	<p>Continued From page 69</p> <p>revealed:</p> <p>*No interventions that had included hospice care.</p> <p>*It had not:</p> <p>-Addressed why she was on hospice.</p> <p>-Identified the services and what care was to have been provided by the provider and by hospice.</p> <p>Interview on 6/10/15 at 2:40 p.m. with registered nurse (RN) A regarding resident 15 revealed:</p> <p>*The provider had not combined hospice care plans into her care plans.</p> <p>*She had been unaware the hospice care plans needed to have been combined into the provider's care plan.</p> <p>*She agreed the hospice care plan needed to have been combined into the provider's care plan.</p> <p>Interview on 6/10/15 at 2:55 p.m. with certified nursing assistant (CNA) B regarding resident 15 revealed:</p> <p>*She had been unaware she was on hospice.</p> <p>*She had not known what services hospice were to have provided.</p> <p>Interview on 6/10/15 at 3:00 p.m. with the director of clinical services at the hospice agency regarding resident 15 revealed:</p> <p>*They had not combined hospice care plans into the provider's care plans.</p> <p>*It was the responsibility of the provider to integrate the care plan provided by the hospice agency into the provider's care plan.</p> <p>*She stated there was a hospice plan of care for her, and that she would send it to the facility.</p> <p>*She agreed the plan of care needed to have been available and combined into the provider's care plan.</p>	F 309		7-16-15	

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F 309	<p>Continued From page 70</p> <p>Interview on 6/10/15 at 4:10 p.m. with CNA PP regarding resident 15 revealed she:</p> <ul style="list-style-type: none"> <li>*Had been aware she was on hospice because she had assisted with her admission on 6/4/15.</li> <li>*Stated "It would have been nice" to have had more information regarding her hospice care.</li> <li>*She was not aware what services hospice was to have provided.</li> </ul> <p>Interview on 6/10/15 at 4:40 p.m. with the DON regarding resident 15 revealed she:</p> <ul style="list-style-type: none"> <li>*Agreed they did not have her facility care plan combined with the hospice one.</li> <li>*Confirmed the provider's care plan needed to have been combined with the hospice one and followed.</li> </ul> <p>3. Review of the provider's January 2009 Care Plans - Preliminary policy revealed to ensure the resident's immediate care needs were met and maintained a short-term care plan was to have been developed on admission.</p> <p>Review of the provider's January 2009 Care Plans-Comprehensive policy revealed:</p> <ul style="list-style-type: none"> <li>*The provider developed a comprehensive care plan for each resident to meet the resident's medical, nursing, and psychological needs.</li> <li>*The above comprehensive care plan had been designed to: <ul style="list-style-type: none"> <li>-Incorporate identified problem areas.</li> <li>-Incorporate risk factors associated with identified problems.</li> <li>-Build on the resident's strengths.</li> <li>-Reflect treatment goals and objectives in measurable outcomes.</li> <li>-Identify the professional services responsible for each element of care.</li> <li>-Prevent decline in the resident's functional status</li> </ul> </li> </ul>	F 309		7-16-15	

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F 309	Continued From page 71 and levels (the measure and levels of a person's ability to perform activities of daily living independently).  Review of the provider's revised 7/25/12 Agreement for Nursing Home Services revealed: *The provider and hospice were to have developed a combined care plan for each hospice resident. *Hospice was to have provided the facility with a copy of any existing care plan upon admission. *If a care plan had not been developed prior to that admission: -Hospice was to have prepared a care plan for that resident within two working days. -And have delivered a copy to the provider. *The provider and hospice were to have worked together to: -Facilitate cooperative efforts between the provider and hospice in providing appropriate care for residents admitted to hospice. -Ensure that care for hospice residents was in compliance with the hospice plan of care.	F 309			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS  A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and record review the provider failed to maintain an effective restorative program for 13 of 13 sampled residents (2, 29, 30, 31, 32, 33, 34, 35, 36, 37,	F 311	The facility will not utilize gerobics as a restorative option and only as an activity function.  The facility will maintain a one to four instructor to resident ratio for other restorative programs. All-staff will be in-serviced on the MDS assessment restorative program regarding the ratios on July 14-15, 2015.  The MDS Coordinator will pick 5 random residents on Restorative per week to audit for ensuring that the conditions for restorative program are being met.	7-16-15	

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F 311	<p>Continued From page 72</p> <p>38, 39, and 40) who participated in the gerobics (geriatric aerobics) program. Findings include:</p> <p>1. Review of the activities with staff detail report from 6/8/15 through 6/13/15 revealed there had been more than four residents in the gerobics program with only one instructor.</p> <p>Observation on 6/9/15 and on 6/10/15 of the gerobics program held in the center dining room revealed it had one instructor for more than four residents.</p> <p>Review of the activities for staff detail reports for gerobics revealed: *On 6/9/15 there were 15 residents in attendance. *On 6/10/15 there were 14 residents in attendance.</p> <p>Interview on 6/10/15 and on 6/16/15 at 3:05 p.m. with the activities director revealed: *There were fifteen residents that attended the gerobics program for restorative therapy. *Nine of those residents went to gerobics today. *She was only able to code four residents for restorative therapy although many more residents attended. *She was unsure why they were only able to code four residents. *They charted attendance in a restorative program for whoever happened to be in their Minimum Data Set (MDS) assessment look back period. *All of the residents were welcome to come to gerobics. *One or two staff usually instructed gerobics. *The week of 6/8/15 through 6/13/15 there was only one staff member working to instruct gerobics.</p>	F 311	The MDS Coordinator will bring the results of the audit to the monthly QAPI meeting for a period of 1 year and then as deemed necessary by the QAPI committee.	7-16-15	

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F 311	Continued From page 73 *On 6/16/15 she was the only instructor for gerobics.  Review of the list of residents on the undated, unlabeled list of residents that attended the gerobics restorative care program included thirteen residents.  Interview on 6/16/15 with the administrator and director of nursing revealed they agreed the gerobics program should have had a one-to-four instructor to resident ratio to be coded as a restorative program to ensure residents receive optimal care.  Review of the provider's 5/21/14 Restorative Nursing Care policy revealed "The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence."	F 311		7-16-15	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488	F 314	The facility pressure ulcer/skin breakdown policy and procedure was revised on 7-02-15. New skin protocol was implemented for resident #2 on 6/10/15. The resident received an overall skin assessment by unit nurse and Clinical Coordinator and was appropriately documented. Orders were obtained from the physician and a new treatment initiated on that day. All other residents in the facility were assessed on 7/6/15. To ensure skin is intact, new skin protocol was implemented on every resident that had skin issues.		

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F 314	<p>Continued From page 74 Surveyor: 32333 Based on observation, interview, record review, plan of correction review from the survey on 9/11/14, job description review, and policy review, the provider failed to appropriately identify, notify, assess, provide treatment, and care plan a pressure ulcer for one of one sampled resident (2) who was at risk for pressure ulcers. Findings include:</p> <p>1. Review of resident 2's complete medical record revealed: *She was admitted on 11/16/10. *There was multiple documentation of pressure ulcers since her admit. *There was multiple conflicting documentation of pressure ulcers on different areas of her body. *Her most recent documented pressure ulcer had been identified on 3/12/15. *On 5/21/15 there was a nursing note that the area was healed. *There was no way to know if the resident had a pressure ulcer currently or not because of conflicting documentation.</p> <p>Random observations on 6/9/15 of resident 2 from 8:45 a.m. through 10:33 a.m. while she was seated in the center dining room revealed: *At 8:45 a.m. she was sitting in her wheelchair at the dining room table with her breakfast in front of her on the table. *At 9:49 a.m. she was seated at the dining room table in her wheelchair with her head down. *At 10:00 a.m. she called out "Someone help me please" several times with no staff response. *At 10:10 a.m. she called out "I need to use the toilet" with no staff response. *At 10:33 a.m. she was still seated in her wheelchair at the dining room table with her head</p>	F 314	<p>All CNAs/Medication Aides and nurses will be educated by the DON on the new skin policy on July 14-15, 2015. The facility toileting and repositioning policies were revised on 7/6/15. All nursing staff will be educated on the new toileting and repositioning policy by the DON on July 14-15, 2015. Resident #2 was placed on the facility toileting/repositioning program on 6/10/2015. All other residents in the facility will be assessed to determine if they need to be placed on the facility toileting and repositioning program if deemed necessary. Weekly audits will be conducted on resident #2's toileting and repositioning program along with 10 other residents on the toileting and repositioning programs for one month and then monthly for 3 months. The assessments and audits will be conducted by the DON and/or designee. The DON and/or designee will report the audits to the monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee. All nursing staff will be educated by an outside wound care specialist on the skin policy on July 14-15, 2015.</p>	7-16-15	

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F 314	Continued From page 75 down. *Dietary staff had been in and out of the dining room while she was calling for help. *No nursing staff were present in the dining room.  Observation on 6/9/15 at 10:45 a.m. of resident 2 in her room revealed certified nursing assistant (CNA) EE and FF were helping her use the toilet.  Interview on 6/9/15 at 10:55 a.m. with resident 2 while she was in her recliner in her room revealed: *The questions asked were written due to her hearing impairment with some of her answers being verbal. *She stated "I have a sore on my bottom [left buttock] and it hurts." *When asked if she was toileted enough she wrote on a piece of paper "It depends on who is working."  Interview on 6/9/15 at 11:15 a.m. with CNA EE regarding resident 2 revealed: *After meals they were supposed to toilet the resident and lay her down. *She had a reddened area on her bottom, but it was not opened. *She complained her bottom was sore when she was toileted.  Interview on 6/9/15 at 11:15 a.m. with CNA FF regarding resident 2 revealed there was no reddened areas on her bottom.  Interview on 6/9/15 at 11:20 a.m with registered nurse (RN) BB revealed she had not heard that resident 2 had a sore on her bottom nor had she heard of any reddened areas on her bottom.	F 314		7-16-15

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F 314	<p>Continued From page 76</p> <p>Review of resident 2's 6/7/15-6/9/15 bowel and bladder detail report revealed: *On 6/7/15 she was toileted at: -12:31 a.m. -10:18 a.m. -2:51 p.m. *On 6/8/15 she was toileted at: -12:48 a.m. -1:41 p.m. -8:48 p.m. *On 6/9/15 she was toileted at: -11:52 p.m. -9:47 a.m. (The observation of resident 2 being toileted was 10:45 a.m. on this date). -9:30 p.m.</p> <p>Record review on 6/10/15 of resident 2's medical record revealed no documentation regarding her 6/9/15 complaints of a sore on her bottom or a pain assessment.</p> <p>Observation and interview on 6/10/15 at 9:00 a.m. while CNA EE toileted resident 2 revealed: *She had a reddened area on her left buttock (bottom). *The CNA stated she would notify the nurse on duty.</p> <p>Observation and interview on 6/10/15 at 11:00 a.m. with MDS case manager X and HH of resident 2's left buttock revealed: *A reddened area with several pinpoint open areas. *A scant amount of blood was noted on her incontinence (loss of bowel and bladder control) brief. *They stated they were unsure if it was a pressure ulcer or an incontinence ulcer. *The resident does sit in her chair a lot.</p>	F 314		7-16-15

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F 314	<p>Continued From page 77</p> <p>Interview on 6/10/15 at 11:25 a.m. with the director of nursing (DON) and licensed practical nurse (LPN) O regarding resident 2's left buttock assessment revealed:                      *LPN O stated "Its just red" when asked if she had assessed the resident's bottom.                      *LPN O had not documented the assessment yet.                      *There was no wound care nurse at the facility, however MDS coordinator HH used to be the wound care nurse.                      *LPN O had asked the CNAs to apply a barrier cream on her bottom.</p> <p>Review of the following documentation on 6/11/15 regarding resident 2 revealed:                      *A nursing note on 6/10/15 at 7:30 p.m. stated "New skin concern on bottom see NPSCR [Non-pressure skin condition report]."                      *NPSCR:                      -Left buttock redness.                      -The size was documented as pinpoint.                      -Provon (skin barrier cream) was placed.                      *Review of resident 2's 6/10/15 skin assessment report revealed:                      -The location of the new skin concern was on the left buttock.                      -The contributing factor was incontinence.                      -The skin concern was redness and a pinpoint area open.                      *Review of resident 2's 6/10/15 interdisciplinary progress (IDP) notes revealed "New skin concern found on left side of residents bottom. There is one pinpoint area on bottom that is open, the rest of her cheek is red with no other open areas noted at this time. PCP [primary care provider] faxed r/t [related to] this reoccurring skin issue. Family notified of skin concern. CNA instructed to put on Provon for time being until PCP faxes back</p>	F 314		7-16-15

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F 314	<p>Continued From page 78 with treatment. No other skin concerns at this time. Call light within reach. Will continue to monitor."</p> <p>Interview on 6/10/15 at 3:55 p.m. with MDS coordinator HH regarding the above noted IDP note revealed: *It was not how she would have documented the assessment of what she observed resident 2's skin concern. * She would have measured the reddened area. *Resident 2's "cheek [entire left buttocks]" was not all reddened. *LPN O should have assessed the resident for pain and documented it. *She confirmed the assessment was inaccurate.</p> <p>Review of resident 2's entire medical record revealed: *There was no documentation on 6/9/15 of her complaint of the sore on her bottom or her complaints of pain. *There had been no pain assessment documented. *There had been no accurate measurement of her reddened area on her left buttock. *The only documentation for measurement stated "pinpoint."</p> <p>Review of resident 2's skin assessment report faxed to the physician on 6/10/15 and then physician response on 6/11/15 revealed it was okay to start with barrier cream and to keep it as clean as possible.</p> <p>Review of a fax sent to the physician on 6/11/15 to clarify the above order revealed: *RN Y asked the physician "Do you want the barrier cream as a PRN [as needed] order or</p>	F 314		7-16-15

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F 314	<p>Continued From page 79 daily? Please clarify." *The physicians response was "If incontinent daily."</p> <p>Review of resident 2's bowel and bladder detail report from 6/12/15 through 6/16/15 revealed she had been incontinent on: *6/12/15 at 12:51 p.m. and 7:54 p.m. *6/13/15 at 12:24 a.m. and 8:05 p.m. *6/14/15 at 12:19 a.m. and 4:40 p.m. *6/15/15 at 10:09 a.m. and 3:35 a.m. *6/16/15 at 12:44 a.m.</p> <p>Review on 6/16/15 of resident 2's June 2015 treatment administration record revealed: *6/12/15 Barrier cream to area on buttocks if incontinent daily. *The time listed to apply the barrier cream was "PRN." *There was no documentation that the barrier cream had been applied.</p> <p>Interview on 6/16/15 at 9:50 a.m. with RN Y regarding resident 2 revealed: *She was incontinent more than usual. *The nurse should have been putting on the barrier cream.</p> <p>Interview on 6/16/15 at 10:05 a.m. with CNAs TT and UU regarding resident 2 revealed: *She was always incontinent. *She had been incontinent that day at 9:45 a.m.</p> <p>Review of resident 2's care plan revealed: *Two focus areas documented as pressure ulcers. *One of the pressure ulcer focus areas updated 3/12/15 was the following: -She was at risk for pressure ulcers, because she</p>	F 314		7-16-15	

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F 314	<p>Continued From page 80</p> <p>was frequently incontinent of urine and she had edema (swelling).</p> <p>-During care observe skin and notify the nurse if there were any areas of concern.</p> <p>-Notify the nurse, family and physician with any areas that were reddened, opened, or with any unexplained bruising.</p> <p>-Remind the resident to reposition when sitting or lying in one place.</p> <p>-On 3/12/15 her care plan was updated "Area to buttock crease open again."</p> <p>-3/12/15 was the last time her care plan had been updated.</p> <p>*Another focus area documented as pressure ulcers updated on May 2015 revealed the following:</p> <p>-"I have a pressure ulcer."</p> <p>-Progress toward the healing of the residents pressure ulcer.</p> <p>-If there were no changes to wound in two weeks seek a different treatment.</p> <p>-If there were no changes in four weeks, seek a consult to the wound clinic.</p> <p>*She had a focus area for pain with the following interventions:</p> <p>-Nursing should assess pain and document it.</p> <p>-Encourage the resident to change positions if she is in the same position for more than two hours.</p> <p>Her care plan had not been updated to reflect when her pressure ulcer identified on 3/12/14 was healed. Review of her care plan on 6/16/15 it had not been updated to include her new skin concern.</p> <p>*A May 2015 focus area of urinary incontinence.</p> <p>-"Please take me to the toilet when I get up in the morning, before and after meals, at bedtime and PRN."</p>	F 314			7-6-15

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F 314	<p>Continued From page 81</p> <p>"Please take me every couple hours at night as well,"</p> <p>"I take a diuretic that makes me have to go often."</p> <p>Review of resident 2's pocket care plan revealed CNAs were to check skin daily.</p> <p>Interview on 6/16/15 at 2:45 p.m. with the director of nursing (DON) and administrator regarding resident 2 revealed:</p> <ul style="list-style-type: none"> <li>*The nursing staff should have assessed her for her complaints of a sore on her bottom and pain.</li> <li>*They would have expected the physician's orders to have been followed.</li> <li>*They would have expected the nurse to have done accurate measurements and accurate assessments of the resident's impaired skin integrity (skin break down).</li> <li>*They would have expected the resident's care plan to have been updated.</li> <li>*The DON would not expect toileting to be real time (actual time it was done).</li> <li>*The DON agreed there was no way to know when the resident was being toileted.</li> <li>*The administrator asked the DON during this interview to have nursing staff go do an accurate assessment to get a baseline of the resident's impaired skin integrity.</li> </ul> <p>Review on 6/17/15 of resident 2's requested by the administrator skin assessment revealed a stage II pressure ulcer (open sore) measuring 2 centimeters by 0.8 centimeters.</p> <p>Review of the provider's 9/11/14 last survey results revealed the provider failed to appropriately assess, intervene, and care plan for three of four residents with pressure ulcers.</p>	F 314		7-16-15

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F 314	Continued From page 82  Review of the provider's plan of correction for their 9/11/14 recertification survey regarding pressure ulcers revealed: *All nursing staff would be re-educated on pressure ulcer prevention, care planning, and treatment including contributing factors. *A certified wound care nurse would be hired within the next sixty days. *A weekly wound care committee was started to include the MDS case managers, DON, the certified wound care nurse, and the consultant registered dietician to review all residents at risk for weight loss and or wound management needs. *At monthly quality assurance and performance improvement meetings, the certified wound care nurse would provide a report, on a continuous basis, on pressure ulcer incidence, and effectiveness of current treatments and prevention program.  Surveyor: 33488 Interview on 6/17/15 at 8:15 a.m. with the administrator regarding audits performed as part of the plan of correction from the 9/11/14 survey related to pressure ulcer prevention revealed: *"A certified wound care nurse will be hired within the next sixty days." *There was no certified wound care nurse hired as directed. *He was unsure why that had not been done. *He agreed they had not followed the plan of correction as stated by hiring a certified wound care nurse.  Surveyor: 32333 Review of the provider's revised March 2013 CNA's job description revealed:	F 314		7-16-15	

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F 314	<p>Continued From page 83</p> <p>***Provides, completes and documents, if applicable, resident care as assigned in a timely and accurate manner."</p> <p>*Examples of resident care included provides personal care in eating, dressing, hair and body care, communication, toileting, bathing, and oral care.</p> <p>***Reports changes in resident's condition immediately to the Staff Nurse."</p> <p>***Responds to request from residents for assistance in a respectful and timely fashion. Answers call lights promptly."</p> <p>***Communicates suggestions or concerns from residents, other staff, visitors or others to the Staff Nurse in a timely, factual and accurate manner."</p> <p>Review of the provider's undated LPN job description revealed: ***Assesses, plans, implements, evaluates plan of care for residents." ***Make changes on the plan of care as necessary."</p> <p>Review of the provider's undated RN job description revealed "Assesses, plans, implements, evaluates plan of care for residents.</p> <p>Review of the provider's September 2011 Standard Operating Procedure Skin Assessments revealed: ***To monitor residents known to have history of or be at risk of pressure ulcers or have skin breakdown." ***All staff are aware of need to notify a nurse concerning any resident's skin concerns." ***Staff nurse will perform skin assessments with measurements on a weekly basis."</p>	F 314		7-16-15

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F 323 F 323 SS=H	Continued From page 84 483.25(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 by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure interventions and safety measures were in place for: *Three of three sampled residents (17, 18, and 19) who had falls and had been discharged. *Two of eight sampled residents (25 and 27) who had falls. Findings include:  1. Review of resident 17's closed medical record with a 12/21/14 post fall risk assessment that was to be completed immediately after a fall revealed: *She was in the bath chair in the bath house. *As the nurse entered the room the resident lifted the arm of the chair and slid out onto the floor. *She hit her head on the floor. *The environmental factors that contributed to the fall were it was wet, and there was no safety belt on the chair. *The resident's cognitive (mental) status was alert and confused. *No available safety belt on the bath chair.	F 323 F 323	The facility fall policy and protocol was revised on 7/6/15. All CNAs/Medication Aides and nurses will be educated by the DON and/or designee on the new fall policy and protocol on July 14-15, 3015. Residents #17 and #19 have expired. Resident #18 was transferred to another facility. Residents #25 and #27 were assessed by the Fall Risk Team (cross section of various departments) on 7/9/15. Interventions were implemented for each of them during that meeting and updated to their care plan. The Fall Committee will meet weekly for one month, then monthly for three months to assess need for fall interventions on all residents in facility with identified fall risks from admission, quarterly, and annually. Interventions will be implemented and individualized if necessary for those residents as well. Audits will be conducted weekly for 1 month and then monthly for 3 months on residents #25 and #27 along with 10 random audits to monitor for fall intervention compliance. The DON and/or designee will be responsible for conducting assessment audits and for overall compliance. Audit findings will be reported by the DON and/or designee at the monthly QAPI meeting for 1 year as deemed necessary by the QAPI committee.	7-16-15	

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F 323	<p>Continued From page 85</p> <p>Review of resident 17's interdisciplinary progress notes revealed:</p> <p>*A nursing note on 12/21/14 at 11:00 a.m. noted the following:</p> <ul style="list-style-type: none"> <li>-The nurse was called into the bath house to do a skin assessment on the resident.</li> <li>-Upon entering the room the resident lifted the side arm on the bath chair and fell out onto the floor landing face first.</li> <li>-The resident was rolled to her back.</li> <li>-Small amount of blood noted on her nose.</li> <li>-Left eye was swollen and bruised.</li> <li>-Bruising noted to right hand.</li> <li>-No complaints of pain noted.</li> <li>-Two staff returned the resident to bed.</li> </ul> <p>*A post-fall nursing note on 12/22/14 at 2:00 p.m. noted:</p> <ul style="list-style-type: none"> <li>-Vital signs (basic indicators of body function) and neurological (neuro) assessments noted to be completed.</li> <li>-No change to left eye bruising, and no further injury noted.</li> <li>-Will continue to monitor for any changes in level of consciousness (awareness) (LOC) or any further injuries.</li> </ul> <p>*A post fall nursing note on 12/22/14 at 9:00 p.m. noted:</p> <ul style="list-style-type: none"> <li>-Vital signs were taken and documented.</li> <li>-Left eye was bruised, but no other injuries noted.</li> <li>-Resident denied pain.</li> <li>-Would continue to monitor for any changes in LOC.</li> </ul> <p>*A post fall nursing note on 12/23/14 at 10:45 p.m. noted:</p> <ul style="list-style-type: none"> <li>-Continued to have bruising to left eye and right hand.</li> <li>-"PEARL [PERRLA (pupils equal, round, and reactive to light, accommodate)] neuro assessments WNL [within normal limits]."</li> </ul>	F 323	<p>All facility bath chairs were assessed on July 7, 2015 by the maintenance department to ensure they are in good repair and that they all have seat belts that are in good working order and are manufacturer recommended. DON and/or designee provided training to CNA's OO and GG on 6-12-15 during the survey. All nursing care staff will be educated regarding the required use of seat belts for bath chairs between July 14-15, 2015.</p> <p>Each whirlpool tub chair will be included on the Monthly Preventative Maintenance Log to ensure the chairs have proper seat belts and are in operational condition. Five random audits will be conducted by the Clinical coordinators weekly for 1 month and monthly for 1 year for CNA's performing baths using the whirlpool tub chairs with proper usage of seat belts. The DON and/or designee will bring the audits on a monthly basis to the QAPI committee meeting for a period of 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15	

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F 323	<p>Continued From page 86</p> <ul style="list-style-type: none"> <li>-Vital signs were taken and noted.</li> <li>*A nursing note on 12/24/14 at 9:46 a.m. noted:               <ul style="list-style-type: none"> <li>-The resident's lung sounds did not sound good.</li> <li>-A fax was sent to the doctor to see what he would like them to do.</li> <li>-The resident was on 2 liters of oxygen and a nebulizer treatment was completed with no change to lung sounds.</li> </ul> </li> <li>*A nursing note on 12/24/14 at noon noted a fax received from the physician that it was ok to send the resident to the emergency room (ER).</li> <li>*A nursing note on 12/24/14 at 12:05 p.m. revealed Sioux Falls wheel chair express picked up the resident and took her to Avera ER.</li> <li>*A nursing note on 12/24/14 at 3:00 p.m. written by MDS care manager HH noted:               <ul style="list-style-type: none"> <li>-She reviewed the resident's fall from 12/21/14.</li> <li>-The resident was in the shower room in the bath chair.</li> <li>-The resident lifted the side arm on the bath chair and fell out onto the floor.</li> <li>-The resident landed face first onto the floor.</li> <li>-Her left eye was bruised and swollen, and her right hand was bruised.</li> <li>-The resident was instructed not to lift the arm on the chair.</li> <li>-The staff were instructed not to leave the resident unattended during her bath.</li> <li>-After further review it was determined there was not evidence of abuse or neglect with the above fall.</li> </ul> </li> <li>*A late entry nursing note on 12/26/14 at 10:00 p.m. revealed:               <ul style="list-style-type: none"> <li>-The resident was admitted to Avera.</li> <li>-Her diagnoses were multiple rib fractures and a left clavicle fracture.</li> <li>-She had a hospice consult on 12/26/14.</li> </ul> </li> <li>*A nursing note on 12/26/14 at 12:35 p.m. noted:               <ul style="list-style-type: none"> <li>-"Two broken vertebrae [bones in the spine] that</li> </ul> </li> </ul>	F 323		7-16-15	

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F 323	<p>Continued From page 87 are old!" -"She stated she is not upset with anyone." *A readmission to the facility nursing note on 12/28/14 stated: -Readmission diagnoses were trauma, multiple rib fractures, and a clavicle (curved bone at the root of the neck) fracture. *A nursing note on 12/30/14: A fax was sent to the physician asking for a hospice order. *A nursing note from 1/1/15 stated the resident was found at 5:45 p.m. without vital signs.</p> <p>Review of Avera McKennan Hospital and University Center's medical records for resident 17 revealed: *Emergency room visit notes: -Date of service was 12/24/14. -Her chief complaint was difficulty breathing. -The report from her daughter was she was sitting after getting out of the shower, she slipped out of her chair, falling onto her left side. -That had happened four days ago. -The nursing home had noticed she has had breathing difficulty since then. -She did complain of pain to her left shoulder. *The emergency department course and plan: -She had a fall four days ago with now difficulty breathing and some significant chest wall tenderness. -An x-ray was obtained. -The resident was noted to have multiple left rib fractures. -She also had a clavicular fracture. *She was admitted on to the trauma service on 12/25/14. -She presented in the emergency department from the nursing home with shortness of breath and wheezing. -In the transfer information it did not mention</p>	F 323		7-16-15

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F 323	<p>Continued From page 88 anything about a recent fall. -Upon evaluation it was evident the resident had some sort of trauma with bruising to her left shoulder, chest, and eye. -Further discussion demonstrated was she might have fallen either yesterday versus three days ago. -Reports were inconsistent. -She described she felt very confused and that was not normal for her. -She described diffuse (widespread) pain. -The chest x-ray showed multiple displaced rib fractures on the left side, and the left clavicle fracture. -It was unclear of the events that lead up to this, with a left clavicle fracture, multiple left rib fractures, on 3 liters of oxygen, bruising to the left eye, and some pelvic tenderness. *On 12/25/14 diagnostic test results showed the left second, third, fourth, fifth, sixth, seventh, ninth, and tenth ribs were fractured both anteriorly and posteriorly forming a "flail segment". *She was discharged back to the nursing home on 12/28/14 with the following diagnoses that included but not limited to: -Fall from "standing height." -Multiple left rib fractures. -Left clavicle fracture. -Hypoxia (inadequate oxygen supply).</p> <p>Review of resident 17's 7/3/14 care plan for falls/psychotropic (mind-altering) drug use revealed: *It had been updated on 12/21/14 with her fall from the bath chair. *She was reminded not to lift her arm up while she was in the bath chair. *She was not to be left unattended while in the bath.</p>	F 323		7-16-15
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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F 323	<p>Continued From page 89</p> <p>*She had a history of falls and was taking psychotropic medication that increased her risk for falls.</p> <p>Observation and interview on 6/11/15 at 11:00 a.m. with CNA GG who was the bath aide that day revealed:</p> <p>*She was not using a seat belt on the bath chair.</p> <p>*There was no seat belt for the bath chair, she did not use anything to secure the residents in the bath chair.</p> <p>*Most residents could support themselves in the bath chair.</p> <p>*She remembered there being a seat belt probably back in April 2015, but she had not used one since then.</p> <p>*She worked at the facility as needed.</p> <p>Interview on 6/11/15 at 12:05 p.m. with Minimum Data Set care manager HH revealed she had not seen a seat belt for the bath chair.</p> <p>Interview on 6/11/15 at 12:35 p.m. with CNA OO who usually worked full-time as a bath-aide (but not on 6/11/15) revealed she had been using a seat belt when she bathed residents. The seat belt was ordered because of resident 17's fall out of the bath chair.</p> <p>Review of the 12/30/14 Penner Patient Care, Incorporated invoice revealed a seat belt had been ordered for the bath chair.</p> <p>Review of the Penner Manufacturing Cascade Patient Transfer Lift System Safe Operations and Daily Maintenance Instructions revealed on page 9 for the bath chair "WARNING Failure to secure the resident properly with the seat belt could result in injury to the resident or operator."</p>	F 323		7-16-15

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F 323	<p>Continued From page 90</p> <p>Review of the revised October 2010 Shower/Tub bath policy revealed: *Never leave the resident unattended in the tub or shower. *No mention of the use of the seat belt for the bath chair.</p> <p>Interview with the director of nursing and administrator on 6/16/15 at 2:25 p.m. revealed: *They had ordered a seat belt after resident 17's fall from the bath chair. *They would have expected the CNAs that were giving baths to have used the seat belt for all baths.</p> <p>2. Review of resident 19's complete medical record revealed: *He was admitted on 2/16/15. *He was at high risk for falls. *His fall risk assessment score was sixteen. *His fall risk assessment report stated any score ten or greater to initiate the following: -Initiate falling star program. -Write on nursing Kardex, care plan, and pocket care plan. -Initiate other safety measure as appropriate. *His 2/16/15 nursing Kardex revealed no mention of falls or interventions for falls. *On 2/17/15 he had a fall with the following noted: -Nursing heard someone yelling for help. -He was found on his floor by his bed. -He complained of left hip pain and was unable to move his left leg. -He was sent by ambulance to the emergency department. -He was admitted to the hospital with a left hip fracture.</p>	F 323		7-16-15

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:  
  
435039

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING \_\_\_\_\_  
B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED  
  
06/17/2015

STREET ADDRESS, CITY, STATE, ZIP CODE  
3600 SOUTH NORTON AVENUE  
SIOUX FALLS, SD 57105

NAME OF PROVIDER OR SUPPLIER

SOUTHRIDGE HEALTH CARE CENTER

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

F 323

Continued From page 91  
Review of the provider's addendum to their final report for resident 19's 2/17/15 event revealed on 2/24/15 staff noted an obituary for him. He had died on 2/21/15.

Surveyor: 14477  
3. Review of resident 18's closed medical record revealed:  
\*An admission date of 7/3/14 with diagnosis of cerebral palsy, mental retardation, diabetes, and several others.  
\*The 7/3/14 Fall Risk Assessment showed a score of 12 (score greater than 10 = high risk for falls).  
\*The 7/14/14 care plan stated he had used a wheel chair for mobility and wanted it tilted.  
\*The 7/15/14 care conference note indicated the family was concerned the resident would slide out of the wheelchair. He had his own wheelchair with a seat belt. The "resident unable to release the seat belt and is thus considered a restraint."  
\*A 7/15/14 faxed request from therapy to the resident's physician requested "OT, PT, and ST [Occupational Therapy, Physical Therapy, and Speech Therapy] evaluations and treatment orders to address seating safety..."  
\*On 9/17/14 at 11:15 a.m. the Interdisciplinary Progress Notes stated the resident was found by a certified nursing assistant (CNA) "setting on floor in room in front of assistive chair - no injury noted on assessment. Assistive chair not tilted appropriately - res [resident] slid out of chair onto floor."  
\*On 9/24/14 at 1:30 p.m. the Interdisciplinary Progress Notes stated the resident's fall of 9/17/14 had been reviewed. It was noted the assistive chair was not tilted appropriately. Staff were reminded to place the assistive chair in the appropriate position. "No injuries were noted and

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F 323	<p>Continued From page 92 no evidence of abuse." *On 3/1/15 at 10:00 a.m. a fax was sent to the physician stating the resident had a scratch to the left side of his nose. An antibiotic ointment was ordered to use on the nose, and an antibiotic via the G-tube (a tube inserted directly into the stomach to provide nutrition) was also ordered. *On 3/1/15 at 1:00 p.m. on the Interdisciplinary Progress Notes by nursing stated "Resident's sister was here and noticed bridge of nose is swollen and left eye sclera [whites of eye] is red and yellow." *A 3/2/15 Sanford Hospital dictation stated the patient reported a fall with bleeding. "A large scratch across the left bridge of nose and a little bit of ecchymosis [reddening] right at the corner of his eye so it suggests that there was probably a fall or injury." An X-ray showed no fracture. *A documented interview on 3/5/15 with the resident's sister revealed the physician had stated the resident had facial trauma. When she had asked the provider what had happened to his face, the administrator and DON told her they did not know, and that they were short staffed.</p> <p>Surveyor: 32335 4. Review of resident 25's 2/11/15 care plan revealed: *From 9/1/14 through 3/14/15 she had forty falls. *The following interventions had been implemented: -On 9/4/14 "Attempt to engage in activities when up", and they had obtained a floor mat to place beside her bed. -On 9/8/14 "Will do frequent observations." -On 9/21/14 "Let resident wake up on own accord in AM." -On 9/29/14 "Offer food monitor freq [frequently]." -On 10/1/14 "keep around nurse's station when</p>	F 323		7-16-15
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F 323	<p>Continued From page 93</p> <p>out of room for easier observation, and toileting every 2 hours while awake and prn."</p> <p>-On 10/10/14 "Will ambulate with restorative [therapy to help restore function] daily."</p> <p>-On 10/23/14 "Toilet between 0500-0600 [5:00 a.m.-6:00 a.m.] Q [every] AM."</p> <p>-On 10/29/14 "New cushion for w/c [wheelchair] per O.T. [occupational therapy]."</p> <p>-On 11/5/14 "Will add toilet at 0001 [12:01 a.m.]. Ambulate at least two times per day and prn [as needed]."</p> <p>-On 11/15/14 "Will start toileting program."</p> <p>-On 11/17/14 "Start falling stars program and toileting program. Monitor every 15 minutes."</p> <p>-On 11/20/14 "Trial of new voice activated bed/chair alarm."</p> <p>-On 1/7/15 "Pommel cushion (helps prevent forward sliding) applied to chair."</p> <p>-On 1/8/15 "Try music therapy with headphones."</p> <p>-No other interventions had been documented after 1/8/15.</p> <p>Interviews and record review revealed resident 25 had skin breakdown to her bottom due to incontinence. There was no documentation the toileting interventions above had been followed. Refer to F309, finding A1.</p> <p>Interview on 6/17/15 at 8:15 a.m. with the director of nursing revealed she did not know resident 25 and directed me to speak with Minimum Data Set (MDS) case manager X. MDS case manager X stated they put several interventions in place and referred to the care plan. All of the documentation regarding the fall interventions was requested.</p> <p>Interview and record review on 6/17/15 at 10:20 a.m. with the director of nursing after she had brought the above requested information</p>	F 323		7/16/15

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F 323	<p>Continued From page 94 revealed: *The activities documentation for resident 25 had only included information from 3/17/15 through 6/16/15. *There was no documentation regarding the frequent observations and monitoring every fifteen minutes. *There were no other interventions put in place.</p> <p>Surveyor: 35625 5. Record review of resident 27's medical record revealed: *He had a Brief Interview for Mental Status (BIMS) assessment score of fifteen out of fifteen indicating no cognitive impairment. *Three falls had been documented since November 2014. *A fall occurred on 11/5/14 with the following noted: -Resident found on floor -He had leaned over to reach for an object and slid out of the wheelchair. -He was not injured in the fall. -Staff encouraged him to use the call light when he needed assistance. -No documentation was provided that indicated additional interventions were put into place to prevent future falls. *A fall occurred on 1/18/15 and noted: -The resident used the call light to request staff assistance after he had fallen. -He attempted to transfer himself from the wheelchair to bed with no staff assistance. -He was not injured in the fall. -Staff encouraged the resident to ask for assistance and use the call light. -Follow-up documentation stated the resident would like to have physical and occupational therapy reevaluate him.</p>	F 323		7-16-15

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F 323	<p>Continued From page 95</p> <ul style="list-style-type: none"> <li>-There was no documentation a physical or occupational therapy consultation had been ordered after it was requested.</li> <li>-No additional documentation was provided up to the end of survey that indicated additional interventions were put into place to prevent future falls.</li> <li>*A fall occurred on 4/28/15 and noted:               <ul style="list-style-type: none"> <li>-Resident was found on the floor</li> <li>-He had slid out of his wheelchair while trying to place his urinal on a table.</li> <li>-He was not injured in the fall.</li> <li>-Education was provided regarding the use of the call light for assistance.</li> <li>-No documentation was provided up to the end of the survey that indicated additional interventions were put into place to prevent future falls.</li> </ul> </li> <li>Interview on 6/16/15 at 3:50 p.m. with resident 27 regarding the above falls revealed:               <ul style="list-style-type: none"> <li>*He acknowledged he "wasn't thinking" prior to each of the falls.</li> <li>*Staff frequently reminded him to use the seatbelt on his motorized scooter.                   <ul style="list-style-type: none"> <li>-He demonstrated he was able to unbuckle the belt without assistance.</li> <li>-Verbalized he had been using the seatbelt for approximately one month.</li> </ul> </li> <li>*He had a tool that allowed him to grasp objects that were out of arms reach.                   <ul style="list-style-type: none"> <li>-The facility had replaced the tool sometime during the winter, because the old one was broken.</li> </ul> </li> <li>*Staff frequently reminded him to use his call light when he needed assistance while in his room.</li> </ul> </li> <li>Interview on 6/16/15 at 4:15 p.m. with registered nurse (RN) Y revealed:               <ul style="list-style-type: none"> <li>*Staff had been instructed to keep items including</li> </ul> </li> </ul>	F 323		7-16-15	

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F 323	Continued From page 96 his call light within reach. *Safety was reinforced with the resident after each fall. *Staff observed the resident more often and estimated it was at an interval of approximately every hour. *No documentation was provided to support the statement the resident had been observed at regular intervals.  6. Review of the provider's 2001 Falls and Fall Risk, Managing policy revealed: *Initial approaches could have included exercise or balance training, rearrangement of room furniture, or medication adjustments. *If falling reoccurred despite initial interventions staff should have implemented additional or different interventions, or indicated why the current approach remained relevant.  Review of the provider's revised December 2007 Falls and Fall Risk, Managing policy revealed "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."	F 323		7-16-15	
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325			

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F 325	<p>Continued From page 97 nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 14477 Based on observation, interview, and record review, the provider failed to ensure accurate weights were consistently monitored and recorded in a central document and the dietary team was notified of significant weight changes for two of two sampled residents (1 and 10) with weight concerns.</p> <p>1. Review of resident 1's entire medical record revealed: *An admission date of 5/19/15. * He was receiving tube feedings (receiving nutrition directly through a tube inserted into the stomach). *Was NPO (nothing by mouth).</p> <p>Review of his weight logs revealed his weight in pounds: *May 2015: -140.6 on 5/20 (day after admission) -150.2 on 5/26 -149.6 on 5/27 -151.8 on 5/30 *June 2015: -152.7 on 6/1 -153.8 on 6/2 -154.1 on 6/3 -154.6 on 6/4 -156.2 on 6/5 -155.2 on 6/6 -156.2 on 6/7</p>	F 325	<p>The facility policy for weighing and measuring a resident was updated on July 8, 2015 to include communication of weight variances to the nurse, dietitian, physician and family to ensure proper follow-up and/or further evaluation. Education for all nursing staff regarding this new policy and procedure for weighing will be done by the DON and/or designee on July 14, 2015.</p> <p>Resident #1 has expired. Resident #10's treatment record has been updated to include the daily weight section to ensure the nurse verifies that #10's daily weight has been obtained and assessed by the nurse.</p> <p>All other residents in the facility on daily weights will have this category added to their treatment records by July 14, 2015.</p> <p>For residents on weekly weights, a new facility bathing/weight sheet has been created to ensure that the weekly weights are obtained, recorded, and compared to the previous weight. The weight is also documented in Caretracker. Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that resident #10 and #5 random residents on daily weighs have had their daily weights taken and documented. Audits will be conducted weekly x 1 month and then monthly x 3 months on 5 random residents on weekly weights to ensure that their weekly weights have been taken and documented appropriately. The DON and/or designee will be responsible for conducting audits and for overall compliance.</p>	7-16-15	

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F 325	<p>Continued From page 98 -157.4 on 6/8</p> <p>Observation on 6/9/15 at 9:50 a.m. of resident 1 being weighed revealed his weight in his wheelchair with peddles on was 218.4 pounds. The weight sheet indicated the wheelchair weight was 61.2 pounds with peddles on. The recorded weight was 156 pounds on the weight log sheet. The correct weight on the log sheet should have been 157.2 pounds.</p> <p>Review of resident 1's 6/9/15 swallow study revealed he had been allowed to start taking foods by mouth that day. His weights following that study were:</p> <ul style="list-style-type: none"> <li>*159.2 on 6/10</li> <li>*160.0 on 6/11</li> <li>*161.0 on 6/12</li> <li>*No weight had been documented on 6/13</li> <li>*168.0 on 6/14</li> <li>*172.4 on 6/15</li> <li>*178.4 on 6/16</li> </ul> <p>Review of the weight log sheet instructions stated "if the weight differs by 5# [pounds], please re-weigh."</p> <p>Review of the provider's policy entitled "Tracking Weight Changes" revealed under Procedure #5: "The RD (registered dietician) or designee will be notified of any individual with an unplanned significant weight change of 5% [percent] in one month, 7.5% in three months, or 10% in six months."</p> <p>Review of resident 1's weight records revealed he had a greater than 10% weight gain in 28 days. No documentation was found regarding: *Any reweights done for differing weights of</p>	F 325	<p>The DON and/or designee will report audit finding to QAPI meetings for one year and as deemed necessary by QAPI committee.</p>	<p>7-16-15</p>
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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F 325	<p>Continued From page 99 greater than five pounds. *If the RD had been notified of the 6/9/15 change from NPO to eating by mouth in addition to the tube feeding.</p> <p>Surveyor: 33265 2. Review of resident 10's complete medical record revealed: *Four different documents on which weights were to have been recorded. -Daily weights were to have been written in by hand for a month at a time. -Weekly weights were to have been written in by hand for an entire year. -Monthly weights were to have been written in by for a two year period. The day of the month the weight was to have been done was not recorded. -A computer print out form of weights had been entered into the computer documentation system. *The resident had weights recorded on all four types of weight records. None of the forms were complete. *On the daily weight form for February 2015 there was notation the resident was to "start daily weights on 2/13/15." -There were 3 daily weights missing for that month. *The daily weight form for March 2015 had not had the month or year filled in. There were: -Three weights documented for the entire month and twenty-eight daily weights missing. *The daily weight form for April 2015 also had "daily wts" (weights) written in on the form. -Seven days had no weight recorded. *The daily weight form for May 2015 had seven daily weights missing for the month. *Daily weights were listed on the June 2015 Treatment Administration Record. The first two days of the month were blank.</p>	F 325		7-16-15
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F 325	Continued From page 100  Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator revealed the DON: *Believed the daily weights had been discontinued. *Stated she had not known of the existence of one of the four different weight documents.  Continued review of the weight documentation revealed: *There was a ten pound weight loss between 3/24/15 and 4/2/15. No re-weight was noted. *There was an eight pound weight loss between 5/15/15 and 5/16/15 with the note "reweigh" written after the 5/16/15 weight. No weight was done for the next two days.  Review of the provider's 11/10/09 Weight and Height Policy and Procedure revealed a reweigh was to be done for any five pound weight change from previous weight.	F 325		7/6-15	
F 353 SS=H	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353	The call light time log for the bed and toilet will be pulled for resident #24 and all other residents on a weekly basis by the Administrator. Results to be given to the DON and Clinical coordinators for trend analysis. The call light monitoring device is operational and has been adjusted to prevent turning the device off.  A username and password of the EMR was given to Dr V on 6-23-15 by the Administrator when Dr. V requested it on 6-23-15 to the Director of Medical Records.		

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F 353	<p>Continued From page 101</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure sufficient nursing services were provided to meet all aspects of resident care needs. Findings include:</p> <p>Surveyor: 32333 1. Group interview on 6/9/15 at 3:15 p.m. with fifteen residents in attendance revealed it was a group consensus: *They were short staffed. *The staffing shortage was mostly in the evenings and overnights. *Sometimes there was only one CNA on duty in a wing to answer the call lights. *Sometimes there was only one nurse for center hall and east hall. *It had taken an hour or an hour and a half to answer call lights. *Resident 24 said he has had to lay in bed and wait to get up in the mornings because there was not enough staff to assist him.</p> <p>Surveyor: 32335 2. Interview on 6/16/15 at 1:15 p.m. with the</p>	F 353	<p>The greatest identified need of staffing was identified as 6 AM – 10 AM and 4 PM-9PM shift for CNAs. The facility continues to offer very competitive wages for CNAs and nurses. The facility continues to recruit on Indeed.com, Keloland.com and speak at the CNA and nurse classes at Southeast Votech and North American University. The facility instituted the use of an online scheduling program called "Schedule Anywhere" to enable all nursing staff to view their schedule online, pick up open shifts, etc.</p> <p>The facility is in the process of starting a CNA preceptor program under the direction of the DON and/or designee with the goal of retaining new hires. The facility will ask 3 nursing staff employees per month to attend the monthly QAPI meeting to solicit their assistance in identifying trends and participate in subcommittees to ask for their ideas for solutions to those trends.</p>	7-16-15

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F 353	<p>Continued From page 102</p> <p>administrator revealed they were unable to provide call light logs from 5/13/15 to the present. The computer that had the call light software installed on it had been accidentally turned off. He had been getting an error message for approximately the past 3 weeks and was unable to get any reports. They had realized it had been turned off after this surveyor had requested the data earlier that morning.</p> <p>Surveyor: 33488 3. Interview on 6/9/15 at 9:20 a.m. with Dr. V revealed: *He had no access to the electronic medical record (EMR) nursing notes or dietary notes. *He had been waiting "a long time for my access" from the facility. *He had to "hunt down a nurse if I want to know about my residents." *No nurse was available to assist him when he made rounds. *He would "have to do my best" with the information he had received. **"They don't have enough staff for that." in regards to sending a nurse with him when he visited residents. **"I will be here until 12:30 I bet. It is slow without a nurse."</p> <p>Surveyor: 32331 4. Interview on 6/16/15 at 9:38 a.m. and at 2:35 p.m. with the staff coordinator revealed: *She was responsible for coordinating the nursing staff schedule. *She prepared a new nursing schedule every six weeks. -There were many changes to that above schedule after it had been posted. *The day of each week that had been the hardest</p>	F 353	<p>The call light time log for the bed and toilet will be pulled weekly for all residents by the Administrator and/or designee. Results to be given to the DON and Clinical coordinators for trend analysis to indicate halls that need additional staffing. The results of the weekly call light times will be provided by the Administrator to the monthly QAPI meeting for 1 year and then as deemed necessary by the committee.</p> <p>The administrator will give a job satisfaction survey to 10 random employees per month to look for trends. The results will be shared with the Monthly QAPI meeting for 1 year and then as deemed necessary by the committee.</p>	7-16-15

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F 353	Continued From page 103 to fill was on Sunday. *The evening shift from 2:00 p.m. until 6:30 p.m. and until 10:30 p.m. were the more difficult ones to have filled. *There were many changes to the schedule after it had been posted. *She stated there were challenges with the staffing schedule.  Interview on 6/16/15 at 5:15 p.m. with the administrator and the director of nursing revealed they both agreed there were challenges with the staffing schedule.  Surveyor: 32335 5. Review of the provider's April 2013 director of nursing (DON) job description revealed she: *"Monitors the nursing staff to maintain sufficient staff to provide quality care for the residents." *Was "Responsible for making sure that there is adequate staff in number and ability to maintain the highest practicable level of physical, mental, and psychosocial well-being for each resident that meets the state and federal regulations."	F 353		7/16/15	
F 366 SS=F	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.	F 366			

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F 366	<p>Continued From page 104</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure all residents on oral diets were given the opportunity to receive menu substitutions.</p> <p>1. Observation and interview on 6/10/15 at 1:05 p.m. with cook J and the certified dietary manager (CDM) revealed: *The provider's Spring Summer 2015 menu consisted of breakfast, lunch, and the dinner (evening) meals. *The above menu listed alternates at the lunch and evening meals. -That menu had meals listed as a #1 (one) or #2 (two) choice on the menu at lunch and evening meals. *They stated the residents were given a choice of which menu they preferred at the lunch and evening meals. *They stated the residents could choose items from either menu. *The CDM stated the residents in the memory care unit were given a "fifty/fifty choice" in the menu items. -Half of the #1 menu items and half of the #2 menu items were sent to that resident area for lunch and the evening meals. -She did not have a dislike file of resident food preferences. -Resident food preferences were obtained from the resident, family, or from the staff working in that area. -Staff were to have called the cook in the kitchen</p>	F 366	<p>After a review of the facility's process of Open Dining, the management team determined that the best use of facility resources to serve the residents in the best way possible was to offer them a choice of one hot meal and a set list of alternates from which to choose. This change is effective 7/13/15.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.</p> <p>A Kitchen Chatter meeting with residents was completed by the CDM and RD on 7/8/15. The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting with the residents once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM and/or designee for a period of one year at the QAPI Meeting and as deemed necessary by the QAPI committee. Reference above meal plan changes.</p> <p>There has been an egg shortage due to the Avian Bird Flu outbreak. Per the Federal Food Code, we are not allowed to purchase unpasteurized eggs, thus residents have not been getting eggs as often as they would prefer.</p> <p><i>* When pasteurized eggs become more readily available, they will be made available on the menu.</i> SC1500H/JJ</p>	7/16/15
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F 366

Continued From page 105  
for any changes to each resident's meal.  
-Those above changes would have been prepared and distributed for that meal after the cook had been called.

Surveyor: 33265  
2. Interview on 6/11/15 at 9:00 a.m. with resident 29 revealed:  
\*There were only two choices for any meal and you could not ask for any substitutions or changes in those two options.  
\*\*"We cannot request anything outside of the two choices. No requests."  
\*\*\*"If you did not like either option you were just out of luck."  
\*\*\*"Had down we were having sweet and sour chicken. What we got was plain chicken on plain noodles."  
\*\*\*"They run out of stuff all the time and then you have no choice."  
\*Lemon-lime parfait bars we were suppose to have changed into plain applesauce.  
\*\*\*"Today I wanted two eggs over easy. My only choice was scrambled eggs."  
\*\*\*"I am a diabetic. Everybody gets the same three choices for a bedtime snack: small can of diet pop, animal crackers, or chips."  
\*\*\*"The dietary manager has meetings called 'Kitchen Chatter.' We were suppose to tell her our likes and dislikes. Has not made any difference. Lots of talk that never happens."  
\*\*\*"Can't understand all the dietary aides. Not sure what language they are speaking sometimes. You can ask and ask for things, like coffee, and they just don't seem to understand."

Surveyor: 32335  
3. Observations and interviews during two of two

F 366

Our snacks range from 0 to 18 grams of carbohydrate each, thus appropriate for residents with diabetes. Snacks include 4 fl oz servings of 100% fruit juice, Crystal Lite, regular and sugar free soda (6 oz cans), ½ cup servings of applesauce, yogurt, ice cream, pudding, Jell-O, diced canned fruit, seasonal fresh fruit (as available), snack crackers, individual bags of chips, small cookies or other baked goods.

Residents with diabetes who have a physician order for a night-time snack will have a planned snack of preference with their name and date on a sticker on their specific snack on the snack cart for their wing.

Nursing staff documents snack acceptance in Care Tracker. A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.

The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed necessary by the QAPI committee.

7-16-15

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F 366	Continued From page 106 meal services revealed residents were not being offered entree choices or alternative choices. Refer to F151, finding B1.	F 366		
F 367 SS=E	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN  Therapeutic diets must be prescribed by the attending physician.  This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, contract review, job description review, and policy review, the provider failed to: *Ensure liquids were thickened appropriately for 1 of 1 resident (10) in the East dining hall. *Ensure 11 of 11 currently employed dietary aides were trained appropriately in providing assistance to residents with therapeutic (medically prescribed) diets. Findings include:  1. Interview on 6/9/15 at 7:52 a.m. with dietary aide F revealed she: *Had been employed five months. *Had started working on the serving line "since day one." *Had "little training."  Interview on 6/9/15 at 8:30 a.m. with the dietary manager (DM) regarding the competencies of the	F 367	Dietary Aide F was educated by the CDM on 6/9/15 on facility policy thickening liquids. The CDM or designee will randomly monitor Dietary Staff F weekly x 4 weeks for compliance. A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on thickening liquids. The CDM or designee will randomly monitor dietary staff weekly x 12 weeks for compliance. A directed in-service was completed by the RD on 6/16/15 for all dietary staff covering the annual food service, nutrition, and hydration requirements set forth in SD Codified Law 44:04:07:16. A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.  The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for one year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.	7-16-15

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F 367	<p>Continued From page 107</p> <p>dietary staff revealed:</p> <ul style="list-style-type: none"> <li>*She does not perform competencies</li> <li>*Staff were competent to perform their duties "Because they have been trained."</li> </ul> <p>Observation and interview on 6/9/15 at 12:25 p.m. of dietary aide F in the east dining room using powdered thickener for resident 10's soup revealed she:</p> <ul style="list-style-type: none"> <li>*Poured the soup into a bowl.</li> <li>*Proceeded to add the powdered thickener by shaking the thickener contents from the open can into the soup.</li> <li>*Had not measured the amount of powdered thickener according to the resident's current thickening requirements on the dietary card or the manufacturer's instructions for use.</li> <li>*Was unsure how much of the powdered thickener would be needed.</li> <li>*Stated he "Just needs it in the liquids."</li> <li>*Had never been trained how to mix the powdered thickener appropriately for any residents requiring thickened liquids.</li> </ul> <p>Interview and record review on 6/10/15 at 10:00 a.m. with the DM upon receipt of the provider's undated Dietary Initial Training Policy and required inservices revealed:</p> <ul style="list-style-type: none"> <li>*Only two inservices had been provided to all dietary staff within one year prior to the survey. Topics included were voicing grievances and changes.</li> <li>*The above policy revealed training was to have been provided to dietary staff within two weeks of being hired and ongoing that included: <ul style="list-style-type: none"> <li>-Resident's rights.</li> <li>-Overview of food service.</li> <li>-Introduction to food service.</li> <li>-Sanitation.</li> </ul> </li> </ul>	F 367		7-16-15	

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F 367	<p>Continued From page 108</p> <ul style="list-style-type: none"> <li>-Safety.</li> <li>-Food preparation.</li> <li>-Standard measurements.</li> <li>-Nutrition.</li> <li>-Therapeutic diets.</li> <li>-Review of policies and procedures.</li> </ul> <p>*The CDM "had been employed for seven months" and "had not had time to train" the dietary staff.</p> <p>*She could provide no further dietary training for any dietary aides except the two above dietary inservices.</p> <p>*She agreed the required mandated training regarding food service had not been provided to dietary personnel.</p> <p>Review of the provider's undated Thickened Liquids policy signed by the registered dietician (RD) on 4/30/15 revealed:</p> <p>***"The facility will determine whether nursing or food service will thicken liquids..."</p> <p>***"Manufacturer's instructions will be followed..."</p> <p>***"The RD and/or nursing supervisor will monitor staff competency for compliance as part of quality assurance."</p> <p>Review of the provider's March 2005 Competency Evaluation Standard Operating Procedure revealed:</p> <p>*The purpose was to ensure quality standards were maintained through competency evaluations yearly.</p> <p>***"Employees would be evaluated on their competency."</p> <p>*Skills could be identified through a needs assessment, the provider's plan of correction, or at the discretion of the director.</p> <p>Review of the provider's 2/1/03 Nutrition</p>	F 367		7-16-15
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/17/2015
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
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F 367	Continued From page 109 Consulting Services Agreement contract revealed the duties of the RD included providing nutritional education to staff.  Review of the provider's undated DM job description revealed she: **Monitors staff performance daily." **Trains new staff and assures they are being oriented well."  Review of the provider's 4/30/15 Evaluating Food Service and Clinical Nutrition Personnel policy revealed: *Food service personnel should have had their first evaluation at the end of their probationary period of ninety days. *Periodic written evaluations for food service staff were completed by the food service manager. *The RD should have evaluated nutrition support staff.	F 367			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.  The facility must offer snacks at bedtime daily.  When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a	F 368	The facility policy was reviewed and the snack list has been clarified to what is expected on each snack cart. Snacks include 4 fl oz servings of 100% fruit juice, 6 oz cans of regular and sugar free soda, ½ cup servings of applesauce, yogurt, ice cream, pudding, Jell-O, diced canned fruit, seasonal fresh fruit (as available), snack crackers, individual bags of chips, small cookies or other baked goods. Our snacks are range from 0 to 18 grams of carbohydrate each, thus appropriate for residents with diabetes. All residents, regardless of diet order or ability to eat independently or with assistance, except those with NPO diet orders, are offered a night-time snack daily.	7-16-15	

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F 368	<p>Continued From page 110 nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265</p> <p>Surveyor: 32333 Based on interview, record review, and policy review, the provider failed to ensure all residents on oral diets were offered a bedtime snack daily. Findings include:</p> <p>1. Group interview on 6/9/15 at 3:15 p.m. with fifteen residents in attendance revealed it was a group consensus they were not being offered a bedtime snack daily.</p> <p>Surveyor: 33265</p> <p>2. Interview on 6/11/15 at 9:00 a.m. with resident 29, a diabetic, revealed her only choices for a bedtime snack when offered were a small can of diet pop, animal crackers, or chips.</p> <p>Surveyor: 33488</p> <p>3. Observation and interview on 6/8/15 at 7:30 p.m. with residents 45 and 46 in their room revealed: *A bedtime snack was not offered all the time. *Resident 45 stated "You have one choice of an item. You can't get two." **"The drink is pop. If a diabetic wants a drink it's pop, no milk or something healthy. Its always a pop, crackers, or potato chips, and only one item." *Observation of her saved snack at the above time revealed it was a cheddar cheese sandwich cracker that was 0.93 ounces.</p>	F 368	<p>Residents with diabetes who have a physician order for a night-time snack will have a planned snack of preference with their name and date on a sticker on their specific snack on the snack cart for their wing.</p> <p>Nursing staff documents snack acceptance in Care Tracker. A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on bedtime snacks. The CDM or designee will randomly monitor dietary staff weekly x 12 weeks for compliance.</p> <p>The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for one year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.</p>	7-16-15
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F 368	<p>Continued From page 111</p> <p>*Resident 46 stated "We haven't had a banana for months. I have asked but you can't get any. They are always short on food. They run out a lot."</p> <p>4. Review of the provider's March 2005 Nourishment Between Meals Standard Operating Procedure revealed: **Each resident will be offered a nourishment/snack between meals and in the evening before bedtime." **A snack will be defined as an offering of items, single or in combination, from the basic food groups, food and or beverage, from the dietary department."</p> <p>5. Review of the provider's undated Nourishment List revealed: **When passing snacks please include at least two things to drink, also include at least three different items to snack on with textured diets in mind." *Nourishment items on the list were: -Soda. -Juice. -Chips. -Cookies. -Pudding. -Ice cream. -Yogurt. -Crackers. -Gelatin.</p> <p>Review of the current USDA food group guidelines, accessed on 6/24/15 at <a href="http://www.choosemyplate.gov/food-groups">www.choosemyplate.gov/food-groups</a>, defined basic food groups as fruits, vegetables, grains, proteins, and dairy.</p>	F 368		7-16-15

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F 368 Continued From page 112  
Surveyor: 32333  
6. Review of the South Dakota Department of Health's 9/11/2014 recertification survey revealed the provider had been cited under F368 for failure to ensure all residents were offered a bedtime snack consistently.

F 368

Review of the provider's plan of correction for F368 from the 9/11/14 recertification survey revealed:  
\*\*Evening snacks, for all residents, will be distributed to the nurses' stations by the dietary department no later than 7:30 p.m., and nursing staff will distribute to residents at that time or no later than 8:00 p.m."  
\*\*Nursing and dietary were educated on the snack cart procedure."

F 371 SS=E 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  
  
The facility must -  
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and  
(2) Store, prepare, distribute and serve food under sanitary conditions

F 371

This REQUIREMENT is not met as evidenced by:  
Surveyor: 33488  
A. Based on observation, interview, record review, and policy review, the provider failed to ensure:  
\*Sinks, shelves, floors, and equipment were

A thorough kitchen cleaning was completed on July 8, 2015 by the CDM and staff. InTek Cleaning and Restoration will professionally clean the floors, walls, corners and equipment on July 13, 14, and 15 2015.  
A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on cleaning schedules, importance of cleaning and sanitation, safe food temperatures and the food danger zone range. The CDM or designee will randomly monitor four dietary staff weekly x 12 weeks for compliance. The Certified Dietary Manager (CDM) or designee will complete directed kitchen audits daily x 12 weeks and weekly thereafter for one year for continued compliance. Results to be reported by the CDM or designee monthly at

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F 371	<p>Continued From page 113</p> <p>routinely cleaned in one of one kitchen.</p> <p>*Pureed hot foods were held and served at safe and palatable temperatures during two of two meal services.</p> <p>*The food thermometer was sanitized prior to being inserted into food and between use with multiple foods.</p> <p>*Staff used clean and sanitized scoops during one of one observed meal service.</p> <p>*Staff had documented food temperatures and kitchen cleaning schedules.</p> <p>*Supervisory staff had appropriately monitored and corrected areas of concern.</p> <p>Findings include:</p> <p>1. Observation of the kitchen on 6/8/15 at 6:20 p.m. revealed:</p> <p>*The dry food storage room under the shelving had a large spot of sticky residue.</p> <p>*The floor in the dirty and clean dish room areas were heavily soiled with food and debris.</p> <p>*In the dirty dish area there was a hand sink that was heavily soiled with brown staining and kernels of corn in the bottom of the sink.</p> <p>-On the wall directly above the sink was a fan that had a thick amount of dust and debris on the blades and the fan cover.</p> <p>*The base of the plate warmer had a moderate amount of visible food residue.</p> <p>*Shelving to the left of the above plate warmer had moderate food debris and was visibly soiled.</p> <p>*The refrigerator in the food preparation area close to the steam table was visibly soiled with a spilled liquid and debris on the bottom.</p> <p>Observation on 6/9/15 at 7:10 a.m. in the kitchen revealed the same areas of concern listed above and were unchanged from the observation on 6/8/15 at 6:20 p.m.</p>	F 371	the QAPI Meeting for 1 year and then until deemed by the QAPI committee.	7-16-15	

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F 371	<p>Continued From page 114</p> <p>Observation on 6/9/15 at 10:40 a.m. in the kitchen revealed the same areas of concern listed above still remained unchanged.</p> <p>Observation on 6/9/15 at 4:05 p.m. in the kitchen revealed:</p> <ul style="list-style-type: none"> <li>*In the dry food storage room the same large spot of sticky residue on the floor remained. Light food debris was seen on the floor.</li> <li>*In the three compartment sink on the clean dish side, the middle rinse sink had approximately three to four inches deep of large amounts of food debris mixed with an unknown liquid.</li> <li>*The floor in the dish machine area remained visibly soiled with heavy food debris.</li> <li>*A dead cockroach was observed on the floor in the far left corner from the dish machine on the floor.</li> <li>*The hand sink in the dishroom remained heavily visibly stained and also contained new trace amounts of orange colored food.</li> <li>*The base of the plate warmer remained visibly soiled.</li> <li>*The shelving to the left of the above plate warmer remained moderately visibly soiled with food debris.</li> </ul> <p>Observation on 6/10/15 at 9:30 a.m. in the kitchen revealed:</p> <ul style="list-style-type: none"> <li>*The clean and dirty dishroom area floors remained heavily visibly soiled.</li> <li>*The dead cockroach remained in the corner on the floor in the dish machine area.</li> <li>*The hand sink in the dishroom remained heavily visibly soiled and stained.</li> <li>*The plate warmer remained visibly soiled at the base.</li> <li>*The shelving to the left of the plate warmer</li> </ul>	F 371		7-16-15

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F 371	<p>Continued From page 115</p> <p>remained moderately visibly soiled with food debris.</p> <p>Observation and interview on 6/10/15 at 3:10 p.m. with the certified dietary manager (CDM) and the administrator while performing a walk-through of the kitchen areas revealed:</p> <ul style="list-style-type: none"> <li>*The large spot of sticky residue in the dry food storage room located under the shelving remained.</li> <li>*The hand washing sink in the dirty dishroom area remained heavily stained and visibly soiled with food.</li> <li>-The fan mounted above that sink had been removed.</li> <li>*The CDM stated she had "called other facilities and they had received deficiencies" regarding dirty fans so she "had it removed."</li> <li>*They agreed the hand sink was visibly stained and soiled.</li> <li>*They agreed the base of the plate warmer and shelves to the left of it had been visibly soiled.</li> <li>*The refrigerator in the food preparation area close to the steam table remained visibly soiled with liquid and food debris.</li> <li>*Both agreed the above areas needed cleaning. The administrator stated "We will get this taken care of."</li> <li>*The CDM stated the staff had been cleaning the kitchen.</li> <li>-She had not supervised the cleaning each day.</li> <li>-She had cleaning logs.</li> </ul> <p>Review of the kitchen cleaning logs for January 2015 through May 2015 revealed five out of twelve tasks listed were not completed by staff for any months reviewed.</p> <p>Review of the daily cleaning logs for the month of</p>	F 371		7-16-15	

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F 371	<p>Continued From page 116</p> <p>April 2015 revealed: *Cleaning the cook's refrigerator had not been cleaned eighteen days out of twenty-eight days. *The steam table had not been cleaned eighteen days for the month. *The hand washing sink had not been cleaned for seventeen days of the month.</p> <p>Review of the daily cleaning logs for the month of May 2015 revealed: *The cook's refrigerator had not been cleaned fourteen out of thirty days. *The steam table had not been cleaned twelve days that month. *The hand washing sink had not been cleaned for four days that month.</p> <p>Review of the deep cleaning logs for weeks one through five of May 2015 provided by the CDM revealed: *Five of sixteen tasks were not completed at all. *Only three of the sixteen tasks listed had been completed for all five weeks.</p> <p>Review of the provider's F371 Kitchen Sanitation Checklists revealed: *On 11/10/14 in the East dining room and serving area: -All items were not covered, labeled, or dated. Bowls and dinnerware had been found sitting on the counter uncovered. -Floors were found sticky and dirty. -The thermometer was found dirty and uncovered in the drawer. -All carts were found dirty. -Used napkins were found on the microwave cart and removed. -Floors, walls, ceilings, and work areas were found not clean.</p>	F 371		7-16-15

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F 371	<p>Continued From page 117</p> <ul style="list-style-type: none"> <li>-Hand washing procedures had not been posted at the sink.</li> <li>-Comments made on the sheet: "Needs close monitoring daily by dietary manager or designee."</li> <li>*On 11/17/14 in the East dining room and serving area:             <ul style="list-style-type: none"> <li>-"Brown sugar had been found unlabeled in the drawer with uncovered cups."</li> <li>-Shelves were not found clean.</li> <li>-Floors were found "very dirty".</li> <li>-No food temperatures were recorded on 11/16/14.</li> <li>-The daily cleaning schedule had not been completed and followed.</li> <li>-Hand washing procedures had not been posted at the sink.</li> <li>-Floors, walls, ceilings and work areas were found not clean.</li> <li>-Work tables and drawers were not clean and neat.</li> <li>-Carts and racks were not clean and in good repair.</li> <li>-Food brought at serving time and was found warm, not hot.</li> <li>-The counters were found dirty.</li> <li>-Garbage containers were found not clean and covered.</li> <li>-Dumpsters were not closed and were overflowing.</li> </ul> </li> <li>*Comments made on the above checklist:             <ul style="list-style-type: none"> <li>-"Glasses stacked, also cups drinking side down on the dirty cart surface."</li> <li>-Dirty glasses and silverware on dirty counter.</li> <li>-Dirty napkin in drawer.</li> <li>-Multiple serving cups found uncovered on bare cupboard.</li> <li>-"Open sweet and sour container unlabeled."</li> <li>-"Refer to dietary manager [DM] for specific action."</li> </ul> </li> </ul>	F 371		7-16-15
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F 371	Continued From page 118 -As before recommend inservices to staff. -Daily rounding with interventions from DM.  *On 11/17/14 through 11/18 of the kitchen and Center dining area: -Items in the storeroom had not been stored six inches above the floor or eighteen inches from the sprinkler heads. -Shelves were not found clean. -Walls, floors, ceilings, and vents were not clean in the storeroom. -Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean. -Refrigerator fans were not found clean from dust. -Refrigerator temperature logs could not be located. -Freezer items had ben stored on floor. -Ice cream had been found not labeled -The thermometer in the freezer had been found laying face down on the floor. *No freezer logs could be located. -Dishwasher temperatures were not logged daily. -Items in the dishwasher area had not been checked to make sure they were clean. -Items in the dishwasher area were found not dried and not stacked. -The dishwasher area was "filthy". *The daily cleaning schedule had not been completed or followed. -"Dirty utility, filthy, disorganized." -Carts were found "very dirty." -Gloves were not worn by staff "Cross-contamination" had been found. -Employees were found not wearing clean, appropriate uniforms and hairnets or coverings. -Food scoops were found not clean and dry. "uncovered under prep table."	F 371		7-16-15	

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F 371	<p>Continued From page 119</p> <ul style="list-style-type: none"> <li>-Table by the steam table very dirty. Gap against wall filthy."</li> <li>-Motor vent on the range/oven "filthy".</li> <li>-Carts, microwave, grill, and ice machine found unclean.</li> <li>-The refrigerator door was found not to close.</li> <li>-Ovens and steamer were found not clean.</li> <li>-Mops had not been stored properly out of the water.</li> <li>-Garbage containers were not clean and covered when not in use.</li> <li>-Dumpsters were found not closed or overflowing.</li> <li>-Outside openings were not protected against pets.</li> </ul> <p>*Hand-written comments made on the above checklist:</p> <ul style="list-style-type: none"> <li>-Exposed cups and plastic silverware.</li> <li>-Shelves totally disorganized.</li> <li>-Trash on floor in exit hallway.</li> <li>-Cooking utensil cart very dirty.</li> <li>-Table by stove filthy. Open container of oil.</li> <li>-Multiple serving tools open under food prep table - scrambled.</li> <li>-Cart under cereal filthy.</li> <li>-Behind steam table: old bacon, multiple packets, spills.</li> <li>-Prep area - very disorganized. Needs cleaning.</li> <li>-Refer to DM and RD. Recommend inservices and other hands-on training.</li> <li>-Please submit plan to administrator.</li> <li>-Dirty washcloths on cart.</li> <li>-Debris (food) just sitting in receptacle.</li> <li>-Splatters on wall and ceiling.</li> <li>-Fan dirty.</li> <li>-Food delivery carts dirty.</li> <li>-Pies uncovered - need parchment (paper) on dirty cart.</li> <li>-Clean dish room floor very dirty.</li> </ul>	F 371		7-16-15

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F 371	<p>Continued From page 120</p> <ul style="list-style-type: none"> <li>-Dish machine chemical log very incomplete. Only one day logged for October (2014)."</li> <li>*On 12/12/14:</li> <li>-Refrigerator shelves, racks, walls, floors ceiling, and doors were found not clean.</li> <li>-Refrigerator temps were not found to be logged daily by staff.</li> <li>*On 12/5/14:</li> <li>-Food supplies were found to have not been rotated.</li> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Temperatures in the refrigerator from the thermometer were found below 41 degrees as required.</li> <li>-Refrigerator temps were not found to be logged daily by staff.</li> <li>-Food had not been discarded after seventy-two hours.</li> <li>-Not all freezer food had been found covered, labeled, and dated.</li> <li>-Not all items were stored on racks for proper ventilation.</li> <li>-The freezer temperature had not been logged daily.</li> <li>-Dishwashing temperatures had not reached proper temperatures for wash and rinse cycles and had not been logged daily.</li> <li>-Dishwasher are was not clean.</li> <li>-The daily cleaning schedule had not been completed and followed.</li> <li>-Floors, walls, ceilings, and work areas were found not clean.</li> <li>-Work areas and tables were not clean.</li> <li>-Carts and racks were not clean and in good repair.</li> <li>-Hood filters had not been cleaned.</li> <li>-Employees had not worn hair covers, clean or wearing the appropriate uniform.</li> </ul>	F 371		7-16-15
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F 371	<p>Continued From page 121</p> <ul style="list-style-type: none"> <li>-Cleaning cloths had not been stored in the sanitizing solution.</li> <li>-Food scoops were not found to be clean and dry.</li> <li>-The sanitizing test kit had not been found.</li> <li>-The walls, racks and floors in the clean dish area were not clean.</li> <li>-Food prep equipment, dishes, utensils were not found clean, sanitized and stored properly.</li> <li>-The toaster, can opener, coffee maker, range, carts, cutting boards, steam table, microwave, grill, hoods and ice machine were not found to be clean.</li> <li>*On 12/19/14:             <ul style="list-style-type: none"> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Food had not been discarded after seventy-two hours.</li> <li>-Freezer temperatures were not logged daily.</li> </ul> </li> <li>*On 12/29/14:             <ul style="list-style-type: none"> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Food had not been discarded after seventy-two hours.</li> <li>-Freezer temperatures were not logged daily.</li> <li>-Dishwasher temperatures were not logged daily.</li> <li>-The daily cleaning schedule had not been completed and followed.</li> <li>-Floors, walls, ceilings, and work areas were found not clean.</li> <li>-Carts and racks were not clean and in good repair.</li> <li>-Gloves had not been worn by employees per policy.</li> <li>-The sanitizing test kit had not been found.</li> <li>-The walls, racks, and floors in the clean dish area were not clean.</li> </ul> </li> <li>*On 1/2/15:             <ul style="list-style-type: none"> <li>-Not all items in the refrigerator had been covered, labeled, and dated.</li> </ul> </li> </ul>	F 371		7-16-15

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F 371	<p>Continued From page 122</p> <p>*On 1/9/15: -Raw food items had not been stored below cooked food items. -All items in the dishwashing area were not dried or stacked. -Hand washing procedures had not been posted at the sink. -Hood filters were not clean and regularly scheduled to be cleaned.</p> <p>Review of the provider's 4/30/15 Cleaning Instructions: Floors, Tables and Chairs policy revealed: *Kitchen and dining room floors, tables, and chairs were to have been kept clean and sanitary. *Kitchen floors were to have been swept and mopped each day after lunch. Major appliances were to have been moved at least once per month in order to clean behind and underneath them.</p> <p>Review of the provider's 4/30/15 Cleaning Instructions: Refrigerators policy revealed the refrigerators were to have been washed inside and out with a detergent and sanitizer at least once every month.</p> <p>Review of the provider's 4/30/15 General Sanitation of the Kitchen policy revealed: *Staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. *Cleaning and sanitation tasks would have been recorded.</p> <p>Review of the provider's April 2011 Dietary Department Standard Operating Procedure revealed: *The food service area was to have been</p>	F 371		7-16-15
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F 371	<p>Continued From page 123</p> <p>maintained in a clean and sanitary manner. *The kitchen and dining areas should have been kept clean, free from litter and rubbish, and protected from insects and rodents. *All counters, shelves and equipment should have been kept clean.</p> <p>Review of the provider's April 2011 Food Storage Standard Operating Procedure revealed: *Food storage areas were to have been kept clean at all times. *Foods stored in walk-in refrigerators and freezers were to have been stored above the floor on shelves.</p> <p>Review of the provider's April 2011 Food preparation Area Standard Operating Procedure revealed the facility was to have maintained a clean, sanitary, and safe food area.</p> <p>Review of the provider's 4/30/15 Food Safety - Food Service Manager's Responsibility policy revealed the food service manager assures: *Good sanitary food handling practices. *Sanitary conditions were maintained. *All personnel were to have followed proper cleaning and sanitizing. *Regular inspections were made by the food service manager or designee to assure food safety.</p> <p>2. Observation and interviews on 6/9/15 with dietary aides F and SS revealed: *At 7:40 a.m. in the East dining room with dietary aide F revealed: *She took the temperature of the oatmeal without cleaning the food thermometer. -Using that same food thermometer and without cleaning it, she inserted it into the cream of</p>	F 371		7-16-15
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F 371	<p>Continued From page 124</p> <p>wheat.</p> <p>*She then attempted to serve the above foods.</p> <p>*Temperature of the pureed meat was 80 degrees Fahrenheit (F).</p> <p>*She was unaware what the safe holding temperature should have been. It depended upon the temperature of the steam in the table.</p> <p>*At 8:04 dietary aide SS brought replacement oatmeal and cream of wheat to the East dining room.</p> <p>*There had been no new clean scoops located in the drawers.</p> <p>*Dietary aide SS grabbed the used scoops, walked to the sink, ran the water, and scrubbed the scoops with her bare hands and wiped them on her apron.</p> <p>*She then proceeded to place the scoop into the new oatmeal and cream of wheat.</p> <p>Interview on 6/9/15 at 8:30 a.m. with the CDM and the registered dietician (RD) revealed both agreed not cleaning the thermometer or the scoops was a problem.</p> <p>3. Observation and interview on 6/9/15 at 11:45 a.m. with dietary aide E during the noon meal service in the Warren dining room revealed:</p> <p>*The pureed foods were not kept in the steam table for hot holding prior to serving.</p> <p>*They were not in the steam table because they had not fit in that area.</p> <p>*The pureed broccoli temperature was 98 degrees F.</p> <p>*The pureed liver temperature was 80 degrees F.</p> <p>*She thought the safe serving temperature was 160 degrees F.</p> <p>*She stated the pureed food was safe to serve.</p> <p>*The temperatures of the pureed hot food needed to have been a minimum of 135 degrees F.</p>	F 371		7-16-15

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F 371	<p>Continued From page 125</p> <p>4. Observation on 6/9/15 at 12:07 p.m. in the east dining room with dietary aide F revealed: *Ground liver was 118 degrees F. *At 12:25 p.m. prior to serving she checked the temperature of the ground liver again and it had dropped to 90 degrees F. *She stated the temperature safe to serve hot held food was 160 degrees F. *The temperature of the pureed hot food needed to have been a minimum of 135 degrees F.</p> <p>Review of the food temperature logs for April 2015 revealed: *Temperature logs in the Central dining room had not been logged for meal services for the entire day of 4/8/15. *Dinner service temperatures in the Central dining room were not logged and were incomplete for the following dates: 4/ 4, 4/5, 4/6, 4/7, 4/9, 4/10, 4/11, 4/14, 4/15, 4/16, 4/17, 4/20, 4/21, 4/24 and 4/28. *East dining meal service had no pureed meat temperatures for the lunch or dinner services on 4/ 2, 4/6, 4/7, 4/8, 4/12, 4/15, 4/16, 4/17, 4/19, 4/20, 4/22, 4/23, and 4/27. *Dinner services temperatures were not logged in the Warren dining room on 4/3 through 4/8, 4/10 through 4/16, 4/18, 4/19, and 4/21 through the 4/28. *Temperature logs in the Warren dining room were not logged for the lunch meal services for 4/13/15. *Incomplete temperature logs were dated 4/1/15 and 4/2/15 in the Warren dining room for the dinner service .</p> <p>Review of the food temperature logs for May 2015 revealed:</p>	F 371		7-16-15
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F 371	<p>Continued From page 126</p> <ul style="list-style-type: none"> <li>*There were no temperatures logged in the month of May for the Warren evening meal service.</li> <li>*5/3/15: No lunch temperatures were taken in the central (main) meal service.</li> <li>*No temperatures were taken on 5/5/15 in the Warren dining room all day.</li> <li>*5/8/15: Only the entree temperature was taken at the evening meal service.</li> <li>*5/10/15: no lunch and dinner temperatures were taken at the central meal service.</li> <li>*5/14/15: No breakfast or lunch temperatures were taken in the central dining service.</li> <li>*Dinner services in the central dining room were not checked or completely checked on 5/17, 5/19, 5/20, 5/24, 5/28, 5/29, and 5/30.</li> <li>*No temperature logs were received for the East dining room for the month of May from the CDM.</li> </ul> <p>Review of the provider's 4/30/15 Safety Guidelines policy revealed staff should have monitored food temperatures on a regular basis at the point they were served.</p> <p>Review of the provider's 4/30/15 Food Temperatures policy revealed:</p> <ul style="list-style-type: none"> <li>*Food should have been held and served at a temperature of at least 135 degrees F.</li> <li>*Hot food items were not to fall below 135 degrees F after cooking.</li> <li>*Temperatures should have been taken periodically.</li> <li>*Tray line and service areas were to avoid holding foods in the temperature danger zone of 41 degrees F to 135 degrees F.</li> </ul> <p>Review of the provider's 4/30/15 Food Safety policy revealed:</p> <ul style="list-style-type: none"> <li>*The flow of food as it goes through kitchen in</li> </ul>	F 371		7-16-15
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F 371	<p>Continued From page 127</p> <p>order was to have been received, stored, prepared, cooked, held, served, cooled, and reheated.</p> <p>*The second leading cause of food born illness is food not thoroughly heated or cooked.</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <p>*Dietary aides and cooks were appropriately trained.</p> <p>*The dietary staff, the DM and the RD appropriately performed their job duties as defined within their job descriptions.</p> <p>Findings include:</p> <p>1. Observation and interview on 6/9/15 at 7:35 a.m. with dietary aide F in the East dining room revealed she:</p> <p>*Cracked unpasteurized eggs, mixed them with milk, and cooked scrambled eggs on a griddle to serve to the residents.</p> <p>*Fried pancakes from batter made with unpasteurized eggs on the griddle.</p> <p>*Had been cooking and serving food to the residents since her first day on the job.</p> <p>*Had been employed for five months.</p> <p>Interview and record review on 6/10/15 at 10:00 a.m. with the CDM upon receipt of the provider's undated Dietary Initial Training Policy and required inservices revealed:</p> <p>*Only two inservices had been provided to all dietary staff within one year prior to the survey. Topics included were "Voicing Grievances" and "Changes".</p> <p>*The Dietary Initial Training Policy revealed training that was to have been provided to dietary staff within two weeks of hire and ongoing</p>	F 371		7-16-15
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F 371	<p>Continued From page 128 included:</p> <ul style="list-style-type: none"> <li>-Resident's rights.</li> <li>-Overview of food service.</li> <li>-Introduction to food service.</li> <li>-Sanitation.</li> <li>-Safety.</li> <li>-Food preparation.</li> <li>-Standard measurements.</li> <li>-Nutrition.</li> <li>-Therapeutic diets.</li> <li>-Review of policies and procedures.</li> </ul> <p>*The CDM "had been employed for seven months" at the facility and "had not had time to train" the dietary staff.</p> <p>*She could provide no further dietary training for any dietary aides except the two above dietary inservices.</p> <p>*She agreed the required mandated training regarding food service had not been provided to dietary personnel.</p> <p>Observation and interview on 6/10/15 at 3:10 p.m. with the CDM and the administrator while performing a walk-through of the kitchen areas revealed:</p> <p>*The CDM stated she had only been at the facility for seven months and had no time to train dietary staff.</p> <p>*The administrator had been unaware dietary staff had not been trained as defined by policy and regulation upon hire and yearly thereafter.</p> <p>*He was unaware the untrained dietary aides had been cooking breakfast in the East and Warren dining rooms.</p> <p>Review of the provider's inservices performed in the last year revealed:</p> <p>*Two had been completed prior to the survey.</p> <p>One was held in January 2015 on "Changes" and</p>	F 371		7-16-15
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F 371	<p>Continued From page 129 one was held in March 2015 on "Voicing Grievances."</p> <p>Review of the provider's March 2005 Competency Evaluation Standard Operating Procedure revealed: *The purpose was to assure quality standards were maintained through competency evaluations yearly. *Employees would be evaluated on their competency..." *Skills can be identified through a needs assessment, the provider's plan of correction, or at the discretion of the director.</p> <p>Review of the provider's 2/1/03 Nutrition Consulting Services Agreement contract revealed the duties of the RD included providing nutritional education to staff.</p> <p>Review of the provider's undated CDM job description revealed she: **"Monitors staff performance daily." ***"Trains new staff and assures they are being oriented well."</p> <p>Review of the provider's 4/30/15 Evaluating Food Service and Clinical Nutrition Personnel policy revealed: *Food service personnel should have had their first evaluation at the end of their probationary period of ninety days. *Periodic written evaluations for food service staff were to have been completed by the food service manager. *The RD should have evaluated the nutrition support staff.</p> <p>Review of the provider's undated Dietary Aide Job</p>	F 371		7-16-15

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F 371

Continued From page 130  
Description revealed they were to:  
\*Provide assistance to the cook in preparation and service of the meals.  
\*Follow cleaning schedules and perform cleaning duties as scheduled.  
\*Follow defined infection control procedures.

F 371

Review of the provider's undated Dietary Cook Job Description revealed they were to:  
\*Prepare, season, and cook the assigned meal.  
\*Monitor temperature of foods through preparation and service.

Review of the provider's 4/30/15 Food Safety-Food Service Manager's Responsibility policy revealed the food service manager assures:  
\*Good sanitary food handling practices.  
\*Sanitary conditions were maintained.  
\*All personnel were to have followed proper cleaning and sanitizing.  
\*Regular inspections were to have been made by the food service manager or designee to assure food safety.

F 441  
SS=F

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,

F 441

The QAPI policy and procedure reviewed and revised to include monthly and more in-depth meetings on 7-09-15.  
The facility's Infection Control Nurse began her duties on 7-9-2015. She was given a copy of the facility's updated Infection Control Manual to review on 7-9-2015. Employee C is the designated infection control nurse and will train with the Infection Control Nurse of a sister facility on July 15, 2015. The Infection Control Nurse will conduct surveillance, prevention, control, and reporting as necessary.

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F 441	Continued From page 131 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: 14477 Surveyor 33265 A. Based on observation, interview, record review, and policy review the provider failed to implement and promote consistent adherence to infection control practices by having a functioning Infection Control Program with appropriate oversight. Findings include:  1. Interview and record review on 6/10/15 at 2:25 p.m. to 2:55 p.m. with infection control nurse revealed:	F 441	This will include random audits of the components of Infection Control. The Infection Control Nurse will participate in continued education of Infection Control programs and policies. The DON will educate all staff between July 14-15, 2015 as to where the Infection Control Manual is located on the facility and on what type of material is included in it. The facility's "Cleaning and Disinfecting Equipment" policy was revised on July 8, 2015, to include the proper cleaning of the blood Glucometer machines between residents. All of the facility Blood Glucometer machines are cleaned according to manufacturer's instructions. Audits will be conducted weekly x 1 month and monthly x 3 months on resident #59 and #10. Audits will also be performed on 5 other random residents who require the use of Blood Glucometers by the DON and/or designee. The DON and/or designee will be responsible for conducting the audits and for overall compliance. The DON will report audit findings to monthly QAPI meetings for one year. The facility Shower/Tub and Bath policy was revised on 7-8-2015 to include the instructions for cleaning and disinfecting the facility tubs and showers and the disinfecting procedure for each whirlpool tub will be located in each tub or shower area.	7-16-15	

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F 441	<p>Continued From page 132</p> <ul style="list-style-type: none"> <li>*She had accepted the position of infection control nurse one month ago.</li> <li>*She had no specialized training or additional training for infection control..</li> <li>*The interim director of nursing was here at that time and was going to assist in her training, but that had not happened.</li> <li>*There had been no infection control report at the last QA (quality assurance) meeting as she had not been trained on the task.</li> <li>*She was not aware of or involved in any training on infection control for new employees.</li> <li>*She was not aware of any training on infection control since the training that had been required due to last survey in September 2014.</li> <li>*She was not aware of any monitoring or auditing of infection control practices since completion of the monitoring/auditing required from the last survey in September 2014.</li> <li>*She agreed there was no current infection control program.</li> <li>*Her role included many other tasks besides infection control.</li> <li>*She resigned her position as infection control nurse earlier that week.</li> </ul> <p>Review of the provider's April 2013 Policies and Procedures - Infection Control document revealed:</p> <ul style="list-style-type: none"> <li>* The Quality Assurance Performance Improvement committee was to have been overseeing the implementation of infection control policies and practices.</li> <li>*All personnel were to have been trained on the infection control policies and practices upon their hire and periodically.</li> <li>-The amount of the employee training was to have been dependent on the time spent on direct resident contact and job responsibilities.</li> </ul>	F 441	<p>C.N.A.'s OO and Q were educated on the proper tub and shower cleaning and disinfection procedure on 6-12-15 during the survey. All other facility staff will be educated on the tub and shower disinfection process and revised policy for each by the DON on between July 14-15, 2015.</p> <p>Audits will be conducted on C.N.A.'s OO and Q along with 10 other random C.N.A.'s weekly x 1 month and monthly x 3 months.</p> <p>Audits will be conducted by the DON and/or designee who will also be responsible for overall compliance.</p> <p>The DON and/or designee will be responsible for reporting audit findings at monthly QAPI meetings for one year.</p> <p>The facility policies – "Dressing Dry Clean and Dressings Soiled" – were revised on 7-8-2015. The entire nursing staff will be educated by the DON on July 14-15,2015 on these procedures. RN BB will be educated on 7-14-2015 by the DON on the proper dressing policy and procedure.</p> <p>Audits will be conducted weekly x 1 month and monthly x 3 months on RN BB and 10 other random RN's or LPN's on dressing changes. Audits will be conducted by the DON and/or designee who will also be responsible for overall compliance.</p> <p>The DON will report audit findings at monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15
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F 441	<p>Continued From page 133</p> <p>*The administrator or governing board, through the QAPI committee, had adopted the policies and practices needed to prevent transmission of infections and communicable diseases.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator concerning above observations and interviews revealed the infection control nurse had resigned her position after one month.</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to follow infection control practices for the following:</p> <ul style="list-style-type: none"> <li>*Two of two randomly observed disinfections of the glucometer (a device used to measure blood sugar) in between resident use.</li> <li>*Two of two whirlpool tub disinfection procedures and one random shower disinfection procedures after resident use.</li> <li>*Two of three sampled residents (9 and 30) observed dressing changes.</li> <li>*One of one randomly observed hand hygiene practice.</li> <li>*One of one randomly observed resident ice water distribution.</li> </ul> <p>Findings include:</p> <p>Surveyor 14477</p> <p>1. Observation and interview on 6/9/15 at 11:48 a.m. revealed staff nurse D was taking resident 59's blood sugar test by doing a fingerstick and then used an Element Compact Blood Glucose Monitoring System (glucometer). After the completion of the test, staff D returned to the medication cart with the glucometer. She then:</p> <ul style="list-style-type: none"> <li>*Laid the glucometer on the top of the medication cart.</li> </ul>	F 441	<p>The facility's Shower, Tub and Bath policy was reviewed and revised on 7-6-15 to include where the cleaning and disinfection procedures will be located within the bathing and shower areas. The manufacture guidelines of disinfecting each whirlpool will be posted in each whirlpool room. CNAs OO and Q were educated on the proper procedure for cleaning and disinfection of the tubs and shower areas on 6/15/15. The entire nursing staff will be educated by the DON on July 14-15,2015 on these procedures. Audits will be conducted on CNAs OO and Q along with 5 other random audits weekly for 1 month and monthly for 1 year. The DON and/or designee will be responsible for conducting audits and for overall compliance. Audit findings will be reported by the DON and/or designee for 1 year and then as deemed necessary by the QAPI committee. Nurse BB will be educated on proper procedure for changing a suprapubic catheter, to include proper hand hygiene on July 14, 2015. Hand hygiene and suprapubic catheter care policies were reviewed on 7/9/15, and found to be current and accurate. All other nursing staff will be educated on these policies during the July 14-15, 2015 in-service. Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for water pass. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance.</p>	7-16-15
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F 441	<p>Continued From page 134</p> <p>*Stated she was putting on gloves because she couldn't stand the smell of the glucometer cleaner.</p> <p>*Put on those gloves and removed a sanitizing wipe from container.</p> <p>*Wiped the the glucometer with the sanitizing wipe for fifteen seconds.</p> <p>*Discarded the wipe and her gloves and replaced the glucometer back in the top drawer of the medication cart. A second glucometer was also in that top drawer. There were no names on either of the glucometers, and they were co-mingled in the drawer.</p> <p>Review of the manufacturer's instruction manual in the glucometer box revealed under "Intended Use: The system is intended for self testing by persons at home, is for single patient use only, and should not be shared."</p> <p>Interview on 6/16/15 at 10:40 a.m. with RN M and unlicensed assistive personnel (UAP) W confirmed those glucometers were being used for multiple residents and were not designated for single person use.</p> <p>Review of the sanitizing germicidal disposable wipe at the above time revealed it was a premoistened wipe with a stabilized bleach solution (equivalent to a 1:10 dilution). The instructions stated it killed bacteria, fungi, and viruses. It was to have maintained a wet contact time of four minutes.</p> <p>Review of the provider's 6/20/11 "Multiple Use Glucometer Cleaning" policy and procedure revealed: **Policy: To provide a healthful environment by reducing soil/contamination on equipment. In</p>	F 441	<p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Resident Water Pass.</p> <p>A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.</p> <p>The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee for 1 year and then until deemed by the QAPI committee. Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for hand sanitation practices for dietary. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance.</p>	7-16-15

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F 441	<p>Continued From page 135</p> <p>accordance with the CDC, Infection Control practices and manufacturer's guidelines, all multiple use Glucometer machines will be disinfected between each patient use." **Procedure: Disinfecting between patient use: -After each patient use, the nurse and/or designee will disinfect the Glucometer machine with a 1:10 bleach solution wipe. -Take extreme care not to get any liquid in the test strip and key code port of the meter. -The glucometer should be allowed to air dry for 2 minutes prior to using again."</p> <p>Surveyor 34030 2. Observation on 6/9/15 at 11:05 a.m. of certified nursing assistant (CNA)/medication tech (MT) Z using the glucometer during the medication pass on the East wing revealed: *She took the glucometer into a residents room to check his blood sugar. -She stated she would use the same glucometer to check multiple residents. *After use wiped it clean with a Sani-Cloth with bleach and let it air dry. *Review of the package instructions revealed it required a contact time of four minutes to kill germs, which required the cloth to be wrapped around the glucometer to ensure contact time.</p> <p>3. Observation and interview on 6/16/15 with CNA/MT AA on the East hallway medication cart revealed: *The Sani-Cloths with bleach were outdated in April 2015. *She usually used alcohol wipes to clean the glucometer as they did not always have Sani-Cloths.</p> <p>4. Observation and interview on 6/16/15 at 10:10</p>	F 441	<p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Handwashing. A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office. The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.</p>	7-16/15
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F 441	<p>Continued From page 136 a.m. with RN Y on the Center hallway medication cart revealed: *The Sani-Cloths with bleach were outdated in April 2015. *She used either the Sani-Cloths or hydrogen peroxide wipes to clean the glucometer.</p> <p>5. Interview on 6/16/15 at 3:30 p.m. with the DON and administrator revealed they were unaware of what was being done to clean the glucometers but would look into it.</p> <p>Surveyor 33265 6. Observation and interview on 6/10/15 at 2:05 p.m. of the cleaning and the disinfection of the Center wing whirlpool tub by CNA OO revealed she: *Used her bare hands. *Sprayed the seat of the transfer lift system with the 3M Neutral Quart (disinfectant) spray. A different cleaner was used to clean the rest of the whirlpool tub. *Added Penner whirlpool disinfectant cleaner solution into the bottom of the tub. *Used a long handled brush to scrub surfaces inside of tub with disinfectant. *Pulled the plug to drain out the disinfectant solution. *Rinsed off the long handled brush and tub immediately. *Wiped off seat with a dry towel. *The entire cleaning and disinfection of the whirlpool tub and transfer lift system took less less than three minutes. *CNA OO stated this was how she was taught to clean and disinfect the whirlpool tub between residents use.</p> <p>Surveyor 14477</p>	F 441		7-16-15
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F 441	<p>Continued From page 137</p> <p>7. Observation on 6/17/15 at 8:10 a.m. in the Warren Wing whirlpool tub room revealed a document entitled: "Warren Wing Spa/Whirlpool Disinfecting procedure." Review of those instructions revealed:</p> <ul style="list-style-type: none"> <li>**Close and lock the tub door.</li> <li>*Rinse the inside tub surfaces with the shower sprayer.</li> <li>*Spray the entire tub inside surface, including the lift chair, with an EPA [Environmental Protection Agency] approved/recommended disinfectant.</li> <li>*Using a long-handled brush, thoroughly scrub all interior surfaces of the tub and chair with the disinfectant. Let disinfectant stay on surface for 10 minutes (or, as recommended by the instructions on the disinfectant container).</li> <li>*With the shower spray, rinse the interior surfaces of the tub and lift chair thoroughly.</li> <li>*Visibly check that the tub was effectively cleaned during the disinfecting procedure. If not, repeat the procedure.</li> <li>*After the last bath of the shift, use a towel to wipe down the door and around the seal. Leave the tub door open."</li> </ul> <p>8. Observation and interview on 6/17/15 at 8:30 a.m. with certified nursing assistant (CNA) Q revealed she:</p> <ul style="list-style-type: none"> <li>*Sprayed Quat (a type of disinfectant) in each of the jets.</li> <li>*Sprayed the entire tub surfaces, added hot water, and waited for 10 minutes before draining the tub. Interview at that time regarding the manufacturer's direction for cleaning the whirlpool tub confirmed she was not taking each jet assembly apart for cleaning after every bath.</li> </ul> <p>Surveyor 33265</p> <p>9. Observation and interview on 6/10/15 at 4:48</p>	F 441		7-16-15
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F 441	<p>Continued From page 138</p> <p>p.m. on East wing in the shower room on cleaning and disinfection of the shower area after resident use with CNA PP revealed she:</p> <ul style="list-style-type: none"> <li>*Used Clorox Germicidal Bleach Spray in a spray bottle.</li> <li>*Sprayed the walls, the shower chair, and the floor of shower area with the bleach spray.</li> <li>*Used a long handled brush to go over the shower chair and the middle sections of wall surfaces.</li> <li>*Immediately rinsed off the walls, the shower chair, and the floor with water from the hand held shower wand.</li> <li>*CNA PP stated this was how she was taught to clean and disinfect the shower area between resident use. She added that she would try to let it air dry before the next use if there was time.</li> <li>*Entire cleaning, disinfecting and rinsing off of bleach spray was completed in 3 minutes.</li> </ul> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator concerning above observations and interviews revealed the:</p> <ul style="list-style-type: none"> <li>*DON was not aware the staff were not following the policies/procedures for cleaning of the whirlpool tubs and shower areas.</li> <li>*DON was not sure why two different disinfectant/cleaner solutions were used in the Center wing whirlpool tub procedure observed.</li> </ul> <p>Review of undated manufacturer's instructions for use of Clorox Bleach Germicidal Cleaners listed a five minute contact time was needed to kill all the germs listed on the label.</p> <p>Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed they were to disinfect the shower chair</p>	F 441		7/16-15
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F 441	<p>Continued From page 139 and the floor after each use following the manufacturer's disinfecting recommendations.</p> <p>Review of the manufacturer's instructions undated instructions on Penner Whirlpool Disinfectant Cleaner label revealed there was a ten minutes contact time (time needed for the disinfectant to kill germs) needed on nonporous (hard) surfaces of whirlpool tubs.</p> <p>Review of the 2012 manufacturer's instructions on the 3M Neutral Quat Disinfectant Cleaner label revealed: *There was a ten minutes contact time needed to kill the majority of germs on surfaces. *It may cause skin irritation; should avoid prolonged skin contact.</p> <p>Review of the manufacturer's 11/07/12 Cascade Aqua -Aire Whirlpool tub Instruction Manual revealed the disinfectant solution should have remained on the surfaces for ten minutes or as disinfectant manufacturer instructed on container label.</p> <p>Review of the provider's undated Cleaning of the Tub policy revealed the disinfectant Provon was to be used and only this cleaner.</p> <p>Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed: *The whirlpool tub was to have been disinfected after every use. *Staff were to follow whirlpool disinfecting procedure posted in the whirlpool room.</p> <p>Review of the provider's undated Whirlpool Disinfecting Procedure posted in the Center wing</p>	F 441		7-16-15
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F 441	<p>Continued From page 140</p> <p>whirlpool tub room revealed the disinfectant spray was to stay on the surfaces for ten minutes or as recommended by the instructions on the disinfectant concentrate container.</p> <p>Review of undated manufacturer's instructions for use of Clorox Bleach Germicidal Cleaners listed a five minute contact time was needed to kill all the germs listed on the label.</p> <p>Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed they were to disinfect the shower chair and the floor after each use following the manufacturer's disinfecting recommendations.</p> <p>Surveyor: 34030 10. Observation and interview on 6/9/15 at 9:30 a.m. of a random resident dressing change (30) with RN BB revealed: *Dressing changes were being done to sores on the resident's lower legs. *RN BB placed all the supplies for the dressing change on the bare floor of the resident's room in front of the resident in her wheelchair. These supplies included: -The scissors used to cut the gauze dressings. -Ace wraps used to go over the gauze dressings to hold them in place. -A tube of ointment. -Sterile gauze dressings taken out of the package and were placed on top of the package on the floor. -A package of tube grip (netting used to keep gauze dressings in place). *She proceeded to do the dressing change and took the tube of ointment to place some on the sterile gauze, then placed the tube back on the bare floor.</p>	F 441		7-16-15
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F 441	<p>Continued From page 141</p> <p>*After the dressing change she: -Placed the ointment into a plastic bag. -Put the scissors into her pocket. -Picked up the remainder of the unused tube grip and placed it, the scissors, and the ointment into the medication cart.</p> <p>*No barrier had been used between the supplies and the floor to keep them clean.</p> <p>*When this surveyor spoke to RN BB about the above dressing change she replied she had put her supplies on the floor because there was no table in the resident's room to use and she had not thought to ask for one.</p> <p>Interview on 6/16/15 at 3:30 p.m. with the DON and administrator regarding the above dressing change revealed the DON agreed this had not been done in a sanitary manner.</p> <p>Review of the provider's August 2011 Dressing Change (Routine) Policy and Procedure revealed: **"Place a barrier (towel/paper towel) between supplies and area placed on." **"Open dressings, etc remembering to keep barrier between supplies and area supplies are placed." Surveyor: 33265</p> <p>11. Observation and interview on 6/9/15 at 1:25 p.m. with registered nurse (RN) BB during a suprapubic catheter (tube to drain urine from bladder out through lower abdominal) dressing change on resident 9 revealed she: *Washed her hands at the sink for five seconds. *Wiped off the area next to the sink with a paper towel. *Placed a paper towel on the counter next to the sink. *Removed supplies from her jacket pocket. *Opened the supplies onto a paper towel.</p>	F 441		7-16-15	

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F 441	<p>Continued From page 142</p> <ul style="list-style-type: none"> <li>*Put on gloves.</li> <li>*Removed the soiled dressing from the suprapubic site and threw it into the trash.</li> <li>*Poured sterile water on a gauze pad and wiped off the suprapubic site and down the catheter tubing.</li> <li>*Removed the gloves and discarded them into the trash.</li> <li>*Washed her hands at the sink for three seconds.</li> <li>*Put on new gloves.</li> <li>*Took tape out of her pocket, tore off a piece a few inches long and placed it on the wheelchair handle.</li> <li>*Took a tube of mupirocin cream (antibiotic) and applied it directly to suprapubic site from tube.</li> <li>*Placed a piece of new gauze over the site.</li> <li>*Pulled the tape off of the wheelchair handle and placed it over the new gauze.</li> <li>*Removed pen from pocket and documented the date on the tape and the sterile water bottle.</li> <li>*Placed the pen back in her pocket.</li> <li>*Took off the soiled gloves and discarded them into the trash.</li> <li>*She pulled the full trash bag out of the trash container and made a knot to seal it.</li> <li>*Washed her hands at the sink for three seconds.</li> <li>*Confirmed that was her routine for dressing changes.</li> </ul> <p>Review of the provider's August 2011 Dressing Change (Routine) policy and procedure revealed:</p> <ul style="list-style-type: none"> <li>*Were to gather supplies and then place on barrier, not put in pocket.</li> <li>*Were to wash hands and put on gloves after supplies were placed on barrier.</li> <li>*Were to open supplies after old dressing and used gloves was removed and thrown away and hands washed.</li> </ul>	F 441		7-16-15	

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F 441	<p>Continued From page 143</p> <p>Review of the provider's June 2014 Hand Washing/Hand Hygiene policy revealed: *Employees must wash their hands for at least fifteen (15-20) seconds using antimicrobial or non-antimicrobial soap and water: -Before and after direct resident contact. -Before and after handling invasive (go into body) devices. -Before and after changing a dressing. -After removing gloves.</p> <p>12. Observation and interview on 6/9/15 at 3:35 p.m. in the Center wing hallway of dietary aide R revealed: *She had an ice chest with ice in it and had been going to each resident room. *Without wearing gloves she: -Went into residents' rooms, pushing on doors or handling door knobs/ handles. -Picked up a resident's water mug. -Opened the mug and discarded ice or water into the sink in the room. -Returned to the hall and the ice chest with the resident's water mug. -Opened the ice chest and dug for scoop in the ice. -Filled the mug with ice using the scoop. -Dropped the scoop back into the ice in the chest and closed the lid. -Filled the mug with water in the resident's room. -Replaced the lid on the mug and placed the mug for resident use. *Dietary aide R had not responded when asked by the surveyor if she had done the ice water pass task daily. *Dietary aide R confirmed it had been her "first time" for the ice water pass task. *She was asked if she was taught to handle the ice scoop as I had observed her. She said "yes".</p>	F 441		7-16-15
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F 441	<p>Continued From page 144</p> <p>Interview on 6/9/15 at 3:42 p.m. with the dietary manager revealed:</p> <ul style="list-style-type: none"> <li>*She agreed the scoop should not have dropped into the ice after use, but should have been put back into the scoop drawer.</li> <li>*The dietary department had taken over refilling of the resident water mugs last week.</li> <li>*She confirmed that it had been dietary aide R's first time doing the task.</li> <li>*The staff had been instructed on how to do that task last week, but she was unsure if it had been on Thursday or Friday.</li> <li>*The training for the ice water pass task had consisted of reviewing the policy.</li> <li>*She had been unsure if there was a return demonstration of the task when staff were instructed.</li> <li>*She had not provided any documentation of training that had been done regarding that task.</li> <li>*The ice chest and scoop should have been retrieved, cleaned and disinfected.</li> <li>*She had twenty-one days to change an employee's habits and had not agreed there was a need to re-educate the staff on the handling of ice at that time.</li> </ul> <p>Review of the provider's April 2011 Ice procedure revealed:</p> <ul style="list-style-type: none"> <li>*Ice was to have been maintained and served to residents in a sanitary manner.</li> <li>*Ice was to have been handled, transported, and stored in such a manner as to have been protected against contamination.</li> <li>*Scoops were to have been stored and handled in a sanitary manner.</li> </ul> <p>Review of provider's undated Ice policy revealed ice was not to be handled with bare hands.</p>	F 441		7/16/15
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F 441	<p>Continued From page 145</p> <p>Review of provider's April 2012 Ice Machines and Ice Storage Chests Policy revealed: * Ice was not to have been handled by hand. *The scoop used in ice chests was to have been kept in a covered container when not in use.</p> <p>13. Observation on 6/9/15 at 11:55 a.m. in East wing dining room regarding dietary aide R revealed: *She sat down at one of the tables where residents needed assistance with eating. *She reached for and used the hand sanitizer on the table. *After rubbing her hands together for ten seconds she stopped, looked at the palms of her hands and then wiped both of her hands down the top of her pant legs several times. *She then waited for the food to arrive.</p> <p>Review of the provider's June 2014 Hand Washing/Hand Hygiene policy revealed: *Employees must wash their hands for at least fifteen (15-20) seconds before and after assisting a resident with meals. *Alcohol based hand sanitizers were not to be used before and after assisting residents with meals.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator concerning above observations and interviews revealed the DON was not aware the staff were not following the policies/procedures for dressing changes, handling of ice, and hand hygiene.</p>	F 441		7-16-15
F 490 SS=H	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	F 490		

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F 490	<p>Continued From page 146</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, record review, and job description review, the provider failed to ensure its resources were used effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:</p> <p>1. Review of the provider's October 2012 Administrator job description revealed: **"The administrator is responsible to lead and direct the overall operations of [provider name] in accordance with customer needs, government regulations and [corporate name] policies." **"The administrator is responsible to maintain a focus in excellent care for the residents while achieving the facility's business objectives." **"Manages overall facility operations and leading by example with regards to customer service, employee relations, and quality assurance." **"Complies with, supporting, and enforcing company safety and infection control policies." **"Promotes, understands, and complies with rules regarding residents' rights."</p> <p>Review of the provider's April 2013 director of nursing (DON) job description revealed: **"The DON is responsible for the daily direct care services of [provider name] in a professional</p>	F 490	<p>The Administrator will direct and/or oversee the plans of correction for all system changes and QAPI audits related to tags F151, F159, F176, F223, F311, F366, F367 and repeated deficiencies from previous recertification survey on 9-11-14: F166, F224, F226, F241, F248, F252, F253, F278, F280, F281, F309, F314, F323, F325, F353, F368, F371, F441, F490, F493, F514, F520. Correction of the above-listed tags will indicate compliance with this requirement.</p>	7-16-15

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F 490	Continued From page 147 manner using its resources effectively and efficiently to attain and maintain the highest level of care to residents/patients in accordance with regulatory standards." **"Keeps the facility in compliance with applicable federal, state, and local standards and regulations." **"Monitors the nursing staff to maintain sufficient staff to provide quality care for the residents." **"Responsible for making sure that there is adequate staff in number and ability to maintain the highest practicable level of physical, mental, and psychosocial well-being for each resident that meets the state and federal regulations."  Refer to F151, F159, F176, F223, F311, F366, F367, and repeated deficiencies from previous recertification survey on 9/11/14: F166, F224, F226, F241, F248, F252, F253, F278, F280, F281, F309, F314, F323, F325, F353, F368, F371, F441, F490, F493, F514, and F520.	F 490			
F 493 SS=H	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN  The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility  This REQUIREMENT is not met as evidenced by: Surveyor: 32335	F 493	The QAPI committee continues to meet monthly. The attendees will include the Medical Director, a member of the governing body, consulting pharmacist, department heads, and 3 random employees or any others that would like to attend. Administrator will submit a weekly spreadsheet listing operational metrics to the CFO. All staff will be in-serviced on July 14-15, 2015 regarding the QAPI policy and procedures and how to be involved.	7-16-15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/17/2015
NAME OF PROVIDER OR SUPPLIER  SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
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F 493	Continued From page 148 Based on observation, interview, record review, job description review, and policy review, the governing body failed to ensure the facility was managed in a manner that ensured the safe management and overall well-being for all ninety-five residents in the facility. Findings include:  1. The following deficiencies were repeated deficiencies from the previous recertification survey on 9/11/14: F166, F224, F226, F241, F248, F252, F253, F278, F280, F281, F309, F314, F323, F325, F353, F368, F371, F441, F490, F493, F514, and F520. The following were newly cited for the current survey: F151, F159, F176, F223, F311, F366, and F367.	F 493	The Administrator will direct and/or oversee the plans of correction for all system changes and QAPI audits related to tags F151, F159, F176, F223, F311, F366, F367 and repeated deficiencies from previous recertification survey on 9-11-14 F166, F224, F226, F241, F248, F252, F253, F278, F280, F281, F309, F314, F323, F325, F353, F368, F371, F441, F490, F493, F514, F520.		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview,	F 514	The following facility policies: "Writing Orders – General Principles", "Physician Services", "Administering Medications", "Charting and Documentation Policy", "Bath/Weights", "Urinary Continence and Incontinence", "Repositioning", "Pressure Ulcer Skin Breakdown", "Accidents and Incidents Investigating and Reporting", "Fall Report", "Shower/Tub Bath" were revised on 7-8-2015 and will be reviewed with facility nurses July 14-15 2015 to ensure they will be followed appropriately. Resident 16 discharged from the facility. Resident 56 expired.	7-16-15	

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F 514	<p>Continued From page 149</p> <p>and policy review, the provider failed to have accurate and readily available documentation on the resident roster, pain assessments, skin assessments, medication administration records (MARS) and, bathing and toileting records. Findings include:</p> <p>1. On 6/8/15 during the entrance conference with the administrator the resident roster had been requested to have in the morning upon the teams return.</p> <p>On 6/9/15 at 7:00 a.m. upon the teams arrival the resident roster was not available.</p> <p>Interview on 6/9/15 at 8:05 a.m. with the Minimum Data Set (MDS) case manager X revealed she had just gotten to work and the "other" girl had just gotten started on it.</p> <p>At 9:00 a.m. the team went ahead and started the phase one meeting without the resident roster. The meeting ended at approximately 10:00 a.m. When the roster was delivered later that morning it had been hand written and not generated by the computer.</p> <p>Interview on 6/16/15 at 10:45 a.m. with director of nursing (DON) and the administrator revealed the DON was unaware the resident roster could have been generated on the computer.</p> <p>2. Review of resident 25's skin assessment report revealed on 2/18/15 she had developed a superficial skin abrasion to her bottom. The contributing factor was incontinence (inability to control elimination of bowel and bladder).</p> <p>Review of resident 25's non-pressure skin</p>	F 514	<p>Resident 25, 6, 10, 22, 21, 53, 54, 36, 55, 38, 57, 58, 2, and 29 had their medical chart audited on 7/10/15 to ensure compliance with charting and documentation is complete and accurate as of that date by Medical Records and/or designee. These residents' charts will be audited weekly for one month and monthly for three months to ensure thorough, complete, accurate documentation has been maintained in all aspects of the medical record and all assessments have been performed as required.</p> <p>A random audit of 10 other residents in facility will have a complete chart audit once per week, then monthly times three months to ensure thorough, complete, accurate documentation has been maintained in all aspects of the medical record and all assessments have been performed as required by Medical Records and/or designee.</p> <p>Results of the audit will be brought to the monthly QAPI meeting by the DON and/or designee for 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15	

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F 514	<p>Continued From page 150 condition report revealed the skin abrasion had not healed until 3/9/15.</p> <p>Review of resident 25's 2/28/15 Monthly Summary report revealed under the skin section they had marked none.</p> <p>Interview on 6/16/15 at 2:15 p.m. with the DON regarding resident 25 revealed the Monthly Summary report was inaccurate.</p> <p>Surveyor: 35625 3. Review of the resident 6's medical record revealed: *On 2/17/15 the resident's physician discontinued the medication olanzapine (an antipsychotic to alter mood or thinking.) *The nursing staff continued to monitor the side effects for the olanzapine until 5/31/15 on the MAR. -The documentation was present on resident 6's medication administration record (MAR.)</p> <p>Interview on 6/16/15 at 2:40 p.m. with the DON regarding resident 6's medication side effects monitoring on MAR revealed: *The medication and side effect portion of the MAR were to have been marked at the time the medication was discontinued. *The side effects continued to have been monitored and documented on the MAR after the medication was discontinued. *She acknowledged the monitoring for the side effects should have been discontinued with the medication.</p> <p>Surveyor: 33265 4. Review of resident 10's complete medical</p>	F 514		7-16-15

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F 514	<p>Continued From page 151 record revealed: *A signed physician's order dated 3/26/15 for discharge to another facility. *The physician's order was noted by the nurse who was the infection control nurse. *There was no further documentation as to why the resident was not transferred. *There was no physician's order to disregard or cancel the transfer orders found in the medical record.. *There was notation that resident 10 was moved to a different room on 3/27/15.</p> <p>Interview on 6/11/15 at 11:00 a.m. with infection control nurse regarding discharge orders written and signed for resident 10 revealed the facility he was to have been transferred to: *Came and completed an assessment. *Found the resident needing more assistance than would have been available at their facility. He was not accepted for transfer. *There was no documentation as to why the other facility made the decision not to accept the resident.</p> <p>5. Review of resident 22's complete medical record revealed: *Documentation of a fall on 6/10/15. *Neuro checks (assessment for possible injury from fall) had not been filled in for the first three hours following the fall.</p> <p>Surveyor: 14477 6. Review of the Pain Monitoring Tool documentation sheet for resident 16 from 5/12/15 through 5/20/15 when a narcotic medication was given revealed multiple missing documentation in the following areas: *Under pain rating: There were three blank</p>	F 514		7-16-15
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F 514	<p>Continued From page 152</p> <p>spaces. One space had been written over and was not legible.</p> <p>*Under Location (of pain): There were two blank spaces.</p> <p>*On 5/14/15: The date had been written over as 1240 (12:40 p.m.); and at 1650 (4:50 p.m.) the time had been written over with no line through nor nurse initials on the error.</p> <p>*Under Pharmaceutical Interventions on 5/15/15 at 12:20 a.m.: No medication name was noted and it was indicated there were "ii" given. There were no nurse initials on that documentation. No follow-up time, follow up/pain rating, or nurses initials had been documented.</p> <p>*On 5/17/15 at 5:45 a.m.: The follow-up time was scribbled out and 0650 (6:50 a.m.) was written below it.</p> <p>*On 5/18/15 at 6:05 a.m.: There was no follow-up time, pain rating, or nurse initials documented .</p> <p>7. Review resident 21's Hydrocodone-Apap (Tylenol) (a narcotic pain medication) 5/325 mg (milligram) tab Controlled Drug Record revealed on 4/24/15 at two different times the date and time documentation had been altered by hand writing over the date and time.</p> <p>Interview with the DON and administrator on 6/17/15 in the afternoon confirmed the proper way to correct a documentation error was to have made a single line through the error, and initial the error. The DON also confirmed it was the expectation all lines on the Pain Monitoring Tool should have been completed.</p> <p>Surveyor: 32333</p> <p>8a. Review of the center bathing log from 6/8/15 through 6/11/15 revealed:</p> <p>*On 6/9/15 resident 53 was scheduled for bath.</p>	F 514		7-16-15

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F 514	<p>Continued From page 153</p> <p>*Resident 53 was moved to the next day on 6/10/15.</p> <p>*On 6/9/15 resident 54 was scheduled for a bath.</p> <p>*There was no documentation for resident 54 on 6/9/15.</p> <p>*On 6/10/15 resident 36 was moved to 6/11/15.</p> <p>Interview on 6/10/15 at 9:45 a.m. with CNA OO who is also a full-time bath aide revealed residents baths would get moved from their scheduled day to the next day. That happened because she would have to help with other CNA duties.</p> <p>Review of the computer Bath Type Detail report from 6/8/15 through 6/11/15 revealed the following documentation:</p> <p>*Resident 53: -On 6/9/15 at 10:16 a.m. she received a shower. -On 6/10/15 at 2:27 p.m. she received a whirlpool bath.</p> <p>*Resident 54: -On 6/10/15 at 8:27 a.m. she received a shower. -On 6/11/15 at 9:51 a.m. she received a whirlpool bath and at 10:28 a.m. she received a shower.</p> <p>*Resident 55: -On 6/11/15 at 10:01 a.m. he received a shower and at 11:18 a.m. he received a whirlpool bath.</p> <p>*Resident 38: -On 6/8/15 at 5:49 a.m. he received a whirlpool bath and at 6:50 a.m. he received a shower.</p> <p>*Resident 56: -On 6/9/15 at 10:10 a.m. he received a shower. -On 6/10/15 at 2:27 p.m. he received a whirlpool bath.</p> <p>*Resident 57: -On 6/11/15 she received a shower at 9:06 a.m. and 9:46 a.m.</p> <p>*Resident 58:</p>	F 514		7-16-15
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F 514	<p>Continued From page 154</p> <p>-On 6/9/15 at 10:15 a.m. she received a shower. -On 6/10/15 at 2:27 p.m. she received a shower.</p> <p>Interview and review of the bath reports on 6/16/15 at 9:05 a.m. with CNA OO who was also a full-time bath aide revealed: *The bath log charting was inaccurate. *The computer bath detail reports were not accurate. *Instead of just the bath aide documenting that a resident would get a bath or shower the other CNAs on that wing would also document it in the computer. *There was no way to know from their documentation if or when a resident received a shower or whirlpool bath. *There was not enough staff to get the care done.</p> <p>b. Observation on 6/9/15 at 10:45 a.m. with resident 2 in her room revealed CNA EE and FF were helping her use the toilet.</p> <p>Review of resident 2's bowel and bladder detail report revealed: *On 6/8/15 she was toileted at 11:52 p.m. *On 6/9/15 she was toileted at: - 9:47 a.m. - 9:30 p.m. *The documentation was not consistent with the observation of when the resident was toileted.</p> <p>Surveyor: 33265</p> <p>c. Interview on 6/11/15 at 9:00 a.m. with resident 29 revealed "there was no time for my shower this morning. Maybe I will get it this afternoon. Otherwise I will have to wait until tomorrow. That happens all the time."</p> <p>d. Interview on 6/16/15 at 2:25 p.m. with the</p>	F 514		7-16-15

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F 514	Continued From page 155 director of nursing and administrator revealed: *They would have expected documentation to have been accurate and timely. *The DON: -Would not expect the documentation of toileting to be "real time" [actual time it was done]. -The CNA's did not have time to document after they assisted the resident to the toilet. -There was no way to know what times the residents were actually toileted from their documentation.  9. Review of the provider's 5/12/12 Charting and Documentation policy revealed: **"All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record." **"All observations, medications administered, services performed, etc., must be documented in the resident's clinical records."	F 514		7-16-15
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520	The QAPI committee continues to meet monthly. The attendees will include the Medical Director, a member of the governing body, consulting pharmacist, department heads, and 3 random employees or any others that would like to attend. Administrator will submit a weekly spreadsheet listing operational metrics to the CFO. Trends and issues brought forth during the QAPI meeting will be listed on an Action Plan. Action Plan items will either be resolved or started on a Performance Improvement Subcommittee. All staff will be in-serviced on July 14-15, 2015 regarding the QAPI policy and procedures and how to be involved. The Administrator will be responsible for the overall QAPI	

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F 520

Continued From page 156

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:  
Surveyor: 33488  
Based on interview, record review, and policy review, the provider failed to implement and follow through with a continuous quality assurance performance improvement (QAPI) program that ensured ongoing oversight of plans of corrections for past deficient practices until they had been resolved. Findings include:

1. Interview and record review on 6/16/15 at 1:15 p.m. and again on 6/17/15 at 8:15 a.m. with the administrator revealed:  
\*He would have been considered the committee chairperson responsible for overseeing each department's duties as defined in the QAPI policy and procedures.  
\*In review of two randomly selected audit processes from the plan of correction from the September 2014 survey, two care areas were analyzed:  
-F 314 Pressure Ulcers: A wound care nurse was to have been hired within sixty days. That had not been done.  
-F 280 Pocket care plans were to have been placed on the back of each resident's door so

F 520

program and the results of the prior months Action Plan will be shared at the monthly QAPI meeting every month.

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F 520	Continued From page 157 staff would be able to review. That had not been done. *In regards to a randomly selected department listed in the QAPI policy, the dietary department was selected. He was to oversee: -Inspections of the kitchen were performed for upkeep. -Determination methods for quality and quantity of food served. -Effective orientation program for dietary staff had been developed, implemented and maintained. *He agreed the above dietary items had not been overseen as indicated in the QAPI policy.  Refer to all findings in F151, F159, F166, F176, F223, F224, F226, F241, F248, F252, F253, F278, F280, F281, F309, F311, F314, F323, F325, F353, F366, F367, F368, F371, F441, F490, F493, F514.	F 520		7-16-15	



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

PRINTED: 07/01/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/10/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105</b>
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K 033	<p>Continued From page 1</p> <p>resistive path of egress from one of three 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:</p> <p>1. Observation at 10:00 a.m. on 6/10/15 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.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column (x5) to indicate correction of the deficiencies identified in K000.</p>	K 033		
K 044 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation, testing, and interview, the provider failed to maintain 90 minute horizontal exit doors in operating condition. One randomly observed set of horizontal exit doors on the east ramp would not latch into the frame and the panic hardware would not operate. Findings include:</p> <p>1. Observation at 10:15 a.m. revealed the east leaf of the cross-corridor horizontal exit doors on the east ramp would not latch into the frame to maintain the 90 minute fire resistive rating of the assembly. Testing of those doors at the time of</p>	K 044	<p>The east leaf of the cross-corridor horizontal exit doors on the east ramp was fixed on 6-10-15 and operates properly. All horizontal exit doors were tested on 6-10-15 and the doors operate properly. Testing the horizontal exit doors will be completed monthly and the results logged into the Preventative Maintenance Log. The results of the monthly horizontal exit doors will be provided by the Director of Environmental Services to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.</p>	7-16-15

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K 044	Continued From page 2 observation revealed the doors would latch into the west leaf and the panic hardware would not operate. Interview with the maintenance supervisor at the time of observation revealed those doors had closed during previous monthly checks. He agreed hardware adjustment was necessary.	K 044		7-16-15
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South Dakota Department of Health

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S 000	Initial Comments  Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/8/15 through 6/11/15 and from 6/16/15 through 6/17/15. Southridge Health Care Center was found not in compliance with the following requirement(s): S115, S124, S145, S166, S199, S206, S210, S236, S253, S281, S286, S287, S289, S291, S294, S301, S445, and S446.	S 000	Addendums noted with an asterisk per 7/13/15 telephone to facility Administrator and DON. 5/15/2015	7-16-15
S 115	44:04:01:07 REPORTS  Each licensed facility, when requested by the department, shall submit to the department the pertinent data necessary to comply with the requirements of SDCL chapter 34-12 and this article.  Each nursing facility shall report to the department within 24 hours and any other facility shall report to the department within 48 hours of the event *any death resulting from other than natural causes originating on facility property such as accidents, abuse, negligence, or suicide; *any missing...resident; and *abuse or neglect of any...resident by any person.  Each facility shall report the results of the investigation within five working days after the event.  Each facility shall also report to the department as soon as possible *any fire with structural damage or where	S 115	Resident #11 resides in the facility. Employee QQ was terminated for neglect resulting from the interview and direct admission of the neglect action to the Administrator and DON. The incident was reported to the State Board of Nursing. There was no documented or suspected harm to these residents (6,8,47,48,49,50,51,52). After review of pain assessments, there was also no documented increased pain or complaints of not receiving appropriate medications requested for pain of these residents. Residents # 47,48,49,50 have discharged. Residents #6,8,51,52 have no further reports of drug diversion. Administrator now understands that drug diversions are required to be reported to the Department of Health and law enforcement immediately within twenty-four hours of the missing medications being noticed and will follow the provider's Resident Abuse/Neglect Policy and Procedure. The consultant pharmacist explained to the Administrator that the diversion needed to	

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

*Officer Burch*

TITLE

*Administrator*

(X6) DATE

RECEIVED  
JUL 13 2015  
SD DOH L&C

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S 115	<p>Continued From page 1</p> <p>injury or death occurs; *any partial or complete evacuation of the facility resulting from natural disaster; or *any loss of utilities such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours.</p> <p>Each facility shall notify the department of any anticipated closure or discontinuation of service at least 30 days in advance of the effective date.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32333 A. Based on interview, record review, and policy review, the provider failed to ensure one of one suspected drug diversion with eight identified residents (6, 8, 47, 48, 49, 50, 51, and 52) was reported and investigated in a timely manner. Findings include:</p> <p>1. Review of the provider's twenty-four hour initial event report required by the South Dakota Department of Health received on 5/31/15 revealed on 5/27/15 it was discovered there was a possible diversion of controlled substances on the Warren rehabilitation wing.</p> <p>Interview on 6/1/15 at 4:55 p.m. with the administrator and registered nurse (RN) C revealed: *Medications were found to have disappeared on 5/12/15. *Sixty hydrocodone (controlled narcotic) were delivered from the pharmacy.</p>	S 115	<p>be reported immediately. The Administrator did report the diversion on 5-31-15 after an email from with the consultant pharmacist. The Administrator and nursing team (DON was on vacation) did have a teleconference about the possible diversion with Pharmacy (consultant pharmacist not present) on the afternoon of 5-27-15 to come up with a plan to prevent further issues and to define if the diversion was actually a diversion. The drug diversion incident is still being investigated in cooperation with, Special Assistant Attorney General, Diversion Unit. The DON and/or designee will observe 5 random medication passes per month to ensure the six "Rs" are being conducted for medication administration. Resident #41 discharged from the facility on 2-20-15. Resident #42 discharged from the facility on 2-28-15. The Controlled Substance Policy and Procedure was reviewed on July 10, 2015 and will be included on the all staff in-service on July 14-15, 2015. All staff will be in-serviced on the facility abuse and neglect policy/procedure, Department of Health abuse/neglect reporting requirements and timelines, and the Controlled Substance Policy and Procedure by July 14-15, 2015. The facility now utilizes a Controlled Substances Record Binder Book provided by Pharmacy to control and reduce the opportunities for a drug diversion to occur. The social services department developed a Resident Property Log on July 8, 2015 that will be used to log the resident name, room number, current date, type of item, final status, and date item given back to resident or resident representative.</p>	7-16-15

to include all shifts  
SLS/SMH/JJ

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S 115	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>*Thirty of those hydrocodone were missing.</li> <li>*Nursing staff discovered they were short twenty-two tramadol (controlled narcotic).</li> <li>*There were multiple other controlled medications missing.</li> <li>*They were in the process of their investigation.</li> <li>*They were unsure of the exact number of residents and medications the suspected diversion involved at that time.</li> <li>*They had not notified law enforcement until 5/31/15.</li> <li>*At the time they notified law enforcement they reported thirty missing hydrocodone tablets.</li> <li>*They had not reported any of the other missing medications.</li> <li>*They had not reported the suspected drug diversion, because they were unsure if it was a diversion.</li> </ul> <p>Review of the provider's final five-working day investigation report received on 6/5/15 into the South Dakota Department of Health revealed:</p> <ul style="list-style-type: none"> <li>*They determined eight residents had missing medications.</li> <li>*All medication documentation records, pain assessments, and controlled substances in the facility were reviewed.</li> <li>*The medications were found to have disappeared from 5/12/15 through 5/15/15 along with the sealed packaging they had arrived in or were kept in.</li> <li>*They were continuing to investigate.</li> </ul> <p>Review of the undated amendment to the drug diversion report revealed:</p> <ul style="list-style-type: none"> <li>*Resident 47 had lorazepam 1 milligram (mg), two tablets missing.</li> <li>*Resident 48 had oxycodone 5 mg 4 tablets missing; hydrocodone/Tylenol (APAP) 5/325 mg 4 tablets missing; tramadol 50 mg 30 tablets</li> </ul>	S 115	<p>DON and/or designee will randomly audit 10 random residents in the facility each month that are listed in the Controlled Substances Record Book for 4 months to look for signs of possible drug diversion. The DON will in-service the Medication Aides and Nurses regarding the drug diversion and measures that the facility takes to reduce the opportunities for drug diversions between July 14-15, 2015.</p> <p>The Social Services department will ask a random sample of 10 residents or resident representatives each month for 4 months if the resident has any property that is missing. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria is met. The Social Services Department will audit the Resident Property Log each month to ensure timely follow-up on all entries during the month.</p> <p>The results of the Controlled Substances Record Binder Book audit will be brought to the monthly QAPI meeting by the Director of Nursing and/or designee for 4 months and then for 1 year until deemed necessary by the QAPI committee if no further patterns persist. The Social Services Department audits of the Quality of Care tool and Resident Property Log will be given to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7/6/15

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S 115	<p>Continued From page 3</p> <p>missing.</p> <p>*Resident 49 had morphine sulfate immediate release 15 mg 24 tablets missing.</p> <p>*Resident 50 had tramadol 50 mg 29 tablets missing.</p> <p>*Resident 51 had hydrocodone/APAP 5/325 mg 4 tablets missing; Oxycodone 5 mg 30 tablets missing</p> <p>*Resident 6 had oxycodone/APAP 5/325 mg 3 tablets missing; tramadol 50 mg 2 tablets missing.</p> <p>*Resident 8 had hydrocodone/APAP 5/325 mg 3 tablets; tramadol 50 mg 2 tablets.</p> <p>*Resident 52 had tramadol 50 mg 21 tablets missing.</p> <p>Interview on 6/16/15 at 2:25 p.m. with the director of nursing and the administrator revealed: *The administrator said he: -Had never had a drug diversion before. -Was unsure if the medications were misplaced or diverted. -The consultant pharmacist told him he needed to report the suspected drug diversion. -Should have notified the South Dakota Department of Health immediately within twenty-four hours of the missing medications being noticed. -Should have notified the police immediately within the same above stated time-frame.</p> <p>Review of the provider's revised June 2014 Resident Abuse/Neglect Policy and Procedure revealed "The administrator or designee will notify the Department of Social Services, the ombudsman, Department of Health and the residents attending physician immediately after being informed of the incident. (Immediately as defined as not longer than twenty-four (24) hours after being informed of the incident."</p>	S 115		7-16-15

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S 115	<p>Continued From page 4</p> <p>Surveyor: 35625</p> <p>B. Based on record review, interview, and policy review, the provider failed to thoroughly investigate four of four sampled incident reports (11, 41, 42) to determine no abuse or neglect had occurred. Findings include:</p> <p>1a. Review of a grievance report dated 2/3/15 regarding resident 41 revealed:                      *The incident occurred on 1/30/15.                      *Her call light had been on for over an hour.                      *Social services designee S had been rude and disrespectful.                      *The facility ran a call light report for resident 41's room with a response time of no longer than twelve minutes for that date.                      *The resident was switched to social worker designee T at the facility.                      *There was no documentation interviews had been conducted or that a thorough investigation had been completed.                      *There was no documentation the facility followed up with resident 41 regarding the grievance.</p> <p>b. Review of a grievance report dated 1/31/15 regarding resident 42 revealed:                      *A certified nursing assistant (CNA) had been rude and disrespectful during the previous night.                      *The resident and spouse were very upset regarding the matter.                      *An apology was offered to resident 42 and his spouse.                      *The CNA no longer worked at the facility.                      *The name of the CNA was not given in the report.                      *No documentation was provided regarding the reason the CNA no longer worked at the facility.                      *No documentation was available regarding investigation of the CNA's behavior.</p>	S 115		7-16-15

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S 115	<p>Continued From page 5</p> <p>c. Review of an event form submitted to the South Dakota Department of Health (SD DOH) dated 5/7/15 for resident 11 revealed:                  *She had sustained a fall while attempting to transfer herself in the bathroom.                  *It had occurred on 4/30/15 at 4:00 a.m.                  *The CNA notified the nurse of the incident.                  *The nurse had left the building for a cigarette break and had not immediately assessed resident 11.                  *The nurse was terminated for neglect.                  *There was no documentation interviews had been conducted or a thorough investigation had been completed.</p> <p>d. Interview on 6/1/15 at 9:30 a.m. with the local ombudsman prior to entering the facility regarding resident 11 revealed:                  *She had given the hearing aids to social services designee S to have repaired.                  *The hearing aids were not delivered in a timely manner to the repair shop.                  *Social services designee S had them in his car for an undetermined length of time.                  *The repair shop had not received payment for the repair of the hearing aids.                  *No dates were provided in regards to the event.</p> <p>Review of a grievance report dated 6/5/15 for resident 11 revealed:                  *The facility had paid for the damaged hearing aids for resident 11 on 6/5/15.                  *A copy of the invoice and check was attached in the report.                  *No additional documentation was provided in the report.</p> <p>Interview on 6/16/15 at 10:00 a.m. with social services designee S revealed he:</p>	S 115		7-16-15
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S 115	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>*Acknowledged the hearing aids were left in his car for an extended period of time.</li> <li>*Was not able to provide a date the hearing aids were given to him or when it was turned in to the repair shop.</li> <li>*Acknowledged he had no system in place for the documentation of items given to him by residents.</li> </ul> <p>e. Interview on 6/16/15 at 10:45 a.m. with the director of nursing and the administrator revealed:</p> <ul style="list-style-type: none"> <li>*Several staff members had visited with resident 41, but those interviews were not documented.</li> <li>*They acknowledged the report for resident 42 should have contained the name of the CNA involved in the incident, and the reason she was no longer employed at the facility.</li> <li>*They were unable to provide documentation the nurse involved in the fall regarding resident 11 was reported to the South Dakota Board of Nursing.</li> <li>*They acknowledged the hearing aids for resident 11 had been left in social services designee S's car.</li> <li>-The administrator referred to that as an "outlying situation."</li> <li>-They were not aware social service designee S had not documented receipt of items for the residents.</li> <li>*They acknowledged the reviewed incidents did not contain thorough documentation of the evidence to determine if abuse, neglect, or misappropriation (theft) of property had occurred.</li> </ul> <p>Review of the provider's June 2014 Resident Abuse/Neglect Policy and Procedures revealed:</p> <ul style="list-style-type: none"> <li>*The completed report should have contained as many details as possible.</li> <li>*All occurrences should have been reported to the administrator immediately.</li> <li>*Social services personnel and nursing</li> </ul>	S 115		7-16-15

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S 115	Continued From page 7 manager/designee were responsible for interviews of witnesses. *Witness reports would be in writing with a signature and date *The administrator or designee would notify the Department of Social Services, the ombudsman, SD DOH, and the attending physician immediately after being informed of the incident.	S 115		
S 124	44:04:02:03 CLEANING METHODS AND FACILITIES  The facility must have equipment, work areas, and complete written procedures for cleaning, sanitizing, disinfecting, or sterilizing all work areas, equipment, utensils, dressings, medical devices, and solutions used for residents'...care. Common use equipment shall be disinfected or sterilized after each use. ...Nursing facilities must have separate clean and soiled utility rooms.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, policy review, and manufacturer instruction review, the provider failed to follow infection control practices for the following: *Two of two randomly observed disinfections of the glucometer (a device used to measure blood sugar) in between resident use. *Two of two whirlpool tub disinfection procedures and one random shower disinfection procedure after resident use. Findings include:  Surveyor 14477 1. Observation and interview on 6/9/15 at 11:48	S 124	The QAPI policy and procedure reviewed and revised to include monthly and more in-depth meetings on 7-09-15. The facility's Infection Control Nurse began her duties on 7-9-2015. She was given a copy of the facility's updated Infection Control Manual to review on 7-9-2015. Employee C is the designated infection control nurse and will train with the Infection Control Nurse of a sister facility on July 15, 2015. The Infection Control Nurse will conduct surveillance, prevention, control, and reporting as necessary. This will include random audits of the components of Infection Control. The Infection Control Nurse will participate in continued education of Infection Control programs and policies. The DON will educate all staff between July 14-15, 2015 as to where the Infection Control Manual is located on the facility and on what type of material is included in it. The facility's "Cleaning and Disinfecting Equipment" policy was revised on July 8, 2015, to include the proper cleaning of the blood Glucometer machines between residents. All of the facility Blood Glucometer machines are cleaned according to manufacturer's instructions.	7-16-15

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S 124	<p>Continued From page 8</p> <p>a.m. revealed registered nurse (RN) D was taking resident 59's blood sugar test by doing a fingerstick and then used an Element Compact Blood Glucose Monitoring System (glucometer). After the completion of the test, RN D returned to the medication cart with the glucometer. She then:</p> <ul style="list-style-type: none"> <li>*Laid the glucometer on the top of the medication cart.</li> <li>*Stated she was putting on gloves because she couldn't stand the smell of the glucometer cleaner.</li> <li>*Put on those gloves and removed a sanitizing wipe from container.</li> <li>*Wiped the glucometer with the sanitizing wipe for fifteen seconds.</li> <li>*Discarded the wipe and her gloves, and replaced the glucometer back in the top drawer of the medication cart. A second glucometer was also in that top drawer. There were no names on either of the glucometers, and they were co-mingled in the drawer.</li> </ul> <p>Review of the manufacturer's instruction manual in the glucometer box revealed under "Intended Use: The system is intended for self testing by persons at home, is for single patient use only, and should not be shared."</p> <p>Interview on 6/16/15 at 10:40 a.m. with RN M and unlicensed assistive personnel (UAP) W confirmed those glucometers were being used for multiple residents and were not designated for single person use.</p> <p>Review of the sanitizing germicidal disposable wipe at the above time revealed it was a premoistened wipe with a stabilized bleach solution (equivalent to a 1:10 dilution). The instructions stated it killed bacteria, fungi, and</p>	S 124	<p>Audits will be conducted weekly x 1 month and monthly x 3 months on resident #59 and #10.</p> <p>Audits will also be performed on 5 other random residents who require the use of Blood Glucometers by the DON and/or designee. The DON and/or designee will be responsible for conducting the audits and for overall compliance. The DON will report audit findings to monthly QAPI meetings for one year.</p> <p>The facility Shower/Tub and Bath policy was revised on 7-8-2015 to include the instructions for cleaning and disinfecting the facility tubs and showers and the disinfecting procedure for each whirlpool tub will be located in each tub or shower area.</p> <p>C.N.A.'s OO and Q were educated on the proper tub and shower cleaning and disinfection procedure on 6-12-15 during the survey. All other facility staff will be educated on the tub and shower disinfection</p> <p>process and revised policy for each by the DON on between July 14-15, 2015.</p> <p>Audits will be conducted on C.N.A.'s OO and Q along with 10 other random C.N.A.'s weekly x 1 month and monthly x 3 months.</p> <p>Audits will be conducted by the DON and/or designee who will also be responsible for overall compliance.</p> <p>The DON and/or designee will be responsible for reporting audit findings at monthly QAPI meetings for one year.</p> <p>The facility policies – "Dressing Dry Clean and Dressings Soiled" – were revised on 7-8-2015. The entire nursing staff will be educated by the DON on July 14-15,2015 on these procedures.</p>	7-16-15

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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S 124	<p>Continued From page 9</p> <p>viruses. It was to have maintained a wet contact time of four minutes.</p> <p>Review of the provider's 6/20/11 "Multiple Use Glucometer Cleaning" policy and procedure revealed:</p> <p><b>**Policy:</b> To provide a healthful environment by reducing soil/contamination on equipment. In accordance with the CDC, Infection Control practices, and manufacturer's guidelines, all multiple use glucometer machines will be disinfected between each patient use."</p> <p><b>**Procedure:</b> Disinfecting between patient use: -After each patient use, the nurse and/or designee will disinfect the Glucometer machine with a 1:10 bleach solution wipe. -Take extreme care not to get any liquid in the test strip and key code port of the meter. -The Glucometer should be allowed to air dry for 2 minutes prior to using again."</p> <p>Surveyor 34030</p> <p>2. Observation on 6/9/15 at 11:05 a.m. of certified nursing assistant (CNA)/medication tech (MT) Z using the glucometer during the medication pass on the East wing revealed: *She took the glucometer into a resident's room to check his blood sugar. -She stated she would use the same glucometer to check multiple residents. *After use wiped it clean with a Sani-Cloth with bleach and let it air dry. *Review of the package instructions revealed it required a contact time of four minutes to kill germs, which required the cloth to be wrapped around the glucometer to ensure contact time.</p> <p>3. Observation and interview on 6/16/15 with CNA/MT AA on the East hallway medication cart revealed:</p>	S 124	<p>RN BB will be educated on 7-14-2015 by the DON on the proper dressing policy and procedure. Audits will be conducted weekly x 1 month and monthly x 3 months on RN BB and 10 other random RN's or LPN's on dressing changes. Audits will be conducted by the DON and/or designee who will also be responsible for overall compliance. The DON will report audit findings at monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee. The facility's Shower, Tub and Bath policy was reviewed and revised on 7-6-15 to include where the cleaning and disinfection procedures will be located within the bathing and shower areas. The manufacture guidelines of disinfecting each whirlpool will be posted in each whirlpool room. CNAs OO and Q were educated on the proper procedure for cleaning and disinfection of the tubs and shower areas on 6/15/15. The entire nursing staff will be educated by the DON on July 14-15,2015 on these procedures. Audits will be conducted on CNAs OO and Q along with 5 other random audits weekly for 1 month and monthly for 1 year. The DON and/or designee will be responsible for conducting audits and for overall compliance. Audit findings will be reported by the DON and/or designee for 1 year and then as deemed necessary by the QAPI committee.</p> <p>Nurse BB will be educated on proper procedure for changing a suprapubic catheter, to include proper hand hygiene on July 14, 2015. Hand hygiene and</p>	7-16-15

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S 124	<p>Continued From page 10</p> <p>*The Sani-Cloths with bleach were outdated in April 2015. *She usually used alcohol wipes to clean the glucometer as they did not always have Sani-Cloths.</p> <p>4. Observation and interview on 6/16/15 at 10:10 a.m. with RN Y on the Center hallway medication cart revealed: *The Sani-Cloths with bleach were outdated in April 2015. *She used either the Sani-Cloths or hydrogen peroxide wipes to clean the glucometer.</p> <p>5. Interview on 6/16/15 at 3:30 p.m. with the DON and administrator revealed they were unaware of what was being done to clean the glucometers. They stated they would look into it.</p> <p>Surveyor 33265</p> <p>6. Observation and interview on 6/10/15 at 2:05 p.m. of the cleaning and the disinfection of the Center wing whirlpool tub by CNA OO revealed she: *Used her bare hands. *Sprayed the seat of the transfer lift system with the 3M Neutral Quat (disinfectant) spray. A different cleaner was used to clean the rest of the whirlpool tub. *Added Penner whirlpool disinfectant cleaner solution into the bottom of the tub. *Used a long handled brush to scrub surfaces inside of the tub with disinfectant. *Pulled the plug to drain out the disinfectant solution. *Rinsed off the long handled brush and tub immediately. *Wiped off the seat with a dry towel. *The entire cleaning and disinfection of the whirlpool tub and transfer lift system took less</p>	S 124	<p>suprapubic catheter care policies were reviewed on 7/9/15, and found to be current and accurate. All other nursing staff will be educated on these policies during the July 14-15, 2015 in-service. Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for water pass. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance. A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Resident Water Pass. A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office. The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee for 1 year and then until deemed by the QAPI committee. Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for hand sanitation practices for dietary. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance. A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Handwashing.</p>	7-16-15

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S 124	<p>Continued From page 11</p> <p>than three minutes. *CNA OO stated this was how she had been taught to clean and disinfect the whirlpool tub between resident's use.</p> <p>Surveyor 14477 7. Observation on 6/17/15 at 8:10 a.m. in the Warren Wing whirlpool tub room revealed a document entitled: "Warren Wing Spa/Whirlpool Disinfecting procedure." Review of those instructions revealed: **Close and lock the tub door. *Rinse the inside tub surfaces with the shower sprayer. *Spray the entire tub inside surface, including the lift chair, with an EPA [Environmental Protection Agency] approved/recommended disinfectant. *Using a long-handled brush, thoroughly scrub all interior surfaces of the tub and chair with the disinfectant. Let disinfectant stay on surface for 10 minutes (or, as recommended by the instructions on the disinfectant container). *With the shower spray, rinse the interior surfaces of the tub and lift chair thoroughly. *Visibly check that the tub was effectively cleaned during the disinfecting procedure. If not, repeat the procedure. *After the last bath of the shift, use a towel to wipe down the door and around the seal. Leave the tub door open."</p> <p>8. Observation and interview on 6/17/15 at 8:30 a.m. with CNA Q revealed she: *Sprayed Quat in each of the whirlpool jets. *Sprayed the entire tub surfaces, added hot water, and waited for 10 minutes before draining the tub. Interview at that time regarding the manufacturer's direction for cleaning the whirlpool tub confirmed she was not taking each jet assembly apart for cleaning after every bath.</p>	S 124	<p>A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.</p> <p>The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.</p>	7-16-15
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S 124	<p>Continued From page 12</p> <p>Surveyor 33265 9. Observation and interview on 6/10/15 at 4:48 p.m. with CNA PP on East wing in the shower room regarding cleaning and disinfection of the shower area after resident use revealed she: *Used Clorox Germicidal Bleach Spray in a spray bottle. *Sprayed the walls, the shower chair, and the floor of shower area with the bleach spray. *Used a long handled brush to go over the shower chair and the middle sections of wall surfaces. *Immediately rinsed off the walls, the shower chair, and the floor with water from the hand held shower wand. *Stated that was how she had been taught to clean and disinfect the shower area between resident use. She added she would try to let it air dry before the next use if there was time. The entire cleaning, disinfecting and rinsing off of bleach spray was completed in 3 minutes.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the DON and the administrator concerning above observations and interviews revealed the DON: *Was not aware the staff were not following the policies/procedures for cleaning of the whirlpool tubs and shower areas. *Was not sure why two different disinfectant/cleaner solutions were used in the Center wing whirlpool tub procedure observed.</p> <p>Review of the undated manufacturer's instructions for use of Clorox Bleach Germicidal Cleaners listed a five minute contact time was needed to kill all the germs listed on the label.</p> <p>Review of the provider's 10/23/12</p>	S 124		7-16-15

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S 124	<p>Continued From page 13</p> <p>Whirlpool/Shower Bathing Policy and Procedure revealed they were to disinfect the shower chair and the floor after each use following the manufacturer's disinfecting recommendations.</p> <p>Review of the manufacturer's undated instructions on the Penner Whirlpool Disinfectant Cleaner label revealed there was a ten minutes contact time (time needed for the disinfectant to kill germs) needed on nonporous (hard) surfaces of whirlpool tubs.</p> <p>Review of the 2012 manufacturer's instructions on the 3M Neutral Quat Disinfectant Cleaner label revealed: *There was a ten minute contact time needed to kill the majority of germs on surfaces. *It might cause skin irritation; should avoid prolonged skin contact.</p> <p>Review of the manufacturer's 11/07/12 Cascade Aqua-Aire Whirlpool Tub Instruction Manual revealed the disinfectant solution should have remained on the surfaces for ten minutes or as the disinfectant manufacturer instructed on the container label.</p> <p>Review of the provider's undated Cleaning of the Tub policy revealed the disinfectant Provon was the only cleaner to have been used.</p> <p>Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed: *The whirlpool tub was to have been disinfected after every use. *Staff were to follow the whirlpool disinfecting procedure posted in the whirlpool room.</p> <p>Review of the provider's undated Whirlpool</p>	S 124		7-16-15

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S 124	Continued From page 14  Disinfecting Procedure posted in the Center wing whirlpool tub room revealed the disinfectant spray was to stay on the surfaces for ten minutes or as recommended by the instructions on the disinfectant concentrate container.  Review of the undated manufacturer's instructions for use of Clorox Bleach Germicidal Cleaners listed a five minute contact time was needed to kill all the germs listed on the label.  Review of the provider's 10/23/12 Whirlpool/Shower Bathing Policy and Procedure revealed they were to disinfect the shower chair and the floor after each use following the manufacturer's disinfecting recommendations.	S 124		
S 145	44:04:02:09 INFECTION CONTROL-PROGRAM  The infection control program must utilize the concept of standard precautions as the basis for infection control pursuant to chapter 44:20:04. Bloodborne pathogen control must include a written exposure control plan, approved by the facility's medical director or physician responsible for infection control, that addresses the requirements contained in 29 C.F.R. 1910.1030, December 6, 1991. The facility must designate an employee to be responsible for the implementation of the infection control program including surveillance and reporting activities.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview, document review, and policy	S 145	The QAPI policy and procedure reviewed and revised to include monthly and more in-depth meetings on 7-09-15. The facility's Infection Control Nurse began her duties on 7-9-2015. She was given a copy of the facility's updated Infection Control Manual to review on 7-9-2015. Employee C is the designated infection control nurse and will train with the Infection Control Nurse of a sister facility on July 15, 2015. The Infection Control Nurse will conduct surveillance, prevention, control, and reporting as necessary. This will include random audits of the components of Infection Control. The Infection Control Nurse will participate in continued education of Infection Control programs and policies. The DON will educate all staff between July 14-15, 2015 as to where the Infection Control Manual is located on the facility and on what type of material is included in it.	7-16-15

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S 145	<p>Continued From page 15</p> <p>review, the provider failed to implement and promote consistent following of infection control practices by having a functioning infection control program with appropriate oversight. Findings include:</p> <p>1. Interview and document review on 6/10/15 at 2:25 p.m. to 2:55 p.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> <li>*She had accepted the position of infection control nurse one month ago.</li> <li>*She had no specialized training or additional training for infection control.</li> <li>*The interim director of nursing was here at that time and was going to assist in her training, but that had not happened.</li> <li>*There had been no infection control report at the last QA (quality assurance) meeting as she had not been trained on the task.</li> <li>*She was not aware of or involved in any training on infection control for new employees.</li> <li>*She was not aware of any training provided on infection control since the required training following the last survey in September 2014.</li> <li>*She was not aware of any monitoring or auditing of infection control practices since completion of the required monitoring/auditing following the last survey in September 2014.</li> <li>*She agreed there was no current infection control program.</li> <li>*Her role included many other tasks besides infection control.</li> <li>*She had resigned her position as infection control nurse earlier that week.</li> </ul> <p>Review of the provider's April 2013 Policies and Procedures - Infection Control document revealed:</p> <ul style="list-style-type: none"> <li>* The Quality Assurance Performance Improvement committee was to have been</li> </ul>	S 145	<p>The facility's "Cleaning and Disinfecting Equipment" policy was revised on July 8, 2015, to include the proper cleaning of the blood Glucometer machines between residents.</p> <p>All of the facility Blood Glucometer machines are cleaned according to manufacturer's instructions.</p> <p>Audits will be conducted weekly x 1 month and monthly x 3 months on resident #59 and #10.</p> <p>Audits will also be performed on 5 other random residents who require the use of Blood Glucometers by the DON and/or designee. The DON and/or designee will be responsible for conducting the audits and for overall compliance. The DON will report audit findings to monthly QAPI meetings for one year.</p> <p>The facility Shower/Tub and Bath policy was revised on 7-8-2015 to include the instructions for cleaning and disinfecting the facility tubs and showers and the disinfecting procedure for each whirlpool tub will be located in each tub or shower area.</p> <p>C.N.A.'s OO and Q were educated on the proper tub and shower cleaning and disinfection procedure on 6-12-15 during the survey. All other facility staff will be educated on the tub and shower disinfection process and revised policy for each by the DON on between July 14-15, 2015.</p> <p>Audits will be conducted on C.N.A.'s OO and Q along with 10 other random C.N.A.'s weekly x 1 month and monthly x 3 months.</p> <p>Audits will be conducted by the DON and/or designee who will also be responsible for overall compliance.</p>	7-16-15

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>
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S 145	<p>Continued From page 15</p> <p>review, the provider failed to implement and promote consistent following of infection control practices by having a functioning infection control program with appropriate oversight. Findings include:</p> <p>1. Interview and document review on 6/10/15 at 2:25 p.m. to 2:55 p.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> <li>*She had accepted the position of infection control nurse one month ago.</li> <li>*She had no specialized training or additional training for infection control.</li> <li>*The interim director of nursing was here at that time and was going to assist in her training, but that had not happened.</li> <li>*There had been no infection control report at the last QA (quality assurance) meeting as she had not been trained on the task.</li> <li>*She was not aware of or involved in any training on infection control for new employees.</li> <li>*She was not aware of any training provided on infection control since the required training following the last survey in September 2014.</li> <li>*She was not aware of any monitoring or auditing of infection control practices since completion of the required monitoring/auditing following the last survey in September 2014.</li> <li>*She agreed there was no current infection control program.</li> <li>*Her role included many other tasks besides infection control.</li> <li>*She had resigned her position as infection control nurse earlier that week.</li> </ul> <p>Review of the provider's April 2013 Policies and Procedures - Infection Control document revealed:</p> <ul style="list-style-type: none"> <li>* The Quality Assurance Performance Improvement committee was to have been</li> </ul>	S 145	<p>designee for 1 year and then as deemed necessary by the QAPI committee.</p> <p>Nurse BB will be educated on proper procedure for changing a suprapubic catheter, to include proper hand hygiene on July 14, 2015. Hand hygiene and suprapubic catheter care policies were reviewed on 7/9/15, and found to be current and accurate. All other nursing staff will be educated on these policies during the July 14-15, 2015 in-service.</p> <p>Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for water pass. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Resident Water Pass.</p> <p>A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.</p> <p>The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee for 1 year and then until deemed by the QAPI committee.</p> <p>the QAPI Meeting for 1 year and then until deemed by the QAPI committee.</p>	7-16-15

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STREET ADDRESS, CITY, STATE, ZIP CODE  
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SIOUX FALLS, SD 57105**

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S 145	<p>Continued From page 15</p> <p>review, the provider failed to implement and promote consistent following of infection control practices by having a functioning infection control program with appropriate oversight. Findings include:</p> <p>1. Interview and document review on 6/10/15 at 2:25 p.m. to 2:55 p.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> <li>*She had accepted the position of infection control nurse one month ago.</li> <li>*She had no specialized training or additional training for infection control.</li> <li>*The interim director of nursing was here at that time and was going to assist in her training, but that had not happened.</li> <li>*There had been no infection control report at the last QA (quality assurance) meeting as she had not been trained on the task.</li> <li>*She was not aware of or involved in any training on infection control for new employees.</li> <li>*She was not aware of any training provided on infection control since the required training following the last survey in September 2014.</li> <li>*She was not aware of any monitoring or auditing of infection control practices since completion of the required monitoring/auditing following the last survey in September 2014.</li> <li>*She agreed there was no current infection control program.</li> <li>*Her role included many other tasks besides infection control.</li> <li>*She had resigned her position as infection control nurse earlier that week.</li> </ul> <p>Review of the provider's April 2013 Policies and Procedures - Infection Control document revealed:</p> <ul style="list-style-type: none"> <li>* The Quality Assurance Performance Improvement committee was to have been</li> </ul>	S 145	<p>Dietary Aide R was educated by the CDM on 6/9/15 on facility policy for hand sanitation practices for dietary. The CDM or designee will randomly monitor Dietary Staff R weekly x 4 weeks for compliance.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on Handwashing.</p> <p>A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.</p> <p>The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for 9 months for continued compliance. Results to be reported by the CDM or designee monthly at</p>	7/10/15

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S 145	Continued From page 16  overseeing the implementation of infection control policies and practices. *All personnel were to have been trained on the infection control policies and practices upon their hire and periodically. *The amount of the employee training was to have been dependent on the time spent on direct resident contact and job responsibilities. *The administrator or governing board, through the QAPI committee, had adopted the policies and practices needed to prevent transmission of infections and communicable diseases.	S 145		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION  The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities.	S 166	The Entry Door Policy and Procedure was revised on 7-09-15. Midwest Alarm set the front door's alarm to an audible alarm 24 hours a day to alert of any entrance or exit if a code is not entered in the keypad. A key pad was installed on 7-10-15 on the main entrance door which will need a code 24 hours a day to enter and there is already an existing key pad to exit. Visitors that do not have a code can press the existing black call button which alerts the center nurses station to verify the visitor and manually open the door for them. An audible alarm will sound if the code is not used which will alert staff to investigate the origin of the alarm. The front door exit will not be locked to exit, but the alarm will sound 24 hours a day if no code is entered while exiting. All other entry and exit doors have an existing audible alarm or keypad code required for entry and exit.	7/16/15

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S 166	<p>Continued From page 17</p> <p>Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility;</p> <p>(8) Household-type electric blankets or heating pads may not be used in a facility;</p> <p>(9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and</p> <p>(10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure the main entrance door had been monitored or alarmed at all times. Findings include:</p> <p>1. Observation on 6/16/15 at 5:30 p.m. of the front entrance door revealed: *The door was not alarmed. *There were no staff present monitoring the door.</p> <p>Interview on 6/16/15 at 5:30 p.m. with the administrator revealed: *The alarm was not activated from 7:00 a.m. to 7:00 p.m. *The secretary left at 5:00 p.m. *No one monitored the door from 5:00 p.m. to 7:00 p.m.</p>	S 166	<p>All staff will be in-serviced on the door on July 13-15, 2015. The Director of Environmental Services and/or designee will audit the front door on a weekly basis for audible operation. The results of the weekly audit will be brought to the monthly QAPI meeting by the Director of Environmental Services for 1 year and then as deemed necessary by the QAPI committee.</p>	<p>7/16/15</p>

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S 166	Continued From page 18  *They had a wander management system (an alarm that sounds if a resident wore a device) on the door. *The main entrance door would have only alarmed if a resident had on a wander management device.  Review of the provider's undated Entry Door Policy and Procedure revealed "It is the policy of this facility that doors be monitored for any resident or visitor that may come or go."	S 166		
S 199	44:04:04:04 PERSONNEL  The facility must have a sufficient number of qualified personnel to provide effective and safe care. Staff members on duty must be awake at all times. Supervisors must be 18 years of age or older. Written job descriptions and personnel policies and procedures must be made available to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility must establish and follow policies regarding special duty or staff members on contract.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure sufficient nursing services were provided to meet all aspects of resident care needs. Findings include:  Surveyor: 32333	S 199	The call light time log for the bed and toilet will be pulled for resident #24 and all other residents on a weekly basis by the Administrator. Results to be given to the DON and Clinical coordinators for trend analysis. The call light monitoring device is operational and has been adjusted to prevent turning the device off.  A username and password of the EMR was given to Dr V on 6-23-15 by the Administrator when Dr. V requested it on 6-23-15 to the Director of Medical Records.  The greatest identified need of staffing was identified as 6 AM – 10 AM and 4 PM-9PM shift for CNAs. The facility continues to offer very competitive wages for CNAs and nurses. The facility continues to recruit on Indeed.com, Keloland.com and speak at the CNA and nurse classes at Southeast Votech and North American University. The facility instituted the use of an online scheduling program called "Schedule Anywhere" to enable all nursing staff to view their schedule online, pick up open shifts, etc.	7/16/15

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S 199	<p>Continued From page 19</p> <p>1. Group interview on 6/9/15 at 3:15 p.m. with fifteen residents in attendance revealed it was a group consensus:                      *They were short staffed.                      *The staffing shortage was mostly in the evenings and overnights.                      *Sometimes there was only one CNA on duty in a wing to answer the call lights.                      *Sometimes there was only one nurse for Center hall and East hall.                      *It had taken an hour or an hour-and-a-half to answer call lights.                      *Resident 24 said he had to lay in bed and wait to get up in the mornings because there was not enough staff to assist him.</p> <p>Surveyor: 32335</p> <p>2. Interview on 6/16/15 at 1:15 p.m. with the administrator revealed they were unable to provide call light logs from 5/13/15 to the present. The computer that had the call light software installed on it had been accidently turned off. He had been getting an error message for approximately the past 3 weeks and was unable to get any reports. They had realized it had been turned off after this surveyor had requested the data earlier that morning.</p> <p>Surveyor: 33488</p> <p>3. Interview on 6/9/15 at 9:20 a.m. with Dr. V revealed:                      *He had no access to the electronic medical record (EMR) nursing notes or dietary notes.                      *He had been waiting "A long time for my access" from the facility.                      *He had to "Hunt down a nurse if I want to know about my residents."                      *No nurse had been available to assist him when he made rounds.                      *He would "Have to do my best" with the</p>	S 199	<p>The facility is in the process of starting a CNA preceptor program under the direction of the DON and/or designee with the goal of retaining new hires. The facility will ask 3 nursing staff employees per month to attend the monthly QAPI meeting to solicit their assistance in identifying trends and participate in subcommittees to ask for their ideas for solutions to those trends.</p> <p>The call light time log for the bed and toilet will be pulled weekly for all residents by the Administrator and/or designee. Results to be given to the DON and Clinical coordinators for trend analysis to indicate halls that need additional staffing. The results of the weekly call light times will be provided by the Administrator to the monthly QAPI meeting for 1 year and then as deemed necessary by the committee.</p> <p>The administrator will give a job satisfaction survey to 10 random employees per month to look for trends. The results will be shared with the Monthly QAPI meeting for 1 year and then as deemed necessary by the committee.</p>	7/16/15

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S 199	<p>Continued From page 20</p> <p>information he had received. *He stated "They don't have enough staff for that" in regards to sending a nurse with him when he visited residents. *He stated "I will be here until 12:30 I bet. It is slow without a nurse."</p> <p>Surveyor: 32331 4. Interview on 6/16/15 at 9:38 a.m. and at 2:35 p.m. with the staff coordinator revealed: *She was responsible for coordinating the nursing staff schedule. *She prepared a new nursing schedule every six weeks. -There were many changes to that above schedule after it had been posted. *The day of each week that had been the hardest to fill was on Sunday. *The evening shift from 2:00 p.m. until 6:30 p.m. and until 10:30 p.m. were the more difficult ones to have filled. *There were many changes to the schedule after it had been posted. *She stated there were challenges with the staffing schedule.</p> <p>Interview on 6/16/15 at 5:15 p.m. with the administrator and the director of nursing revealed they both agreed there were challenges with the staffing schedule.</p> <p>Surveyor: 32335 5. Review of the provider's April 2013 director of nursing (DON) job description revealed she: *"Monitors the nursing staff to maintain sufficient staff to provide quality care for the residents." *Was "Responsible for making sure that there is adequate staff in number and ability to maintain the highest practicable level of physical, mental, and psychosocial well-being for each resident that</p>	S 199		7/16/15

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S 199	Continued From page 21 meets the state and federal regulations."  6. Interviews, observations, record review, and policy review throughout the course of the survey from 6/8/15 through 6/11/15 and from 6/16/15 through 6/17/15 revealed the provider failed to ensure resident needs were met. Refer to S124, S145, S147, and S445.	S 199		
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.	S 206	The In-service Program Attendance policy was revised and updated on 7-08-15. A general orientation program with a checklist has been created. General Orientation will be held weekly on Wednesday/Thursday based on the number of new hires. New employees will not be allowed to begin floor/specific job orientation until the general orientation program has been completed. All staff inservicing will be video taped for one session and made available for staff to watch and record their attendance via an attestation of attendance form. All meeting agendas and scanned sign-in sheets will be kept on the "S" drive for secure storage of information and ease of access. A calendar of in-services will be made by July 14, 2015 and set out for a year to be followed and updated if changes need to be made. All-staff meetings will occur monthly.	7/16/15

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S 206	<p>Continued From page 22</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 33265</p> <p>Surveyor: 35625</p> <p>A. Based on record review and interview, the provider failed to formally orientate all new employees prior to beginning their duties. Findings include:</p> <p>1. Record review and interview on 6/11/15 at 10:30 a.m. with human resource staff employee P revealed: *A general orientation was held once a month for all new employees. -The employee handbook, abuse policies, and fire and prevention materials were covered. -She confirmed a new employee would be able to work with residents prior to completion of orientation. *When a new staff member started they were paired with an another employee. -She was unable to give a timeline for the length of time a new employee would be paired with another staff person. -There was no documentation of an orientation checklist to ensure the new employee had been trained in all aspects of the job or the above materials.</p> <p>B. Based on record review and interview, the provider failed to ensure the required annual training was completed for all personnel. Findings include:</p> <p>1. Record review and interview on 6/11/15 at 11:00 a.m. with human resource staff employee P and the director of nursing regarding annual</p>	S 206	<p>A CNA preceptor program has been created and will be overseen by the DON and Director of Employee Relations. This will help to ensure staff is receiving consistent and uniform training. Preceptors will have competency checklists. Direct care staff will have access to 10 shifts of orientation unless the employee waives the training by their choice.</p> <p>All staff will be inserviced on July 14-15, 2015 regarding general orientation and required annual education and the In-service Program Attendance policy.</p> <p>The Director Employee Relations and/or designee will audit 5 employees per month to assess for the required general orientation and required annual inservicing. The results of the audits will be presented by The Director Employee Relations and/or designee on a monthly basis for 1 year to the monthly QAPI meeting and then as deemed necessary by the QAPI committee.</p>	7/16/15

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S 206	Continued From page 23 training revealed: *They were unable to provide documentation of an agenda or sign-in sheet for the October 2014 training for infection control. -They had provided staff training based on the 2014 survey results instead. *They were unable to provide documentation of an agenda or sign-in sheet for the November 2014 training for handwashing and resident assessments. *No training occurred in December 2014. *They were unable to provide documentation of an agenda or sign-in sheet for the January 2015 training on isolation protocols. *Therapy and resident lift training for February 2015 was postponed to a later date. *Nutrition/hydration was scheduled for March 2015 but was re-scheduled to 6/19/15. *Emergency and disaster training for April 2015 was not finished completely and would have to be redone. *The local ombudsman presented at the May 2015 meeting on abuse. *Mandatory training topics were not covered as scheduled due to management staff not in place to complete the task. Topics not covered included: -Emergency procedures and preparedness -Infection control and prevention -Accident prevention and safety procedures -Reportable diseases -Dining assistance, nutritional risks, and hydration needs	S 206		7/14/15
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM  The facility must have an employee health program for the protection of the...residents. All	S 210		

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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S 210	<p>Continued From page 24</p> <p>personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 35625 Based on review of employee health files and interview, the provider failed to ensure five of five new employees (D, G, CC, DD, and the director of nursing [DON]) were evaluated by a health professional for freedom from communicable diseases. Findings include:</p> <p>1. Review of the employee files revealed: *Employee D's hired date was 2/12/15. *Employee CC's hired date was 3/2/15. *The DON's hired date was 3/4/15. *Employee DD's hired date was 3/30/15. *Employee G's hired date was 5/18/15. *There was no documentation in the each of the above employees' files to support they had been evaluated by a health professional and were determined to be free from communicable diseases.</p>	S 210	<p>The Employee Health Program was reviewed and revised on 7-08-15. New employees will be required to be evaluated by the DON and/or RN/LPN to be free from communicable diseases. New and existing employees will fill out an employee health questionnaire which will be reviewed by the DON and/or RN/LPN to be free from communicable diseases. All existing employees will be evaluated by the DON and/or RN/LPN to be free from communicable diseases by July 15, 2015. All staff will be inserviced on July 14-15, 2015 regarding the Employee Health Program policy.</p> <p>The Director Employee Relations and/or designee will audit 5 employees per month to assess for completion of the health questionnaire and verification to be free from communicable diseases. The results of the audits will be presented by the Director Employee Relations and/or designee on a monthly basis for 1 year to the monthly QAPI meeting and then as deemed necessary by the QAPI committee.</p>	7/16/15

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S 210	Continued From page 25  Interview on 6/11/15 at 10:30 a.m. with human resource staff employee P revealed: *She was not aware of the required health evaluation. *An employment post-job offer medical questionnaire was enclosed in each personnel record. -It had not evaluated the employee was free from communicable diseases. -A licensed health professional had not reviewed the questionnaire or done an assessment.	S 210		
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Tuberculin screening requirements for healthcare workers or residents are as follows:  (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;  This Administrative Rules of South Dakota is not met as evidenced by:	S 236	The Tuberculosis, Employee Screening For policy was reviewed and revised on July 8, 2015. The policy will be followed and no new employees will be allowed to work or attend general orientation until the 1st Step TB test is completed and read without a positive reading. The second step will be given 7 to 14 days after the 1st step. Director of Employee Relations will place all information in a database calendar to ensure that all existing employees receive timely TB testing. All other existing employees have been audited by the Director of Employee Relations and all existing employees have current TB results or chest X-rays that are negative and comply with the policy. All staff will be inserviced on July 14-15, 2015 regarding the TB screening policy and procedure. The Director Employee Relations and/or designee will audit 5 employees per month to assess for completion of the required TB screening process as listed in the policy.	7/16/15

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S 236	<p>Continued From page 26</p> <p>Surveyor: 32335</p> <p>Surveyor: 35625</p> <p>Based on employee file review and interview, the provider failed to ensure three of five sampled new employees (G, CC, and DD) completed the two-step tuberculin (TB) screening within fourteen days of being hired. Findings include:</p> <p>1. Review of employee G's file revealed her hired date was 5/18/15. The first step was given on 5/18/15 and read on 5/21/15. There was no documentation the second step of the TB screening had been completed.</p> <p>2. Review of employee CC's file revealed her hired date was 3/2/15. The first step was given on 6/1/15 and read on 6/3/15. A second step was given on 6/8/15 and was not read at the time of review on 6/11/15. The TB screening was started thirteen weeks after being hired.</p> <p>3. Review of employee DD's file revealed her hired date was 3/30/15. A note was placed on her file that read "getting TB [copied] from previous employer." No documentation of the TB screening was in the file.</p> <p>4. Interview on 6/11/15 at 10:30 a.m. with human resources staff employee P revealed: *TB screenings for the three sampled employees had not been completed within fourteen days of being hired. *No system was in place to ensure TB screenings were administered or read in a timely manner for new employees.</p> <p>Policies concerning the TB screenings were requested. None were received before the end of the survey.</p>	S 236	<p>The results of the audit will be presented by The Director Employee Relations and/or designee on a monthly basis for 1 year to the monthly QAPI meeting and then as deemed necessary by the QAPI committee.</p>	7/16/15
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S 253	<p>44:04:04:11.01 SECURED UNITS</p> <p>Each facility with secured units must comply with the following provisions:                      (1) A physician's orders for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the...resident's chart and must be reviewed periodically by the physician;                      (2) Therapeutic programming must be provided and must be documented in the overall plan of care;                      (3) Confinement may not be used as a punishment or for the convenience of the staff;                      (4) Confinement and its necessity must be based on a comprehensive assessment of the...resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the...resident's family;                      (5) Locked doors must conform to Sections 18.2.2.2.4 and 19.2.2.2.4 of NFPA 101 Life Safety Code, 2000 edition; and                      (6) Staff assigned to the secured unit must have specific training regarding the unique needs of...residents in that unit. At least one caregiver must be on duty on the secured nursing unit at all times.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by:                      Surveyor: 32335</p> <p>Surveyor: 35625                      Based on observation and interview, the provider failed to train one of one new certified nursing assistant (CNA (N)) to work in the memory care unit (Memory Lane). Findings include:</p>	S 253	<p>CNA (N) is no longer employed at the facility. All other staff members working in the Memory Care unit have specific training regarding the care of cognitively impaired residents via the CMS Hand In Hand training within 2015. The Director of Employee Relations will audit 2 staff members that work in the Memory Care unit per month to audit if they have specific dementia training. The results of the audit will be presented by The Director Employee Relations and/or designee on a monthly basis for 1 year to the monthly QAPI meeting and then as deemed necessary by the QAPI committee.</p>	7/16/15

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S 253	Continued From page 28  1. Observation and interview on 6/8/15 at 6:25 p.m. with CNA N revealed she: *Had been working in the memory care unit for approximately one week *Was scheduled to work in the memory care unit from 6 p.m. to 6 a.m. *Was working alone from 10:30 p.m. to 6:00 a.m. *Had received no training to meet the specialized needs of residents on the memory care unit.  Interview on 6/11/15 at 11:00 a.m. with human resource staff employee P revealed CNA N had no specialized training from the provider prior to working in the memory care unit. She was certified as a nursing assistant upon hire. There had been no orientation checklist regarding her completed training.	S 253		
S 281	44:04:06:05 RESIDENT CARE PLANS AND PROGRAMS  The nursing service of a health care facility must provide safe and effective care from the day of admission through the ongoing development and implementation of written care plans for each...resident. The care plan must address medical, physical, mental, and emotional needs of the...resident. The health care facility must establish and implement procedures for assessment and management of symptoms including pain.  The care plan for nursing facility residents must be based on the resident assessments required in sections 44:04:06:15 and 44:04:06:16 and must be developed and approved by the resident's physician; the resident, the resident's family, or the resident's legal representative; the	S 281	The facility care plan policy was updated on July 8, 2015, which includes direction to ensure that care plans are updated regularly to ensure accurate and current information is available for staff to follow through with resident cares. Resident 19 was discharged from our facility. Care plans for residents #11, 2, 10 and 12 have been updated to include current and accurate information. Care plans for all other residents in the facility have been assessed to ensure they include accurate information as well. Education for all nursing staff on the revised care plan policy and procedure will be conducted by the DON and/or designee on July 14-15, 2015.	7/16/15

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S 281	<p>Continued From page 29</p> <p>interdisciplinary team consisting of at least a licensed nurse, the facility's social worker or social service designee, the dietary manager or dietitian, the activities coordinator, and other staff in disciplines determined by the resident's needs. The care plan shall describe the services necessary to meet the resident's medical, physical, mental or cognitive, nursing, and psychosocial needs and shall contain objectives and timetables to attain and maintain the highest level of functioning of the resident. The care plan must be completed within seven days after the completion of each resident assessment required in sections 44:04:06:15 and 44:04:06:16.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans had been updated and revised to reflect the residents' current needs for 4 of 16 sampled residents (2, 10, 11, and 19) and for 2 of 3 hospice residents (14 and 15) who did not have the hospice care plan integrated with the provider's care plan. Findings include:</p> <p>1. Review of resident 11's complete medical record revealed: *She had been admitted on 4/22/14. *Her 4/8/15 Minimum Data Set (MDS) assessment revealed: -A Brief Interview for Mental Status assessment that showed her to be aware and able to make decisions. -She needed extensive assistance of one staff member to transfer out of bed and to the bathroom. *Her 4/12/15 comprehensive care plan stated she was unsteady, and she needed assistance with</p>	S 281	<p>Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that care plans for residents #11, 2, 10 and 12 include current and accurate information. Five (5) random care plan audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that care plans are updated as needed to ensure they include current and accurate information for 5 random residents as well.</p> <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings to QAPI meetings for 1 year and then as deemed necessary by the QAPI committee. The following facility policies: "Writing Orders – General Principles", "Physician Services", "Administering Medications", and "Charting and Documentation Policy" were revised on 7-8-2015 and will be reviewed with facility nurses on July 14-15 2015 to ensure they will be followed appropriately.</p> <p>Audits conducted on numbers F-281 - 1, 2 and 3 below will be reviewed as stated to ensure compliance. The DON and/or designee will be responsible for audits and overall compliance. The DON and/or designee will report audit findings at monthly QAPI meetings for 3 months.</p> <p>The physician's order for resident #1's Aspirin EC 325mg tablet BID – give 1 tablet by mouth bid was verified changed to regular Aspirin 325 on 6-09-15 and all medications were changed to PO on 6-11-15. Resident #10's order for metoprolol</p>	7/16/15
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S 281	<p>Continued From page 30</p> <p>transfers and activities of daily living.</p> <p>Interview on 6/9/15 at 10:30 a.m. with certified nursing assistant (CNA)/medication aide W revealed resident 11 transferred into the bathroom by herself. Staff did not assist her.</p> <p>Interview on 6/9/15 at 3:30 p.m. with resident 11 revealed she usually transferred herself to the bathroom.</p> <p>Review of the undated CNA pocket care plan for resident 11 revealed she needed the assistance of two staff to transfer her.</p> <p>Interview on 6/16/15 at 10:45 a.m. with MDS case manager X regarding resident 11 revealed: *She decided how to code resident care needs based on discussion with staff and reviewing Care Tracker (where the CNAs charted their care for a resident). *She coded based on how the activity was done the majority of time. *She stated "Sometimes the resident transferred herself and sometimes she needed help." *She agreed neither the comprehensive care plan nor the pocket care plan for resident 11 had been updated to reflect she frequently transferred herself to the bathroom.</p> <p>Interview on 6/16/15 at 3:30 p.m. with the director of nursing (DON) and the administrator regarding resident 11 revealed they agreed her care plan had not been updated to reflect her current care.</p> <p>Surveyor: 33265 2. Review of resident 10's complete medical record revealed: *He had been admitted on 2/12/15. *He weighed 205.6 pounds (lb) on admission.</p>	S 281	<p>tartrate 25mg bid which included parameters to check heart rate and blood pressure was verified on 7/10/15. Resident #6's physician order for side effect follow up on prescribed Seroquel medication was verified on 7/10/15. Physician's orders for all other residents receiving medication per tube feeding were reviewed to ensure they were accurate and medications were given as ordered. Physician's orders for all other residents on medications that need side effect follow up were assessed to ensure the proper side effect follow-up stickers are in place.</p> <p>The facility policies listed above were all revised as listed above. The DON will provide education on all of the above policies to all nursing staff on July 14-15 2015. Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that residents #1 and 6 and on five random residents with tube feeding medications and on five random residents receiving medication that need side-effect follow up to ensure that the physician's orders are being followed appropriately for each.</p> <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings to QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p>	7/16/15

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S 281	<p>Continued From page 31</p> <p>*He weighed 177 lb on 5/19/15, which was a loss of 28 lb.</p> <p>*He had upper and lower dentures.</p> <p>*He was hard of hearing and used hearing aides. On 3/13/15 a hearing aide was documented as having been in his left ear.</p> <p>*He had a cell phone when he was admitted. The cell phone had gone through the washing machine in the laundry.</p> <p>*He wanted to be a full code (wanted CPR [cardiopulmonary resuscitation]), but was also listed as a "do not resuscitate" (DNR [do not do CPR]).</p> <p>*He was on honey thickened liquids (all liquids to drink were thickened to be like honey) since 6/4/15.</p> <p>*The undated care plan had documented:</p> <ul style="list-style-type: none"> <li>-He used a hearing aid in his left ear and still had difficulty hearing. Resident 10 had not worn a hearing aide in either ear during the survey.</li> <li>-He needed nectar thickened liquids. That had not been updated to the honey thickened liquids.</li> <li>-Stated he wanted to be a full code and a DNR.</li> <li>-Had not included any update on weight loss.</li> <li>-Had not included when the resident was to be weighed.</li> <li>-Had not included the resident had not been using his dentures to eat.</li> <li>-Had not included any update as to the washing and loss of a cell phone.</li> </ul> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the DON and the administrator revealed the DON:</p> <ul style="list-style-type: none"> <li>*Thought the daily weights had been discontinued.</li> <li>*Would expect the care plan to have been updated when changes occurred.</li> </ul>	S 281		7/16/15

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S 281	<p>Continued From page 32</p> <p>Surveyor: 32333</p> <p>3. Review of resident 2's care plan revealed: *Two focus areas documented as pressure ulcers (injury to the skin from prolonged pressure). a.*One of the pressure ulcer focus areas updated on 3/12/15 included the following: -She was at risk for pressure ulcers, because she was frequently incontinent (loss of bladder control) of urine and she had edema (swelling). -During care they were to observe her skin and notify the nurse if there were any areas of concern. -Notify the nurse, family and doctor with any areas that are reddened, opened, or with any unexplained bruising. -Remind the resident to reposition when sitting or lying in one place. -On 3/12/15 her care plan was updated "Area to buttock [bottom] crease open again." -3/12/15 was the last time her care plan had been updated for that focus area. b. *The other focus area documented as pressure ulcers updated on May 2015 included the following: -"I have a pressure ulcer." -Progress toward the healing of the resident's pressure ulcer. -If there were no changes to wound in two weeks seek a different treatment. -If there were no changes in four weeks, seek a consultation to the wound clinic. c.*She had a focus area for pain with the following interventions: -Nursing should assess pain and document it. -Encourage the resident to change positions if she was in the same position for more than two hours. *Review of her care plan on 6/16/15 revealed it had not been updated to include a new skin concern noted on 6/10/15.</p>	S 281		7/16/15
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S 281	<p>Continued From page 33</p> <p>Review of resident 2's complete medical record revealed: *A 3/12/15 skin assessment report that stated she had a stage II pressure ulcer (open sore)to her buttock crease (no documentation as to the exact location). *A 3/12/15 fax to the physician with the concern of a new stage II pressure ulcer. *On 5/21/15 at 10:30 p.m. a nursing note: -Her coccyx open to air. -DuoDerm (Type of wound dressing) discontinued and area healed. -No areas of concerns. *There was no mention of her pressure ulcer as being healed on her care plan.</p> <p>4. Review of resident 19's fall risk assessment revealed he scored a sixteen which indicated he was at high risk for falls.</p> <p>Review of resident 19's nursing notes revealed he had a fall resulting in a left hip fracture on 2/17/15.</p> <p>Review of resident 19's 2/16/15 nursing Kardex (temporary care plan) revealed no mention or interventions for falls.</p> <p>5. Interview on 6/16/15 at 2:25 p.m. with the administrator and director of nursing revealed they would have expected care plans to have been complete and updated to reflect the residents' current status.</p> <p>Surveyor: 32331 Surveyor 34030</p> <p>6. Review of resident 14's medical record revealed she had been admitted on 8/9/14. Hospice care had started on 5/22/15.</p>	S 281		7/16/15

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S 281	<p>Continued From page 34</p> <p>Review of resident 14's current provider's 2/12/15 care plan revealed: *It was located in a Care Plan binder with the hospice agency's care plan placed behind it. *No mention was made to show who was responsible for what care the resident was to have received.</p> <p>Interview on 6/16/15 at 3:30 p.m. with the DON and the administrator revealed they were unaware of the need to specify provider and hospice care for residents. No hospice specific policy on resident care plans existed.</p> <p>Surveyor 32331 7. Review of resident 15's medical record revealed: *She had been admitted on 6/4/15. *She was currently on hospice care and had been receiving hospice services at another facility. *A 6/3/15 physician's order for hospice care for "No change in level of care at this time only change of location."</p> <p>Review of resident 15's undated care plan revealed: *No interventions that had included hospice care. *It had not: -Addressed why she was on hospice. -Identified the services and what care was to have been provided by the provider and by hospice.</p> <p>Interview on 6/10/15 at 2:40 p.m. with RN A regarding resident 15 revealed: *The provider had not combined hospice care plans into her care plans. *She had been unaware the hospice care plans needed to have been combined into the</p>	S 281		7/16/15

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S 281	<p>Continued From page 35</p> <p>provider's care plan. *She agreed the hospice care plan needed to have been combined into the provider's care plan.</p> <p>Interview on 6/10/15 at 2:55 p.m. with certified nursing assistant CNA B regarding resident 15 revealed: *She had been unaware she was on hospice. *She had not known what services hospice staff were to have provided.</p> <p>Interview on 6/10/15 at 3:00 p.m. with the director of clinical services at the hospice agency regarding resident 15 revealed: *They had not combined hospice care plans into the provider's care plans. *It was the responsibility of the provider to integrate the care plan provided by the hospice agency into the provider's care plan. *She stated there was a hospice plan of care for her, and that she would send it to the facility. *She agreed the plan of care needed to have been available and combined into the provider's care plan.</p> <p>Interview on 6/10/15 at 4:10 p.m. with CNA PP regarding resident 15 revealed she: *Had been aware she was on hospice because she had assisted with her admission on 6/4/15. *Stated "It would have been nice" to have had more information regarding her hospice care. *She was not aware what services hospice was to have provided.</p> <p>Interview on 6/10/15 at 4:40 p.m. with the DON regarding resident 15 revealed she: *Agreed they did not have her facility care plan combined with the hospice one. *Confirmed the provider's care plan needed to have been combined with the hospice one and</p>	S 281		7/16/15	

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S 281	<p>Continued From page 36 followed.</p> <p>Review of the provider's revised 7/25/12 Agreement for Nursing Home Services revealed: *The provider and hospice were to have developed a combined care plan for each hospice resident. *Hospice was to have provided the facility with a copy of any existing care plan upon admission. *If a care plan had not been developed prior to that admission: -Hospice was to have prepared a care plan for that resident within two working days. -And have delivered a copy to the provider. *The provider and hospice were to have worked together to: -Facilitate cooperative efforts between the provider and hospice in providing appropriate care for residents admitted to hospice. -Ensure that care for hospice residents was in compliance with the hospice plan of care.</p> <p>8. Review of the provider's January 2009 Care Plans - Preliminary policy revealed to ensure the resident's immediate care needs were met and maintained a short-term care plan was to have been developed on admission.</p> <p>Review of the provider's January 2009 Care Plans-Comprehensive policy revealed: *The provider developed a comprehensive care plan for each resident to meet the resident's medical, nursing, and psychological needs. *The above comprehensive care plan had been designed to: -Incorporate identified problem areas. -Incorporate risk factors associated with identified problems. -Build on the resident's strengths. -Reflect treatment goals and objectives in</p>	S 281		7/16/15

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S 281	Continued From page 37  measurable outcomes. -Identify the professional services responsible for each element of care. -Prevent decline in the resident's functional status and levels (the measure and levels of a person's ability to perform activities of daily living independently).	S 281		
S 286	44:04:07:02. Dietetic Services  There must be an organized dietetic service that meets the daily nutritional needs of...residents and ensures that food is stored, prepared, distributed, and served in a manner that is safe, wholesome, and sanitary in accordance with section 44:04:02:06.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Sinks, shelves, floors, and equipment were routinely cleaned in one of one kitchen. *Pureed hot foods were held and served at safe and palatable temperatures during two of two meal services. *The food thermometer was sanitized prior to being inserted into food and between use with multiple foods. *Staff used clean and sanitized scoops during one of one observed meal service. *Staff had documented food temperatures and kitchen cleaning schedules. *Supervisory staff had appropriately monitored and corrected areas of concern. Findings include:	S 286	A thorough kitchen cleaning was completed on July 8, 2015 by the CDM and staff. InTek Cleaning and Restoration will professionally clean the floors, walls, corners and equipment on July 13, 14, and 15 2015.  A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on cleaning schedules, importance of cleaning and sanitation, safe food temperatures and the food danger zone range. The CDM or designee will randomly monitor four dietary staff weekly x 12 weeks for compliance.  The Certified Dietary Manager (CDM) or designee will complete directed kitchen audits daily x 12 weeks and weekly thereafter for one year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.	7/16/15

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S 286	<p>Continued From page 38</p> <p>1. Observation of the kitchen on 6/8/15 at 6:20 p.m. revealed:                      *The dry food storage room under the shelving had a large spot of sticky residue.                      *The floor in the dirty and clean dishroom areas were heavily soiled with food and debris.                      *In the dirty dish area there was a hand sink that was heavily soiled with brown staining and kernels of corn in the bottom of the sink.                      -On the wall directly above the sink was a fan that had a thick amount of dust and debris on the blades and the fan cover.                      *The base of the plate warmer had a moderate amount of visible food residue.                      *Shelving to the left of the above plate warmer had moderate food debris and was visibly soiled.                      *The refrigerator in the food preparation area close to the steam table was visibly soiled with a spilled liquid and debris on the bottom.</p> <p>Observation on 6/9/15 at 7:10 a.m. in the kitchen revealed the same areas of concern listed above and were unchanged from the observation on 6/8/15 at 6:20 p.m.</p> <p>Observation on 6/9/15 at 10:40 a.m. in the kitchen revealed the same areas of concern listed above still remained unchanged.</p> <p>Observation on 6/9/15 at 4:05 p.m. in the kitchen revealed:                      *In the dry food storage room the same large spot of sticky residue on the floor remained. Light food debris was seen on the floor.                      *In the three compartment sink on the clean dish side, the middle rinse sink had approximately three to four inches deep of large amounts of food debris mixed with an unknown liquid.                      *The floor in the dish machine area remained</p>	S 286		7/16/15

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S 286	<p>Continued From page 39</p> <p>visibly soiled with heavy food debris. *A dead cockroach was observed on the floor in the far left corner from the dish machine on the floor. *The hand sink in the dishroom remained heavily visibly stained and also contained new trace amounts of orange colored food. *The base of the plate warmer remained visibly soiled. *The shelving to the left of the above plate warmer remained moderately visibly soiled with food debris.</p> <p>Observation on 6/10/15 at 9:30 a.m. in the kitchen revealed: *The clean and dirty dishroom area floors remained heavily visibly soiled. *The dead cockroach remained in the corner on the floor in the dish machine area. *The hand sink in the dishroom remained heavily visibly soiled and stained. *The plate warmer remained visibly soiled at the base. *The shelving to the left of the plate warmer remained moderately visibly soiled with food debris.</p> <p>Observation and interview on 6/10/15 at 3:10 p.m. with the certified dietary manager (CDM) and the administrator while performing a walk-through of the kitchen areas revealed: *The large spot of sticky residue in the dry food storage room located under the shelving remained. *The hand washing sink in the dirty dishroom area remained heavily stained and visibly soiled with food. -The fan mounted above that sink had been removed. *The CDM stated she had "called other facilities</p>	S 286		7/16/15

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S 286	<p>Continued From page 40</p> <p>and they had received deficiencies" regarding dirty fans so she "had it removed."                      *They agreed the hand sink was visibly stained and soiled.                      *They agreed the base of the plate warmer and shelves to the left of it had been visibly soiled.                      *The refrigerator in the food preparation area close to the steam table remained visibly soiled with liquid and food debris.                      *Both agreed the above areas needed cleaning. The administrator stated "We will get this taken care of."                      *The CDM stated the staff had been cleaning the kitchen.                      -She had not supervised the cleaning each day.                      -She had cleaning logs.</p> <p>Review of the kitchen cleaning logs for January 2015 through May 2015 revealed five out of twelve tasks listed were not completed by staff for any months reviewed.</p> <p>Review of the daily cleaning logs for the month of April 2015 revealed:                      *The cook's refrigerator had not been cleaned eighteen days out of twenty-eight days.                      *The steam table had not been cleaned eighteen days for the month.                      *The hand washing sink had not been cleaned for seventeen days of the month.</p> <p>Review of the daily cleaning logs for the month of May 2015 revealed:                      *The cook's refrigerator had not been cleaned fourteen out of thirty days.                      *The steam table had not been cleaned twelve days that month.                      *The hand washing sink had not been cleaned for four days that month.</p>	S 286		7/16/15

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S 286	<p>Continued From page 41</p> <p>Review of the deep cleaning logs for weeks one through five of May 2015 provided by the CDM revealed: *Five of sixteen tasks were not completed at all. *Only three of the sixteen tasks listed had been completed for all five weeks.</p> <p>Review of the provider's F371 Kitchen Sanitation Checklists revealed: *On 11/10/14 in the East dining room and serving area: -All items were not covered, labeled, or dated. Bowls and dinnerware had been found sitting on the counter uncovered. -Floors were found sticky and dirty. -The thermometer was found dirty and uncovered in the drawer. -All carts were found dirty. -Used napkins were found on the microwave cart and removed. -Floors, walls, ceilings and work areas were found not clean. -Hand washing procedures had not been posted at the sink. -Comments made on the sheet: "Needs close monitoring daily by dietary manager or designee." *On 11/17/14 in the East dining room and serving area: -"Brown sugar had been found unlabeled in the drawer with uncovered cups." -Shelves were not found clean. -Floors were found "very dirty". -No food temperatures were recorded on 11/16/14. -The daily cleaning schedule had not been completed and followed. -Hand washing procedures had not been posted at the sink. -Floors, walls, ceilings, and work areas were found not clean.</p>	S 286		7/16/15

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S 286	<p>Continued From page 42</p> <ul style="list-style-type: none"> <li>-Work tables and drawers were not clean and neat.</li> <li>-Carts and racks were not clean and in good repair.</li> <li>-Food brought at serving time was found warm, not hot.</li> <li>-The counters were found dirty.</li> <li>-Garbage containers were found not clean and covered.</li> <li>-Dumpsters were not closed and were overflowing.</li> <li>*Comments made on the above checklist:             <ul style="list-style-type: none"> <li>-"Glasses stacked, also cups drinking side down on the dirty cart surface."</li> <li>-Dirty glasses and silverware on dirty counter.</li> <li>-Dirty napkin in drawer.</li> <li>-Multiple serving cups found uncovered on bare cupboard.</li> <li>-"Open sweet and sour container unlabeled."</li> <li>-"Refer to dietary manager [DM] for specific action."</li> <li>-As before recommend inservices to staff.</li> <li>-Daily rounding with interventions from DM.</li> </ul> </li> <li>*On 11/17/14 through 11/18/14 of the kitchen and Center dining area:             <ul style="list-style-type: none"> <li>-Items in the storeroom had not been stored six inches above the floor or eighteen inches from the sprinkler heads.</li> <li>-Shelves were not found clean.</li> <li>-Walls, floors, ceilings, and vents were not clean in the storeroom.</li> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Refrigerator fans were not found clean from dust.</li> <li>-Refrigerator temperature logs could not be located.</li> <li>-Freezer items had been stored on floor.</li> <li>-Ice cream had been found not labeled</li> </ul> </li> </ul>	S 286		7/16/15
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S 286	<p>Continued From page 43</p> <ul style="list-style-type: none"> <li>-The thermometer in the freezer had been found laying face down on the floor.</li> <li>*No freezer logs could be located.</li> <li>-Dishwasher temperatures were not logged daily.</li> <li>-Items in the dishwasher area had not been checked to make sure they were clean.</li> <li>-Items in the dishwasher area were found not dried and not stacked.</li> <li>-The dishwasher area was "filthy".</li> <li>*The daily cleaning schedule had not been completed or followed.</li> <li>-"Dirty utility, filthy, disorganized."</li> <li>-Carts were found "very dirty."</li> <li>-Gloves were not worn by staff</li> <li>"Cross-contamination" had been found.</li> <li>-Employees were found not wearing clean, appropriate uniforms and hairnets or coverings.</li> <li>-Food scoops were found not clean and dry "uncovered under prep table."</li> <li>-"Table by the steam table very dirty. Gap against wall filthy."</li> <li>-Motor vent on the range/oven "filthy".</li> <li>-Carts, microwave, grill, and ice machine found unclean.</li> <li>-The refrigerator door was found not to close.</li> <li>-Ovens and steamer were found not clean.</li> <li>-Mops had not been stored properly out of the water.</li> <li>-Garbage containers were not clean and covered when not in use.</li> <li>-Dumpsters were found not closed or overflowing.</li> <li>-Outside openings were not protected against pets.</li> <li>*Hand-written comments made on the above checklist:</li> <li>-Exposed cups and plastic silverware.</li> <li>-Shelves totally disorganized.</li> <li>-Trash on floor in exit hallway.</li> <li>-Cooking utensil cart very dirty.</li> <li>-Table by stove filthy. Open container of oil.</li> </ul>	S 286		7/16/15
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S 286	Continued From page 44 <ul style="list-style-type: none"> <li>-Multiple serving tools open under food prep table - scrambled.</li> <li>-Cart under cereal filthy.</li> <li>-Behind steam table: old bacon, multiple packets, spills.</li> <li>-Prep area- very disorganized. Needs cleaning.</li> <li>-Refer to DM and RD. Recommend inservices and other hands-on training.</li> <li>-Please submit plan to administrator.</li> <li>-Dirty washcloths on cart.</li> <li>-Debris (food) just sitting in receptacle.</li> <li>-Splatters on wall and ceiling.</li> <li>-Fan dirty.</li> <li>-Food delivery carts dirty.</li> <li>-Pies uncovered - need parchment (paper) on dirty cart.</li> <li>-Clean dish room floor very dirty.</li> <li>-Dish machine chemical log very incomplete. Only one day logged for October (2014)."</li> <li>*On 12/12/14:</li> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Refrigerator temps were not found to be logged daily by staff.</li> <li>*On 12/5/14:</li> <li>-Food supplies were found to have not been rotated.</li> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Temperatures in the refrigerator from the thermometer were not found below 41 degrees as required.</li> <li>-Refrigerator temps were not found to be logged daily by staff.</li> <li>-Food had not been discarded after seventy-two hours.</li> <li>-Not all freezer food had been found covered, labeled, and dated.</li> <li>-Not all items were stored on racks for proper ventilation.</li> </ul>	S 286		7/16/15

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S 286	<p>Continued From page 45</p> <ul style="list-style-type: none"> <li>-The freezer temperature had not been logged daily.</li> <li>-Dishwashing temperatures had not reached proper temperatures for wash and rinse cycles and had not been logged daily.</li> <li>-Dishwasher area was not clean.</li> <li>-The daily cleaning schedule had not been completed and followed.</li> <li>-Floors, walls, ceilings, and work areas were found not clean.</li> <li>-Work areas and tables were not clean.</li> <li>-Carts and racks were not clean and in good repair.</li> <li>-Hood filters had not been cleaned.</li> <li>-Employees had not worn hair covers, clean or wearing the appropriate uniform.</li> <li>-Cleaning cloths had not been stored in the sanitizing solution.</li> <li>-Food scoops were not found to be clean and dry.</li> <li>-The sanitizing test kit had not been found.</li> <li>-The walls, racks, and floors in the clean dish area were not clean.</li> <li>-Food prep equipment, dishes, utensils were not found clean, sanitized, and stored properly.</li> <li>-The toaster, can opener, coffee maker, range, carts, cutting boards, steam table, microwave, grill, hoods, and ice machine were not found to be clean.</li> <li>*On 12/19/14: <ul style="list-style-type: none"> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Food had not been discarded after seventy-two hours.</li> <li>-Freezer temperatures were not logged daily.</li> </ul> </li> <li>*On 12/29/14: <ul style="list-style-type: none"> <li>-Refrigerator shelves, racks, walls, floors, ceiling, and doors were found not clean.</li> <li>-Food had not been discarded after seventy-two hours.</li> <li>-Freezer temperatures were not logged daily.</li> </ul> </li> </ul>	S 286		<i>7/16/15</i>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</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 286	<p>Continued From page 46</p> <ul style="list-style-type: none"> <li>-Dishwasher temperatures were not logged daily.</li> <li>-The daily cleaning schedule had not been completed and followed.</li> <li>-Floors, walls, ceilings, and work areas were found not clean.</li> <li>-Carts and racks were not clean and in good repair.</li> <li>-Gloves had not been worn by employees per policy.</li> <li>-The sanitizing test kit had not been found.</li> <li>-The walls, racks, and floors in the clean dish area were not clean.</li> <li>*On 1/2/15:</li> <li>-Not all items in the refrigerator had been covered, labeled, and dated.</li> <li>*On 1/9/15:</li> <li>-Raw food items had not been stored below cooked food items.</li> <li>-All items in the dishwashing area were not dried or stacked.</li> <li>-Hand washing procedures had not been posted at the sink.</li> <li>-Hood filters were not clean and regularly scheduled to be cleaned.</li> </ul> <p>Review of the provider's 4/30/15 Cleaning Instructions: Floors, Tables and Chairs policy revealed:</p> <ul style="list-style-type: none"> <li>*Kitchen and dining room floors, tables, and chairs were to have been kept clean and sanitary.</li> <li>*Kitchen floors were to have been swept and mopped each day after lunch. Major appliances were to have been moved at least once per month in order to clean behind and underneath them.</li> </ul> <p>Review of the provider's 4/30/15 Cleaning Instructions: Refrigerators policy revealed the refrigerators were to have been washed inside and out with a detergent and sanitizer at least</p>	S 286		<i>7/16/15</i>

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S 286	<p>Continued From page 47</p> <p>once every month.</p> <p>Review of the provider's 4/30/15 General Sanitation of the Kitchen policy revealed: *Staff shall maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. *Cleaning and sanitation tasks would have been recorded.</p> <p>Review of the provider's April 2011 Dietary Department Standard Operating Procedure revealed: *The food service area was to have been maintained in a clean and sanitary manner. *The kitchen and dining areas should have been kept clean, free from litter and rubbish, and protected from insects and rodents. *All counters, shelves, and equipment should have been kept clean.</p> <p>Review of the provider's April 2011 Food Storage Standard Operating Procedure revealed: *Food storage areas were to have been kept clean at all times. *Foods stored in walk-in refrigerators and freezers were to have been stored above the floor on shelves.</p> <p>Review of the provider's April 2011 Food Preparation Area Standard Operating Procedure revealed the facility was to have maintained a clean, sanitary, and safe food area.</p> <p>Review of the provider's 4/30/15 Food Safety-Food Service Manager's Responsibility policy revealed the food service manager assured: *Good sanitary food handling practices. *Sanitary conditions were maintained. *All personnel were to have followed proper</p>	S 286		7/16/15

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S 286	<p>Continued From page 48</p> <p>cleaning and sanitizing. *Regular inspections were made by the food service manager or designee to assure food safety.</p> <p>2. Observation and interviews on 6/9/15 with dietary aides F and SS revealed: *At 7:40 a.m. in the East dining room with dietary aide F revealed: *She took the temperature of the oatmeal without cleaning the food thermometer. -Using that same food thermometer and without cleaning it, she inserted it into the cream of wheat. *She then attempted to serve the above foods. *Temperature of the pureed meat was 80 degrees Fahrenheit (F). *She was unaware what the safe holding temperature should have been. It depended upon the temperature of the steam in the table. *At 8:04 dietary aide SS brought replacement oatmeal and cream of wheat to the East dining room. *There had been no new clean scoops located in the drawers. *Dietary aide SS grabbed the used scoops, walked to the sink, ran the water, and scrubbed the scoops with her bare hands and wiped them on her apron. *She then proceeded to place the scoop into the new oatmeal and cream of wheat.</p> <p>Interview on 6/9/15 at 8:30 a.m. with the CDM and the registered dietician (RD) revealed both agreed not cleaning the thermometer or the scoops was a problem.</p> <p>3. Observation and interview on 6/9/15 at 11:45 a.m. with dietary aide E during the noon meal service in the Warren dining room revealed:</p>	S 286		7/16/15
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S 286	<p>Continued From page 49</p> <p>*The pureed foods were not kept in the steam table for hot holding prior to serving. *Those foods were not in the steam table because they had not fit in that area. *The pureed broccoli temperature was 98 degrees F. *The pureed liver temperature was 80 degrees F. *She thought the safe serving temperature was 160 degrees F. *She stated the pureed food was safe to serve. *The temperatures of the pureed hot food needed to have been a minimum of 135 degrees F.</p> <p>4. Observation on 6/9/15 at 12:07 p.m. in the east dining room with dietary aide F revealed: *Ground liver was 118 degrees F. *At 12:25 p.m. prior to serving she checked the temperature of the ground liver again, and it had dropped to 90 degrees F. *She stated the temperature safe to serve hot held food was 160 degrees F. *The temperature of the pureed hot food needed to have been a minimum of 135 degrees F.</p> <p>Review of the food temperature logs for April 2015 revealed: *Temperature logs in the Central dining room had not been logged for meal services for the entire day of 4/8/15. *Dinner service temperatures in the Central dining room were not logged and were incomplete for the following dates: 4/4, 4/5, 4/6, 4/7, 4/9, 4/10, 4/11, 4/14, 4/15, 4/16, 4/17, 4/20, 4/21, 4/24 and 4/28. *East dining meal service had no pureed meat temperatures for the lunch or dinner services on 4/2, 4/6, 4/7, 4/8, 4/12, 4/15, 4/16, 4/17, 4/19, 4/20, 4/22, 4/23, and 4/27. *Dinner services temperatures were not logged in the Warren dining room on 4/3 through 4/8, 4/10</p>	S 286		7/16/15

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S 286	<p>Continued From page 50</p> <p>through 4/16, 4/18, 4/19, and 4/21 through 4/28.</p> <p>*Temperature logs in the Warren dining room were not logged for the lunch meal services for 4/13/15.</p> <p>*Incomplete temperature logs were dated 4/1/15 and 4/2/15 in the Warren dining room for the dinner service .</p> <p>Review of the food temperature logs for May 2015 revealed:</p> <p>*There were no temperatures logged in the month of May for the Warren evening meal service.</p> <p>*5/3/15: No lunch temperatures were taken in the central (main) meal service.</p> <p>*No temperatures were taken on 5/5/15 in the Warren dining room all day.</p> <p>*5/8/15: Only the entree temperature was taken at the evening meal service.</p> <p>*5/10/15: No lunch and dinner temperatures were taken at the central meal service.</p> <p>*5/14/15: No breakfast or lunch temperatures were taken in the central dining service.</p> <p>*Dinner services in the central dining room were not checked or completely checked on 5/17, 5/19, 5/20, 5/24, 5/28, 5/29, and 5/30.</p> <p>*No temperature logs were received for the East dining room for the month of May from the CDM.</p> <p>Review of the provider's 4/30/15 Safety Guidelines policy revealed staff should have monitored food temperatures on a regular basis at the point they were served.</p> <p>Review of the provider's 4/30/15 Food Temperatures policy revealed:</p> <p>*Food should have been held and served at a temperature of at least 135 degrees F.</p> <p>*Hot food items were not to fall below 135 degrees F after cooking.</p>	S 286		7/16/15

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S 286	Continued From page 51  *Temperatures should have been taken periodically. *Tray line and service areas were to avoid holding foods in the temperature danger zone of 41 degrees F to 135 degrees F.  Review of the provider's 4/30/15 Food Safety policy revealed: *The flow of food as it goes through kitchen in order was to have been received, stored, prepared, cooked, held, served, cooled, and reheated. *The second leading cause of food born illness is food not thoroughly heated or cooked.	S 286		
S 287	44:04:07:02.01 Food SAFety  The dietetic service must ensure that food is prepared and served in a manner that is safe and palatable. Hot food must be held at or above 140 degrees Fahrenheit (60 degrees Centigrade) and served promptly after being removed from the temperature holding device. Cold foods must be held at or below 41 degrees Fahrenheit (5 degrees centigrade) and served promptly after being removed from the holding device. Milk and milk products must be from a source approved by the state Department of Agriculture. Fluid milk must be Grade A, and only fluid milk may be used for drinking purposes. Grade A pasteurized dried milk may be used to fortify nutritional supplements only if consumed within four hours of preparation.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review,	S 287	After a review of the facility's process of Open Dining, the management team determined that the best use of facility resources to serve the residents in the best way possible was to offer them a choice of one hot meal and a set list of alternates from which to choose. This change is effective 7/13/15.  A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.  A Kitchen Chatter meeting with residents was completed by the CDM and RD on 7/8/15. The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting with the residents once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM and/or designee for a period of one year at the QAPI Meeting and as deemed necessary by the QAPI committee.	7/16/15

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S 287	<p>Continued From page 52</p> <p>and policy review, the provider failed to ensure: *Dietary aides and cooks were appropriately trained. *The dietary staff, the certified dietary manager (CDM), and the registered dietitian (RD) appropriately performed their job duties as defined within their job descriptions. Findings include:</p> <p>1. Observation and interview on 6/9/15 at 7:35 a.m. with dietary aide F in the East dining room revealed she: *Cracked unpasteurized eggs, mixed them with milk, and cooked scrambled eggs on a griddle to serve to the residents. *Fried pancakes from batter made with unpasteurized eggs on the griddle. *Had been cooking and serving food to the residents since her first day on the job. *Had been employed for five months.</p> <p>Interview and record review on 6/10/15 at 10:00 a.m. with the CDM upon receipt of the provider's undated Dietary Initial Training policy and required inservices revealed: *Only two inservices had been provided to all dietary staff within one year prior to the survey. Topics included were "Voicing Grievances" and "Changes." *The Dietary Initial Training policy revealed training that was to have been provided to dietary staff within two weeks of being hired and ongoing included: -Resident's rights. -Overview of food service. -Introduction to food service. -Sanitation. -Safety. -Food preparation. -Standard measurements.</p>	S 287	<p>Reference above meal plan changes. There has been an egg shortage due to the Avian Bird Flu outbreak. Per the Federal Food Code, we are not allowed to purchase unpasteurized eggs, thus residents have not been getting eggs as often as they would prefer.</p> <p>Our snacks range from 0 to 18 grams of carbohydrate each, thus appropriate for residents with diabetes. Snacks include 4 fl oz servings of 100% fruit juice, Crystal Lite, regular and sugar free soda (6 oz cans), ½ cup servings of applesauce, yogurt, ice cream, pudding, Jell-O, diced canned fruit, seasonal fresh fruit (as available), snack crackers, individual bags of chips, small cookies or other baked goods.</p> <p>Residents with diabetes who have a physician order for a night-time snack will have a planned snack of preference with their name and date on a sticker on their specific snack on the snack cart for their wing.</p> <p>Nursing staff documents snack acceptance in Care Tracker.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.</p> <p>The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed necessary by the QAPI committee.</p>	7/10/15

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S 287	<p>Continued From page 53</p> <p>-Nutrition. -Therapeutic diets. -Review of policies and procedures. *The CDM "had been employed for seven months" at the facility and "had not had time to train" the dietary staff. *She could provide no further dietary training for any dietary aides except the two above dietary inservices. *She agreed the required mandated food service training had not been provided to dietary personnel.</p> <p>Observation and interview on 6/10/15 at 3:10 p.m. with the CDM and the administrator while performing a walk-through of the kitchen areas revealed: *The CDM stated she had only been at the facility for seven months and had no time to train dietary staff. *The administrator had been unaware dietary staff had not been trained as defined by policy and regulation upon being hired and yearly thereafter. *He was unaware the untrained dietary aides had been cooking breakfast in the East and Warren dining rooms.</p> <p>Review of the provider's inservices performed in the last year revealed: *Two had been completed prior to the survey. One was held in January 2015 on "Changes" and one was held in March 2015 on "Voicing Grievances."</p> <p>Review of the provider's March 2005 Competency Evaluation Standard Operating Procedure revealed: *The purpose was to ensure quality standards were maintained through competency evaluations</p>	S 287	<p>A thorough kitchen cleaning was completed on July 8, 2015 by the CDM and staff. InTek Cleaning and Restoration will professionally clean the floors, walls, corners and equipment on July 13, 14, and 15 2015.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on cleaning schedules, importance of cleaning and sanitation, safe food temperatures and the food danger zone range. The CDM or designee will randomly monitor four dietary staff weekly x 12 weeks for compliance.</p> <p>The Certified Dietary Manager (CDM) or designee will complete directed kitchen audits daily x 12 weeks and weekly thereafter for one year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.</p>	7/10/15

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S 287	<p>Continued From page 54</p> <p>yearly.</p> <p>**Employees would be evaluated on their competency...</p> <p>*Skills could be identified through a needs assessment, the provider's plan of correction, or at the discretion of the director.</p> <p>Review of the provider's 2/1/03 Nutrition Consulting Services Agreement contract revealed the duties of the RD included providing nutritional education to staff.</p> <p>Review of the provider's undated CDM job description revealed she:</p> <p>**Monitors staff performance daily."</p> <p>**Trains new staff and assures they are being oriented well."</p> <p>Review of the provider's 4/30/15 Evaluating Food Service and Clinical Nutrition Personnel policy revealed:</p> <p>*Food service personnel should have had their first evaluation at the end of their probationary period of ninety days.</p> <p>*Periodic written evaluations for food service staff were to have been completed by the food service manager.</p> <p>*The RD should have evaluated the nutrition support staff.</p> <p>Review of the provider's undated Dietary Aide Job Description revealed they were to:</p> <p>*Provide assistance to the cook in preparation and service of the meals.</p> <p>*Follow cleaning schedules and perform cleaning duties as scheduled.</p> <p>*Follow defined infection control procedures.</p> <p>Review of the provider's undated Dietary Cook Job Description revealed they were to:</p>	S 287		7/14/15

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S 287	Continued From page 55  *Prepare, season, and cook the assigned meal. *Monitor temperature of foods through preparation and service.  Review of the provider's 4/30/15 Food Safety-Food Service Manager's Responsibility policy revealed the food service manager ensures: *Good sanitary food handling practices. *Sanitary conditions were maintained. *All personnel were to have followed proper cleaning and sanitizing. *Regular inspections were to have been made by the food service manager or designee to assure food safety.	S 287		
S 289	44:04:07:02.03 FOOD SUBSTITUTIONS  Reasonable substitutions of equal nutritional value shall be offered to...residents who refuse or are unable to eat the food served.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265  Surveyor: 32335  Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure all residents on oral diets were given the opportunity to receive menu substitutions. Findings include:  1. Observation and interview on 6/10/15 at 1:05 p.m. with cook J and the certified dietary manager (CDM) revealed: *The provider's Spring/Summer 2015 menu	S 289	After a review of the facility's process of Open Dining, the management team determined that the best use of facility resources to serve the residents in the best way possible was to offer them a choice of one hot meal and a set list of alternates from which to choose. This change is effective 7/13/15.  A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.  A Kitchen Chatter meeting with residents was completed by the CDM and RD on 7/8/15. The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting with the residents once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM and/or designee for a period of one year at the QAPI Meeting and as deemed necessary by the QAPI committee.	7/16/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</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 289	<p>Continued From page 56</p> <p>consisted of breakfast, lunch, and dinner (evening) meals.</p> <p>*The above menu listed alternates at the lunch and evening meals.</p> <p>-That menu had meals listed as a #1 (one) or #2 (two) choice on the menu at lunch and evening meals.</p> <p>*They stated the residents were given a choice of which menu they preferred at the lunch and evening meals.</p> <p>*They stated the residents could choose items from either menu.</p> <p>*The CDM stated the residents in the memory care unit were given a "fifty/fifty choice" in the menu items.</p> <p>-Half of the #1 menu items and half of the #2 menu items were sent to that resident area for lunch and the evening meals.</p> <p>-She did not have a dislike file of resident food preferences.</p> <p>-Resident food preferences were obtained from the resident, family, or from the staff working in that area.</p> <p>-Staff were to have called the cook in the kitchen for any changes to each resident's meal.</p> <p>-Those above changes would have been prepared and distributed for that meal after the cook had been called.</p> <p>Surveyor: 33265 2. Interview on 6/11/15 at 9:00 a.m. with resident 29 revealed:</p> <p>*There were only two choices for any meal and you could not ask for any substitutions or changes in those two options.</p> <p>**"We cannot request anything outside of the two choices. No requests."</p> <p>**"If you did not like either option you were just out of luck."</p> <p>*The menu "Had down we were having sweet and</p>	S 289	<p>Reference above meal plan changes. There has been an egg shortage due to the Avian Bird Flu outbreak. Per the Federal Food Code, we are not allowed to purchase unpasteurized eggs, thus residents have not been getting eggs as often as they would prefer.</p> <p>Our snacks range from 0 to 18 grams of carbohydrate each, thus appropriate for residents with diabetes. Snacks include 4 fl oz servings of 100% fruit juice, Crystal Lite, regular and sugar free soda (6 oz cans), ½ cup servings of applesauce, yogurt, ice cream, pudding, Jell-O, diced canned fruit, seasonal fresh fruit (as available), snack crackers, individual bags of chips, small cookies or other baked goods.</p> <p>Residents with diabetes who have a physician order for a night-time snack will have a planned snack of preference with their name and date on a sticker on their specific snack on the snack cart for their wing.</p> <p>Nursing staff documents snack acceptance in Care Tracker.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.</p> <p>The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed necessary by the QAPI committee.</p>	7/16/15

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>
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S 289	<p>Continued From page 57</p> <p>sour chicken. What we got was plain chicken on plain noodles."                      "They run out of stuff all the time and then you have no choice."                      *Lemon-lime parfait bars they were suppose to have changed into plain applesauce.                      "Today I wanted two eggs over easy. My only choice was scrambled eggs."                      "I am a diabetic. Everybody gets the same three choices for a bedtime snack: small can of diet pop, animal crackers, or chips."                      "The dietary manager has meetings called 'Kitchen Chatter.' We were suppose to tell her our likes and dislikes. Has not made any difference. Lots of talk that never happens."                      "Can't understand all the dietary aides. Not sure what language they are speaking sometimes. You can ask and ask for things, like coffee, and they just don't seem to understand."</p> <p>Surveyor: 32335                      3. During two observed meal services throughout the survey revealed residents were not being offered entree (main part of the meal) choices or alternative choices.</p> <p>4. Review of the provider's undated Open Style Dining policy revealed dietary staff were to have offered food and beverage choices to the individual at the point of service.</p>	S 289		7/16/15
S 291	<p>44:04:07:02:05 Therapeutic diets</p> <p>In licensed facilities the dietetic service must provide for the needs of those...residents requiring therapeutic diets.</p>	S 291		

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S 291	<p>Continued From page 58</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33488</p> <p>Based on observation, interview, record review, contract review, job description review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> <li>*Ensure liquids were thickened appropriately for 1 of 1 resident (10) in the East dining hall.</li> <li>*Ensure 11 of 11 currently employed dietary aides were trained appropriately in providing assistance to residents with therapeutic (medically prescribed) diets.</li> </ul> <p>Findings include:</p> <p>1. Interview on 6/9/15 at 7:52 a.m. with dietary aide F revealed she:</p> <ul style="list-style-type: none"> <li>*Had been employed five months.</li> <li>*Had started working on the serving line "since day one."</li> <li>*Had "little training."</li> </ul> <p>Interview on 6/9/15 at 8:30 a.m. with the dietary manager (DM) regarding the competencies of the dietary staff revealed:</p> <ul style="list-style-type: none"> <li>*She does not perform competencies</li> <li>*Staff were competent to perform their duties</li> <li>"Because they have been trained."</li> </ul> <p>Observation and interview on 6/9/15 at 12:25 p.m. of dietary aide F in the east dining room using powdered thickener for resident 10's soup revealed she:</p> <ul style="list-style-type: none"> <li>*Poured the soup into a bowl.</li> <li>*Proceeded to add the powdered thickener by shaking the thickener contents from the open can into the soup.</li> <li>*Had not measured the amount of powdered thickener according to the resident's current thickening requirements on the dietary card or the manufacturer's instructions for use.</li> </ul>	S 291	<p>Dietary Aide F was educated by the CDM on 6/9/15 on facility policy thickening liquids. The CDM or designee will randomly monitor Dietary Staff F weekly x 4 weeks for compliance.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on thickening liquids. The CDM or designee will randomly monitor dietary staff weekly x 12 weeks for compliance.</p> <p>A directed in-service was completed by the RD on 6/16/15 for all dietary staff covering the annual food service, nutrition, and hydration requirements set forth in SD Codified Law 44:04:07:16.</p> <p>A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.</p> <p>The Certified Dietary Manager (CDM) or designee will complete random audits will be completed weekly x 12 weeks and monthly thereafter for one year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.</p>	7/10/15

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S 291	<p>Continued From page 59</p> <p>*Was unsure how much of the powdered thickener would be needed. *Stated he "Just needs it in the liquids." *Had never been trained how to mix the powdered thickener appropriately for any residents requiring thickened liquids.</p> <p>Interview and record review on 6/10/15 at 10:00 a.m. with the DM upon receipt of the provider's undated Dietary Initial Training Policy and required in-services revealed: *Only two inservices had been provided to all dietary staff within one year prior to the survey. Topics included were voicing grievances and changes. *The above policy revealed training was to have been provided to dietary staff within two weeks of being hired and ongoing that included: -Resident's rights. -Overview of food service. -Introduction to food service. -Sanitation. -Safety. -Food preparation. -Standard measurements. -Nutrition. -Therapeutic diets. -Review of policies and procedures. *The CDM "had been employed for seven months" and "had not had time to train" the dietary staff. *She could provide no further dietary training for any dietary aides except the two above dietary in-services. *She agreed the required mandated training regarding food service had not been provided to dietary personnel.</p> <p>Review of the provider's undated Thickened Liquids policy signed by the registered dietician</p>	S 291		7/16/15	

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S 291	<p>Continued From page 60</p> <p>(RD) on 4/30/15 revealed:                      *"The facility will determine whether nursing or food service will thicken liquids..."                      *"Manufacturer's instructions will be followed..."                      *"The RD and/or nursing supervisor will monitor staff competency for compliance as part of quality assurance."</p> <p>Review of the provider's March 2005 Competency Evaluation Standard Operating Procedure revealed:                      *The purpose was to ensure quality standards were maintained through competency evaluations yearly.                      *"Employees would be evaluated on their competency."                      *Skills could be identified through a needs assessment, the provider's plan of correction, or at the discretion of the director.</p> <p>Review of the provider's 2/1/03 Nutrition Consulting Services Agreement contract revealed the duties of the RD included providing nutritional education to staff.</p> <p>Review of the provider's undated DM job description revealed she:                      *"Monitors staff performance daily."                      *"Trains new staff and assures they are being oriented well."</p> <p>Review of the provider's 4/30/15 Evaluating Food Service and Clinical Nutrition Personnel policy revealed:                      *Food service personnel should have had their first evaluation at the end of their probationary period of ninety days.                      *Periodic written evaluations for food service staff were completed by the food service manager.                      *The RD should have evaluated nutrition support</p>	S 291		7/16/15

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S 291	Continued From page 61 staff.	S 291		
S 294	<p>44:04:07:04 Written Menus</p> <p>Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure the menu changes for all residents on oral diets were reviewed and approved from month-to-month by the registered dietitian (RD). Findings include:</p> <p>1. Interview on 6/10/15 at 1:40 p.m. with the certified dietary manager (CDM) revealed the following statements: *There had been changes on the menu for the</p>	S 294	<p>A Food Substitution Log was initiated on 6/6/15. All cooks were trained by the CDM on 6/6/15 on how to use the log.</p> <p>All dietary staff were trained by the RD on 7/10/15 on the log, it's location, and appropriate food substitutions.</p> <p>After a review of the facility's process of Open Dining, the management team determined that the best use of facility resources to serve the residents in the best way possible was to offer them a choice of one hot meal and a set list of alternates from which to choose. This change is effective 7/13/15.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.</p> <p>A Kitchen Chatter meeting with residents was completed by the CDM and RD on 7/8/15. The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting with the residents once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM and/or designee for a period of one year at the QAPI Meeting and as deemed necessary by the QAPI committee. Reference above meal plan changes. There has been an egg shortage due to the Avian Bird Flu outbreak. Per the Federal Food Code, we are not allowed to purchase unpasteurized eggs, thus residents have not been getting eggs as</p>	7/16/15

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S 294	<p>Continued From page 62</p> <p>residents.</p> <p>*It was not uncommon to have one change each week on that menu.</p> <p>*She had no documentation of those changes for the RD to review and to approve on the menu.</p> <p>*Menu changes were to have been documented, reviewed, and approved by the RD.</p> <p>*She had no process in place to document menu substitutions.</p> <p>*The provider was not following their policy for menu substitutions.</p> <p>Interview on 6/10/15 at 4:30 p.m. with the RD revealed:</p> <p>*The provider was not documenting changes to the menu for her to review and approve changes to the menu.</p> <p>*She agreed there needed to have been a process in place to document menu substitutions for her review.</p> <p>Review of the provider's 2013 Menu Substitutions policy revealed:</p> <p>*All changes to the menu would have been recorded on the Menu Extension Sheets and the Menu Substitution sheet.</p> <p>*Those changes would have included the date, menu items, substitution, and reason for the substitution recorded on the Menu Substitution Sheet.</p> <p>*Menu changes were to have been evaluated periodically by the RD or designee.</p> <p>*Records of menu substitutions were to have been retained (kept) for twelve months.</p> <p>-Those above records would have been reviewed periodically by the CDM and/or RD or designee to assess for any concerns that might have needed to have been addressed.</p> <p>Surveyor: 33488</p>	<p>S 294</p> <p><i>When pasteurized eggs become more readily available, they will be made available on the menu.</i></p> <p><i>sc 150004/BJ</i></p>	<p>often as they would prefer. Our snacks range from 0 to 18 grams of carbohydrate each, thus appropriate for residents with diabetes. Snacks include 4 fl oz servings of 100% fruit juice, Crystal Lite, regular and sugar free soda (6 oz cans), ½ cup servings of applesauce, yogurt, ice cream, pudding, Jell-O, diced canned fruit, seasonal fresh fruit (as available), snack crackers, individual bags of chips, small cookies or other baked goods.</p> <p>Residents with diabetes who have a physician order for a night-time snack will have a planned snack of preference with their name and date on a sticker on their specific snack on the snack cart for their wing.</p> <p>Nursing staff documents snack acceptance in Care Tracker.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.</p> <p>The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed necessary by the QAPI committee.</p>	<p><i>7/16/15</i></p>

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S 294	Continued From page 63  Review of the provider's 2/1/03 Nutrition Consulting Services Agreement contract revealed the duties of the RD included: *Monitoring the accuracy of menu substitutions. *Reviewing menus for compliance with regulations.	S 294		
S 301	44:04:07:16 Required dietary in-service training  The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Dietary aides and cooks were appropriately trained. *The dietary staff, the dietary manager (DM) and the registered dietitian (RD) appropriately performed their job duties as defined within their job descriptions. Findings include:  1. Observation and interview on 6/9/15 at 7:35 a.m. with dietary aide F in the East dining room revealed she:	S 301	After a review of the facility's process of Open Dining, the management team determined that the best use of facility resources to serve the residents in the best way possible was to offer them a choice of one hot meal and a set list of alternates from which to choose. This change is effective 7/13/15.  A directed in-service was completed by the RD on 6/16/15 for all dietary staff covering the annual food service, nutrition, and hydration requirements set forth in SD Codified Law 44:04:07:16.  A competency checklist has been completed by the CDM or designee between 7/7/15 and 7/10/15 for each dietary staff, and will be completed by the CDM annually for all dietary staff. Records to be kept in the CDM office.  A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.  A Kitchen Chatter meeting with residents was completed by the CDM and RD on 7/8/15. The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting with the residents once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction.	7/16/15

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S 301	<p>Continued From page 64</p> <p>*Cracked unpasteurized eggs, mixed them with milk, and cooked scrambled eggs on a griddle to serve to the residents. *Fried pancakes from batter made with unpasteurized eggs on the griddle. *Had been cooking and serving food to the residents since her first day on the job. *Had been employed for five months.</p> <p>Interview and record review on 6/10/15 at 10:00 a.m. with the CDM upon receipt of the provider's undated Dietary Initial Training policy and required disservice revealed: *Only two in-services had been provided to all dietary staff within one year prior to the survey. Topics included were "Voicing Grievances" and "Changes." *The Dietary Initial Training policy revealed training that was to have been provided to dietary staff within two weeks of being hired and ongoing included: -Resident's rights. -Overview of food service. -Introduction to food service. -Sanitation. -Safety. -Food preparation. -Standard measurements. -Nutrition. -Therapeutic diets. -Review of policies and procedures. *The CDM "had been employed for seven months" at the facility and "had not had time to train" the dietary staff. *She could provide no further dietary training for any dietary aides except the two above dietary in-services. *She agreed the required mandated training regarding food service had not been provided to dietary personnel.</p>	S 301	<p>Results to be reported by the CDM and/or designee for a period of one year at the QAPI Meeting and as deemed necessary by the QAPI committee.</p> <p>Reference above meal plan changes. There has been an egg shortage due to the Avian Bird Flu outbreak. Per the Federal Food Code, we are not allowed to purchase unpasteurized eggs, thus residents have not been getting eggs as often as they would prefer.</p> <p>Our snacks range from 0 to 18 grams of carbohydrate each, thus appropriate for residents with diabetes. Snacks include 4 fl oz servings of 100% fruit juice, Crystal Lite, regular and sugar free soda (6 oz cans), ½ cup servings of applesauce, yogurt, ice cream, pudding, Jell-O, diced canned fruit, seasonal fresh fruit (as available), snack crackers, individual bags of chips, small cookies or other baked goods.</p> <p>Residents with diabetes who have a physician order for a night-time snack will have a planned snack of preference with their name and date on a sticker on their specific snack on the snack cart for their wing.</p> <p>Nursing staff documents snack acceptance in Care Tracker.</p> <p>A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and the new procedure.</p>	7/10/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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S 301	Continued From page 65  Observation and interview on 6/10/15 at 3:10 p.m. with the CDM and the administrator while performing a walk-through of the kitchen areas revealed: *The CDM stated she had only been at the facility for seven months and had no time to train dietary staff. *The administrator had been unaware dietary staff had not been trained as defined by policy and regulation upon being hired and yearly thereafter. *He was unaware the untrained dietary aides had been cooking breakfast in the East and Warren dining rooms.  Review of the provider's in-services performed in the last year revealed: *Two had been completed prior to the survey. -One was held in January 2015 on Changes. -One was held in March 2015 on Voicing grievances.  Review of the provider's March 2005 Competency Evaluation Standard Operating Procedure revealed: *The purpose was to assure quality standards were maintained through competency evaluations yearly. *"Employees would be evaluated on their competency..." *Skills could be identified through a needs assessment, the provider's plan of correction, or at the discretion of the director.  Review of the provider's 2/1/03 Nutrition Consulting Services Agreement contract revealed the duties of the RD included providing nutritional education to staff.	S 301	The Certified Dietary Manager (CDM) or designee will complete a Kitchen Chatter meeting once a week for four weeks and then monthly thereafter for one year for continued resident satisfaction. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed necessary by the QAPI committee. A thorough kitchen cleaning was completed on July 8, 2015 by the CDM and staff. InTek Cleaning and Restoration will professionally clean the floors, walls, corners and equipment on July 13, 14, and 15 2015. A directed in-service was completed by the Registered Dietitian (RD) on 7/10/15 for all dietary staff with review of example and current facility policy and procedure on cleaning schedules, importance of cleaning and sanitation, safe food temperatures and the food danger zone range. The CDM or designee will randomly monitor four dietary staff weekly x 12 weeks for compliance. The Certified Dietary Manager (CDM) or designee will complete directed kitchen audits daily x 12 weeks and weekly thereafter for one year for continued compliance. Results to be reported by the CDM or designee monthly at the QAPI Meeting for 1 year and then until deemed by the QAPI committee.	7/16/15

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S 301	<p>Continued From page 66</p> <p>Review of the provider's undated CDM job description revealed she: *"Monitors staff performance daily." *"Trains new staff and assures they are being oriented well."</p> <p>Review of the provider's 4/30/15 Evaluating Food Service and Clinical Nutrition Personnel policy revealed: *Food service personnel should have had their first evaluation at the end of their probationary period of ninety days. *Periodic written evaluations for food service staff were to have been completed by the food service manager. *The RD should have evaluated the nutrition support staff.</p> <p>Review of the provider's undated Dietary Aide Job Description revealed they were to: *Provide assistance to the cook in preparation and service of the meals. *Follow cleaning schedules and perform cleaning duties as scheduled. *Follow defined infection control procedures.</p> <p>Review of the provider's undated Dietary Cook Job Description revealed they were to: *Prepare, season and cook the assigned meal. *Monitor temperature of foods through preparation and service.</p> <p>Review of the provider's 4/30/15 Food Safety-Food Service Manager's Responsibility policy revealed the food service manager ensures: *Good sanitary food handling practices. *Sanitary conditions were maintained. *All personnel were to have followed proper cleaning and sanitizing. *Regular inspections were to have been made by</p>	S 301		7/16/15

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S 301	Continued From page 67  the food service manager or designee to assure food safety.	S 301		
S 445	44:04:17:09 Quality of Life  A facility must provide care and an environment that contributes to the resident's quality of life, including: (1) A safe, clean, comfortable, and homelike environment; (2) Maintenance or enhancement of the resident's ability to preserve individuality, exercise self-determination, and control everyday physical needs; (3) Freedom from physical or chemical restraints imposed for purposes of discipline or convenience; (4) Freedom from verbal, sexual, physical, and mental abuse and from involuntary seclusion, neglect, or exploitation imposed by anyone, and theft of personal property; and (5) Retention and use of personal possessions, including furnishings and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents; and (6) Support and coordination to assure pain is recognized and addressed appropriately.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 A. Based on observation, record review, interview, and policy review, the provider failed to perform a task of daily living (toileting) and implement individualized interventions for three of three sampled cognitively (memory, thinking, reasoning) impaired residents (10, 18, and 25)	S 445	The facility Pressure Ulcer/Skin Breakdown protocol was revised on 7-06-15. The new protocol will be implemented on residents #10 and #25 on 7-13-15. All other residents in the facility were assessed on 7-06-15 to ensure skin was intact and to begin the revised protocol on 7-13-15. All nursing staff will be inserviced on the revised Pressure Ulcer/Skin Breakdown protocol on July 14-15, 2015. The facility is actively setting up an outside wound care specialist to in-service the nursing staff regarding pressure ulcer/skin breakdown prevention within the next 30 days. Audits will be conducted weekly for 1 month and then monthly for 3 months on residents #10 and #25 and on all residents found to have skin issues on the facility wide assessment process to ensure skin protocol is being followed appropriately. A new skin integrity team has been created and meet weekly to assess, monitor and document all pressure related skin concerns. The DON and/or designee will be responsible for ensuring compliance and audit findings will be reported by the DON at the monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.	7/16/15

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S 445	<p>Continued From page 68</p> <p>resulting in skin breakdown. Findings include:</p> <p>1. Interview on 6/10/15 between the timeframe of 2:30 p.m. and 3:30 p.m. with resident 25's daughter revealed she: *Visited almost everyday. *Felt her mother was taken to the bathroom too late sometimes. *Purposely did her mother's laundry to see how wet her clothes were from being incontinent (loss of bladder or bowel control). *Had a system where staff were to put wet clothes into one laundry bag and dry clothes into the other, but staff had not followed it. *Stated the clothes were consistently very wet. *Stated her mother had skin breakdown on her bottom that had healed about one month ago.</p> <p>Review of resident 25's skin assessment report revealed on 2/18/15 she had developed a superficial abrasion (loss of top surface of skin) to her bottom. The contributing factor was incontinence.</p> <p>Review of resident 25's 4/30/15 Minimum Data Set (MDS) assessment revealed she was frequently incontinent of bladder (urine). She needed extensive assistance of two plus staff members for toileting. Her mental status score (thinking ability) was zero meaning her thinking was severely impaired.</p> <p>Review of resident 25's 2/11/15 care plan revealed: *Urinary incontinence had been identified as a focus area on 8/26/14. *Interventions included: -"Assist me to the toilet before and after meals, at bedtime, and every couple of hours at night." -"If I am anxious, ask me if I need to use the</p>	S 445	<p>The facility bathing policy and procedure was reviewed on 7-06-15. All nursing staff will be educated by the DON on the new bathing policy and procedure on July 14-15, 2015. Residents #3,29,36,38,53,54,55,56,57 and 58 records and all other residents in the facility were reviewed on July 9, 2015 to ensure that they had received a bath during the week. A daily bathing record was implemented to assist the assigned bath aide with documenting baths or showers appropriately. Caretracker charting has been modified to include scheduled baths given, as well as not given and the reason for the missed bath. The Unit Coordinators and/or designee will be responsible for ensuring the bath aides get their daily baths completed and documented. Weekly audits will be conducted by the Unit Coordinators and/or designee weekly for one month and then monthly for 3 months on the residents listed above as being deficient during the survey and on 10 random residents in the facility to ensure compliance. The DON and/or designee will be responsible for overall compliance and will present audit findings at the monthly QAPI meeting for 1 year.</p> <p>The facility hospice policy and procedure was revised on 7-06-15 to include how to incorporate the hospice agency care plans into the facility's care plans. All facility nursing and social service staff will be educated on this new policy and procedures on July 14-15, 2015 by the DON. Resident # 14 and 15 care plans have been updated to ensure they have been updated per the new facility policy. Care plans for all other residents in the facility on hospice have been updated to ensure they are in compliance with</p>	7/16/15

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S 445	<p>Continued From page 69</p> <p>toilet." -On 11/16/14 toilet every two hours while awake; at 12:01 a.m. and between 5:00 a.m. and 6:00 a.m. had been added. -On 11/19/14 "I want to be kept clean and dry throughout our next meeting" had been added. *There were no other interventions added for urinary incontinence after 11/19/14. *There had been no documentation on the care plan regarding the documented 2/18/15 skin abrasion.</p> <p>Interview on 6/10/15 between the timeframe of 2:30 p.m. and 3:30 p.m. with certified nursing assistant (CNA) II revealed some residents who needed assistance with toileting were "soaked" in the morning when she got to work. She defined "soaked" as meaning the bed and their clothes had been wet. She stated the overnight staff did not always toilet residents, especially those that might have behaviors or were more difficult.</p> <p>Interview on 6/16/15 at 2:30 p.m. with CNA NN regarding resident 25 revealed: *The resident was dependent on staff for most of her care. *She was to have assistance from one staff person for toileting. *Sometimes when she arrived at work in the morning the resident was "really wet." -When asked to explain what really wet meant she replied, "The bed, her clothes, and everything." *She did not think the overnight staff always toileted her. *She felt they did not change her, because they were short staffed or because sometimes the resident would fight with staff.</p> <p>Interview on 6/16/15 at 2:15 p.m. with the director</p>	S 445	<p>the new policy as well. Audits will be conducted weekly for 1 month and then monthly for 3 months on the hospice care plans for residents #14 and 15 and on five random hospice residents. These audits will be conducted by the DON and /or designee who will also be responsible for overall compliance. Audit findings will be reported at the monthly QAPI meetings by the DON and/or designee for 1 year.</p> <p>The facility pressure ulcer/skin breakdown policy and procedure was revised on 7-02-15. New skin protocol was implemented for resident #2 on 6/10/15. The resident received an overall skin assessment by unit nurse and Clinical Coordinator and was appropriately documented. Orders were obtained from the physician and a new treatment initiated on that day. All other residents in the facility were assessed on 7/6/15. To ensure skin is intact, new skin protocol was implemented on every resident that had skin issues. All CNAs/Medication Aides and nurses will be educated by the DON on the new skin policy on July 14-15, 2015. The facility toileting and repositioning policies were revised on 7/6/15. All nursing staff will be educated on the new toileting and repositioning policy by the DON on July 14-15, 2015. Resident #2 was placed on the facility toileting/repositioning program on 6/10/2015. All other residents in the facility will be assessed to determine if they need to be placed on the facility toileting and repositioning program if deemed necessary. Weekly audits will be conducted on resident #2's toileting and repositioning program along with 10 other residents on the toileting and repositioning</p>	7/16/15

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S 445	<p>Continued From page 70</p> <p>of nursing revealed: *CNAs did not document every time they assisted the resident with toileting. They would document one time during their shift. *There was no documentation to verify staff had been toileting her "before and after meals, at bedtime, every couple of hours at night" or "every two hours while awake, at 12:01 a.m., and between 5:00 a.m. and 6:00 a.m." *There had been no updated interventions on the care plan.</p> <p>A toileting policy had been requested on 6/11/15 but had not been received by the time the survey team had exited on 6/17/15.</p> <p>Review of the provider's 11/13/14 Bowel and Bladder Assessment policy revealed: *Residents would achieve their highest possible level of bowel and bladder function. *Each resident would be assessed for bowel and bladder incontinence upon admission, re-admission, annual review, and with significant changes. *The bladder screening sheet should have been completed by staff for three days to provide information on potential patterns of incontinence. *The nurse was to implement an individualized toileting plan based on the information obtained. *The care plan should have included goals and interventions.</p> <p>Surveyor: 33265 2. Observation and interview on 6/10/15 at 1:00 p.m. with CNA II during resident 10's care after toileting with assistance from CNAs II and JJ revealed: *Both sides of his buttocks were bright pink and dry with cracks in the skin at the outer edges of the bright pink area.</p>	S 445	<p>programs for one month and then monthly for 3 months. The assessments and audits will be conducted by the DON and/or designee. The DON and/or designee will report the audits to the monthly QAPI meetings for 1 year and then as deemed necessary by the QAPI committee.</p> <p>All nursing staff will be educated by an outside wound care specialist on the skin policy on July 14-15, 2015.</p> <p>The facility fall policy and protocol was revised on 7/6/15. All CNAs/Medication Aides and nurses will be educated by the DON and/or designee on the new fall policy and protocol on July 14-15, 2015. Residents #17 and #19 have expired. Resident #18 was transferred to another facility. Residents #25 and #27 were assessed by the Fall Risk Team (cross section of various departments) on 7/9/15. Interventions were implemented for each of them during that meeting and updated to their care plan. The Fall Committee will meet weekly for one month, then monthly for three months to assess need for fall interventions on all residents in facility with identified fall risks from admission, quarterly, and annually. Interventions will be implemented and individualized if necessary for those residents as well. Audits will be conducted weekly for 1 month and then monthly for 3 months on residents #25 and #27 along with 10 random audits to monitor for fall intervention compliance. The DON and/or designee will be responsible for conducting assessment audits and for overall compliance. Audit findings will be reported by the DON and/or designee at the monthly QAPI meeting for 1 year as deemed necessary by the QAPI committee.</p>	7/16/15

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S 445	Continued From page 71  *There was a small open area (top layer of skin was gone) on the upper right buttock. *There was an area the size of a quarter on the back side of the upper left thigh with small dark brown scabbed areas throughout. -CNA II stated she had not known of the scabbed area on the upper left thigh. *There were several small open areas on the back side of the scrotum. Those areas were open, red inside, and about half the size of a pencil eraser. -CNA II stated those were from his constant dribbling of urine. -He had dribbling of urine during the time of the assessment. *When asked how those areas were being cared for CNA II replied they were to use a cream on the scrotum and buttocks. -The Calmoseptine cream (a moisture barrier) that had been in the resident's room was applied in a thick layer over both sides of the buttocks, the back side of the upper left thigh, and the back side of the scrotum.  Review of resident 10's complete medical record revealed: *From 2/28/15 to 4/11/15 the skin was documented as intact (no open areas) with no areas of concern. *On 4/13/15 the groin area was pink. *On 4/14/15 there was an open area on the right upper buttocks and the family and the physician were notified. -"Moisture cream applied to area." -No time was documented. *On 4/14/15 the Skin Assessment Report had documented an open area on the upper right buttocks with "sitting in urine" listed as a causal or contributing factor. -The diagram to identify the location of the skin	S 445	All facility bath chairs were assessed on July 7, 2015 by the maintenance department to ensure they are in good repair and that they all have seat belts that are in good working order and are manufacturer recommended. DON and/or designee provided training to CNA's OO and GG on 6-12-15 during the survey. All nursing care staff will be educated regarding the required use of seat belts for bath chairs between July 14-15, 2015.  Each whirlpool tub chair will be included on the Monthly Preventative Maintenance Log to ensure the chairs have proper seat belts and are in operational condition. Five random audits will be conducted by the Clinical coordinators weekly for 1 month and monthly for 1 year for CNA's performing baths using the whirlpool tub chairs with proper usage of seat belts.  The DON and/or designee will bring the audits on a monthly basis to the QAPI committee meeting for a period of 1 year and then as deemed necessary by the QAPI committee.	7/16/15

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S 445	<p>Continued From page 72</p> <p>concern had an "X" over the left groin. *On multiple dates the wound was tracked on a Non-Pressure Skin Condition Report form and was identified as a "skin tear." -The intervention started was listed as a "moisture barrier." *On 4/27/15 the left ischial crease (skin fold at bottom of buttocks and top part of thigh) was documented as a new area of concern. *On 4/27/15 the Skin Assessment Report identified friction from briefs as a causal or contributing factor. -Skin was described as sheared (rubbed off). *On 5/4/15 there were no new areas of concern noted; wounds to buttocks "not improving much." *No physician's order or nursing order for the use of the Calmoseptine cream was found. *Calmoseptine cream was not documented on the treatment administration record.</p> <p>Review of the undated manufacturer's instructions stated to apply Calmoseptine in a thin layer.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and administrator revealed the DON: *Had not seen resident 10's open skin area. *Was not aware a barrier cream was being used on resident 10's open skin areas.</p> <p>Surveyor: 14477 3. Review of resident 18's closed medical record revealed an admission skin assessment had been completed on 7/3/14 with no skin concerns noted on buttocks, coccyx (tailbone area), or heels. Review of his 7/4/14 nursing note revealed he had been a total staff assistance for all activities of daily living (ADL), was incontinent of</p>	S 445	<p>The door of resident #10 was adjusted and operates properly. Maintenance audited all doors of the facility on July 10, 2015 to ensure proper operation and ensure that the door doesn't stick to the frame. All doors are now open and close properly.</p> <p>Involuntary seclusion could affect all residents: All staff will be educated on the facility's abuse and neglect policy including the different types of abuse including involuntary seclusion between July 14-15, 2015.</p> <p>The Social Services department will ask every resident or resident representative by July 13, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident has ever experienced involuntary seclusion. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria are met. The social services department will audit 10 random residents per month and ask if a staff member has involuntarily secluded them. Audit findings will be reported to the monthly QAPI meeting for 1 year by the Social Work Department and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7/16/15

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S 445	<p>Continued From page 73</p> <p>both bladder and bowel, and wore incontinent products. Further review of the Interdisciplinary Progress Notes revealed on: *7/11/14 - Admission Minimum Data Set (MDS) assessment revealed a: -Braden (a skin assessment tool) score of 13 (at risk for skin breakdown). -Pressure reducing mattress was to have been on his bed at all times. -Pressure reducing cushion was to have been in the wheelchair when he was in it. *9/9/14- At 11:15 a.m. the nutrition documentation revealed "a Braden score of 13 and coccyx may be red." A nursing note on that same day at 5:16 p.m. stated a half-dollar size red area was noted on the lower coccyx but was not open. *9/24/14 - A nutrition note indicated his skin did not have a pressure ulcer per the nurse, and the skin team notes had been reviewed. *10/7/14 - The care plan conference record revealed the family was concerned the resident was not getting a bath three times a week as expected. *11/6/14 - A new skin concern of an open area 1 centimeter (cm) x 1 cm on the inner aspect of the buttock (bottom) had been documented. The physician was notified, and an order received for Calmoseptine (moisture barrier ointment). The area was also documented on a non-pressure skin condition report and was noted as incontinence skin break down. *11/7/14 - On a weekly pressure ulcer record the coccyx was noted to have been a stage II ulcer (an open sore in the top layer of the skin) measuring 1.0 cm x (by) 1.0 cm. Risk factors/cause were noted to have been diabetes and incontinence. *11/14/14 - On the weekly pressure ulcer record the coccyx was noted to be a stage I (reddened area without being open) and was 0.5 cm x 0.5</p>	S 445	<p>The facility policy for weighing and measuring a resident was updated on July 8, 2015 to include communication of weight variances to the nurse, dietitian, physician and family to ensure proper follow-up and/or further evaluation. Education for all nursing staff regarding this new policy and procedure for weighing will be done by the DON and/or designee on July 14, 2015.</p> <p>Resident #1 has expired. Resident #10's treatment record has been updated to include the daily weight section to ensure the nurse verifies that #10's daily weight has been obtained and assessed by the nurse.</p> <p>All other residents in the facility on daily weights will have this category added to their treatment records by July 14, 2015.</p> <p>For residents on weekly weights, a new facility bathing/weight sheet has been created to ensure that the weekly weights are obtained, recorded, and compared to the previous weight. The weight is also documented in Caretracker.</p> <p>Audits will be conducted weekly x 1 month and then monthly x 3 months to ensure that resident #10 and #5 random residents on daily weighs have had their daily weights taken and documented. Audits will be conducted weekly x 1 month and then monthly x 3 months on 5 random residents on weekly weights to ensure</p>	7/16/15

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 445	<p>Continued From page 74</p> <p>cm.</p> <p>*11/21/14 - The weekly pressure ulcer record stated the coccyx area was healed, but a new area was observed. The non-pressure skin condition report stated the inner buttock cheek area was healed.</p> <p>*11/21/14 - The skin assessment revealed a new open area on the inner lower aspect of buttocks cheek measuring 2 cm x 2 cm. Incontinence had been listed as a causal or contributing factor.</p> <p>*11/29/14 - The nutrition notes indicated nursing assessments had documented an open area from incontinence; the nutrition team discussed it was a closed area; but a voice mail message left for dietary by nursing stated it was an open area. There was no change regarding extra protein until clarification of the skin condition had been received. The resident's family had been made aware of the open areas.</p> <p>*12/8/14 - Licensed Nurses Notes stated the DuoDerm (type of wound dressing) had been replaced on the coccyx, however there was no documentation of a start date for the DuoDerm.</p> <p>*12/21/14- Licensed Nurses Notes stated the DuoDerm dressing had been reapplied to the reddened coccyx.</p> <p>*12/23/14 - The nutrition notes indicated the pressure area was healed.</p> <p>*1/5/14 (should have been 2015) - Licensed Nurses Notes stated the coccyx area was pink and intact, and DuoDerm had been used for protection of fragile skin.</p> <p>Surveyor: 32333</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (3), one randomly interviewed resident (29), and eight randomly reviewed residents (36, 38, 53, 54, 55, 56, 57, and 58) who resided in Center hall had</p>	S 445	<p>that their weekly weights have been taken and documented appropriately.</p> <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit finding to QAPI meetings for one year and as deemed necessary by QAPI committee.</p> <p>The scratched flooring is estimated to be replaced around September 22, 2015 when the flooring arrives. The flooring has been ordered. The four doors (room 317, center tub room, center soiled utility room, and east shower room) were adjusted and operate correctly.</p> <p>The Memory Care tables have new tablecloths and napkins. All staff will be in-serviced on July 14-15, 2015 to make sure that all items are removed off the tray while serving the meal to the residents on all halls and no soft plastic cups are to be used during mealtime.</p> <p>The Director of Environmental Services tested all doors on July 10, 2015 to ensure proper operation. All doors now operate correctly. The Director of Environmental Services audited all common area flooring on July 10, 2015 and all common area flooring is now in compliance.</p> <p>The Homelike Environment policy and procedure was reviewed and updated on 7-07-15. All staff will be in serviced on the Homelike Environmental policy and procedure between July 14-15, 2015.</p> <p>Checking the flooring and proper door function has been added to the Monthly Preventative Maintenance checklist. A work order will be created for any issues. The Preventative Maintenance checklist will be given to the Administrator on a monthly basis.</p>	7/16/15
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S 445	<p>Continued From page 75</p> <p>received scheduled baths/showers and accurate documentation was maintained for when baths/showers had been given. Findings include:</p> <p>1. Review on 6/10/15 of resident 3's Bath Type Detail Report revealed she had not had a bath since 5/31/15.</p> <p>Review of resident 3's May 2015 care plan for activities of daily living function/incontinence revealed: *She was always incontinent of bowel and bladder. *She would like to be kept clean and dry.</p> <p>Interview on 6/10/15 at 9:45 a.m. with CNA OO who was also a full-time bath-aide revealed: *There were usually three CNAs including the bath-aide that worked on Center Hall. *She would get pulled from giving baths to help the other CNAs. *There were more than forty residents on Center hall. *Three CNAs were not enough for that many residents. *Sometimes there was only one CNA on night shift. *Baths did not get done everyday. *Some of yesterdays baths had not been done. *Last nights scheduled baths had not been done. *There were a lot of wet beds and urine soaked residents in the mornings.</p> <p>Interview on 6/9/15 at 11:40 a.m. with CNA EE revealed there were two to three CNAs during the day to approximately forty-seven residents. Sometimes baths did not get done, and they were moved to the next day. They usually had nine baths on Mondays and about twelve to thirteen on Wednesdays and Thursdays. Sometimes they</p>	S 445	<p>The Dietary Manager and/or designee will ensure that all dietary items are removed off the tray while serving the residents during mealtime on the Memory Care Community. The Dietary Manager and/or designee will randomly audit 3 times a week per month during mealtime to ensure all dietary items are removed off the tray while serving the residents during mealtime on the Memory Care Community.</p> <p>The Director of Environmental Services will audit 10 random rooms per month to ensure that the doors close properly and audit all resident common area locations for floor condition.</p> <p>The Director of Environmental Services will bring the door and floor audit to the Monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee.</p> <p>The Dietary Manager and/or designee will bring the results of the mealtime audits to the monthly QAPI meeting for 1 year and then as deemed necessary by the QAPI committee if no further patterns persist.</p>	7/16/15

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S 445	<p>Continued From page 76</p> <p>would have to change three to four urine soaked beds in the mornings when they got to work.</p> <p>Interview on 6/10/15 at 1:55 p.m. with CNA EE revealed the bath logs that were kept in the bath house were inaccurate. The bath log in the computer should have been more accurate. When a resident was given a bath even if it was after their scheduled bath day, they would still document that the bath was given on their scheduled day. Sometimes they would put the correct date of the bath behind the residents' names on the bath logs that were kept in the bath house. There was not consistent documentation.</p> <p>Review of the Center bathing log from 6/8/15 through 6/11/15 revealed:                      *On 6/9/15 resident 53 was scheduled for a bath.                      *Resident 53 was moved to the next day on 6/10/15.                      *On 6/9/15 resident 54 was scheduled for a bath.                      *There was no documentation for resident 54 on 6/9/15 they had received a bath.                      *On 6/10/15 resident 36 was moved to 6/11/15.</p> <p>Review of the Bath Type Detail Report from 6/8/15 through 6/11/15 for the residents below revealed the following documentation::                      *Resident 53:                      -On 6/9/15 at 10:16 a.m. she received a shower.                      -On 6/10/15 at 2:27 p.m. she received a whirlpool bath.                      *Resident 54:                      -On 6/10/15 at 8:27 a.m. she received a shower.                      -On 6/11/15 at 9:51 a.m. she received a whirlpool bath.                      -On 6/11/15 at 10:28 a.m. she received a shower.                      *Resident 55:                      -On 6/11/15 at 10:01 a.m. he received a shower.                      -On 6/11/15 at 11:18 a.m. he received a whirlpool</p>	S 445		7/16/15

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S 445	<p>Continued From page 77</p> <p>bath.</p> <p>*Resident 38: -On 6/8/15 at 5:49 a.m. he received a whirlpool bath.</p> <p>-On 6/8/15 at 6:50 a.m. he received a shower.</p> <p>*Resident 56: -On 6/9/15 at 10:10 a.m. he received a shower.</p> <p>-On 6/10/15 at 2:27 p.m. he received a whirlpool bath.</p> <p>*Resident 57: -On 6/11/15 she received a shower at 9:06 a.m. and 9:46 a.m.</p> <p>*Resident 58: -On 6/9/15 at 10:15 a.m. she received a shower.</p> <p>-On 6/10/15 at 2:27 p.m. she received a shower.</p> <p>Surveyor: 33265 Interview on 6/11/15 at 9:00 a.m. with resident 29 revealed "there was no time for my shower this morning. Maybe I will get it this afternoon. Otherwise I will have to wait until tomorrow. That happens all the time."</p> <p>Surveyor: 32333 Interview on 6/16/15 at 9:05 a.m. with CNA OO who was also a full-time bath aide revealed: *The bath detail reports were not accurate. *Instead of just the bath aide documenting that a resident would get a bath or shower all the CNAs would document it. *The charting would be inaccurate. *There was no way to know from their documentation if or when a resident received a shower or whirlpool bath. *There was just not enough staff to get all the care done.</p> <p>Interview on 6/16/15 at 2:25 p.m. with the director of nursing and administrator revealed: *They would have expected baths and showers to</p>	S 445		7/16/15

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S 445	<p>Continued From page 78</p> <p>have been completed the day they were scheduled. *They would have expected documentation to have been accurate and timely.</p> <p>Review of the revised October 2010 Shower/Tub policy/procedure revealed: *"The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the residents skin." *The following information should have been recorded on the residents activities of daily living and/or in the medical record: -The date and time the shower/tub bath was performed. -The name and title of the individual who assisted the resident with the shower/tub bath. -All assessment data obtained during the shower/tub bath. -How the resident tolerated the shower/tub bath. -If the resident refused the shower/tub bath, the reason why, and the intervention taken. -The signature and title of the person recording the data. -Notify the supervisor if the resident refused the shower/tub bath.</p> <p>Surveyor: 32333 C. Based on observation, interview, record review, and policy review, the provider failed to ensure interventions and safety measures were in place for: *Three of three sampled residents (17, 18, and 19) who had falls and had been discharged from the facility. *Two of eight sampled residents (25 and 27) who had falls. Findings include:  1. Review of resident 17's closed medical record</p>	S 445		7/16/15

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S 445	<p>Continued From page 79</p> <p>with a 12/21/14 post fall risk assessment that was to be completed immediately after a fall revealed:                      *She was in the bath chair in the bath house.                      *As the nurse entered the room the resident lifted the arm of the chair and slid out onto the floor.                      *She hit her head on the floor.                      *The environmental factors that contributed to the fall were it was wet, and there was no safety belt on the chair.                      *The resident's cognitive (mental) status was alert and confused.                      *No available safety belt on the bath chair.</p> <p>Review of resident 17's interdisciplinary progress notes revealed:                      *A nursing note on 12/21/14 at 11:00 a.m. noted the following:                      -The nurse was called into the bath house to do a skin assessment on the resident.                      -Upon entering the room the resident lifted the side arm on the bath chair and fell out onto the floor landing face first.                      -The resident was rolled to her back.                      -Small amount of blood noted on her nose.                      -Left eye was swollen and bruised.                      -Bruising noted to right hand.                      -No complaints of pain noted.                      -Two staff returned the resident to bed.                      *A post fall nursing note on 12/22/14 at 2:00 p.m. noted:                      -Vital signs (basic indicators of body function including blood pressure, heart rate and breathes per minute, and temperature) and neurological (neuro) (mental) assessments noted to be completed.                      -No change to left eye bruising, and no further injury noted.                      -Will continue to monitor for any changes in level of consciousness (LOC) (awareness) or any further injuries.</p>	S 445		7/16/15

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S 445	<p>Continued From page 80</p> <p>*A post fall nursing note on 12/22/14 at 9:00 p.m. noted: -Vital signs were taken and documented. -Left eye was bruised, but no other injuries noted. -Resident denied pain. -Would continue to monitor for any changes in LOC.</p> <p>*A post fall nursing note on 12/23/14 at 10:45 p.m. noted: -Continued to have bruising to left eye and right hand. -"PEARL [PERRLA (pupils equal, round, and reactive to light, accommodate)] neuro assessments WNL [within normal limits]." -Vital signs were taken and noted.</p> <p>*A nursing note on 12/24/14 at 9:46 a.m. noted: -The resident's lung sounds did not sound good. -A fax was sent to the physician to see what he would like them to do. -The resident was on 2 liters of oxygen, and a nebulizer treatment was completed with no change to lung sounds.</p> <p>*A nursing note on 12/24/14 at noon noted a fax received from the physician that it was okay to send the resident to the emergency room (ER).</p> <p>*A nursing note on 12/24/14 at 12:05 p.m. revealed Sioux Falls wheel chair express picked up the resident and took her to Avera ER.</p> <p>*A nursing note on 12/24/14 at 3:00 p.m. written by the Minimum Data Set (MDS) assessment care manager HH noted: -She reviewed the resident's fall from 12/21/14. -The resident was in the shower room in the bath chair. -The resident lifted the side arm on the bath chair and fell out onto the floor. -The resident landed face first onto the floor. -Her left eye was bruised and swollen, and her right hand was bruised. -The resident was instructed not to lift the arm on</p>	S 445		7/16/15

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S 445	<p>Continued From page 81</p> <p>the chair.</p> <p>-The staff were instructed not to leave the resident unattended during her bath.</p> <p>-After further review it was determined there was not evidence of abuse or neglect with the above fall.</p> <p>*A late entry nursing note on 12/26/14 at 10:00 p.m. revealed:</p> <p>-The resident was admitted to Avera.</p> <p>-Her diagnoses were multiple rib fractures and a left clavicle fracture.</p> <p>-She had a hospice consult on 12/26/14.</p> <p>*A nursing note on 12/26/14 at 12:35 p.m. noted:</p> <p>-"Two broken vertebrae [bones in the spine] that are old!"</p> <p>-"She stated she is not upset with anyone."</p> <p>*A readmission to the facility nursing note on 12/28/14 stated:</p> <p>-Readmission diagnoses were trauma, multiple rib fractures, and a clavicle (curved bone at the base of the neck) fracture.</p> <p>*A nursing note on 12/30/14: A fax was sent to the physician asking for a hospice order.</p> <p>*A nursing note from 1/1/15 stated the resident was found at 5:45 p.m. without vital signs.</p> <p>Review of Avera Mckennan Hospital and University Center's medical records for resident 17 revealed:</p> <p>*Emergency room visit notes:</p> <p>-Date of service was 12/24/14.</p> <p>-Her chief complaint was difficulty breathing.</p> <p>-The report from her daughter was she was sitting after getting out of the shower, she slipped out of her chair, falling onto her left side.</p> <p>-That had happened four days ago.</p> <p>-The nursing home had noticed she had breathing difficulty since then.</p> <p>-She complained of pain to her left shoulder.</p> <p>*The emergency department course and plan</p>	S 445		7/16/15

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S 445	<p>Continued From page 82</p> <p>were:</p> <ul style="list-style-type: none"> <li>-She had a fall four days ago, and now had difficulty breathing and some significant chest wall tenderness.</li> <li>-An x-ray was obtained.</li> <li>-The resident was noted to have multiple left rib fractures.</li> <li>-She also had a clavicular fracture.</li> <li>*She was admitted on to the trauma service on 12/25/14.</li> <li>-She presented in the emergency department from the nursing home with shortness of breath and wheezing.</li> <li>-In the transfer information it did not mention anything about a recent fall.</li> <li>-Upon evaluation it was evident the resident had some sort of trauma with bruising to her left shoulder, chest, and eye.</li> <li>-Further discussion demonstrated she might have fallen either yesterday versus three days ago.</li> <li>-Reports were inconsistent.</li> <li>-She described she felt very confused, and that was not normal for her.</li> <li>-She described diffuse (widespread) pain.</li> <li>-The chest x-ray showed multiple displaced rib fractures on the left side, and the left clavicle fracture.</li> <li>-It was unclear of the events that lead up to that with a left clavicle fracture, multiple left rib fractures, on 3 liters of oxygen, bruising to the left eye, and some pelvic tenderness.</li> <li>*On 12/25/14 diagnostic test results showed the left second, third, fourth, fifth, sixth, seventh, ninth, and tenth ribs were fractured both anteriorly (front) and posteriorly (back) forming a "flail segment."</li> <li>*She was discharged back to the nursing home on 12/28/14 with the following diagnoses that included but not limited to:</li> <li>-Fall from "standing height."</li> </ul>	S 445		7/16/15
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S 445	<p>Continued From page 83</p> <ul style="list-style-type: none"> <li>-Multiple left rib fractures.</li> <li>-Left clavicle fracture.</li> <li>-Hypoxia (inadequate oxygen supply).</li> </ul> <p>Review of resident 17's 7/3/14 care plan for falls/psychotropic (mood altering) drug (medication) use revealed: *It had been updated on 12/21/14 with her fall from the bath chair. *She was reminded not to lift her arm up while she was in the bath chair. *She was not to be left unattended while in the bath. *She had a history of falls and was taking psychotropic medication that increased her risk for falls.</p> <p>Observation and interview on 6/11/15 at 11:00 a.m. with CNA GG who was the bath aide that day revealed: *She was not using a seat belt on the bath chair. *There was no seat belt for the bath chair; she did not use anything to secure the residents in the bath chair. *Most residents could support themselves in the bath chair. *She remembered there being a seat belt probably back in April 2015, but she had not used one since then. *She worked at the facility as needed.</p> <p>Interview on 6/11/15 at 12:05 p.m. with MDS care manager HH revealed she had not seen a seat belt for the bath chair.</p> <p>Interview on 6/11/15 at 12:35 p.m. with CNA OO who usually worked full-time as a bath-aide (but not on 6/11/15) revealed she had been using a seat belt when she bathed residents. The seat belt was ordered because of resident 17's fall out</p>	S 445		7/16/15

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S 445	<p>Continued From page 84 of the bath chair.</p> <p>Review of the 12/30/14 Penner Patient Care Incorporated invoice revealed a seat belt had been ordered.</p> <p>Review of the Penner Manufacturing Cascade Patient Transfer Lift System Safe Operations and Daily Maintenance Instructions revealed on page 9 for the bath chair "WARNING Failure to secure the resident properly with the seat belt could result in injury to the resident or operator."</p> <p>Review of the revised October 2010 Shower/Tub bath policy revealed: *Never leave the resident unattended in the tub or shower. *No mention of the use of the seat belt for the bath chair.</p> <p>Interview with the director of nursing and administrator on 6/16/15 at 2:25 p.m. revealed: *They had ordered a seat belt after resident 17's fall from the bath chair. *They would have expected the CNAs that were giving baths to have used the seat belt for all baths.</p> <p>2. Review of resident 19's complete medical record revealed: *He was admitted on 2/16/15. *He was at high risk for falls. *His fall risk assessment score was sixteen. *His fall risk assessment report stated any score ten or greater to initiate the following: -Initiate falling star program. -Write on nursing Kardex, care plan, and pocket care plan. -Initiate other safety measure as appropriate. *His 2/16/15 nursing Kardex revealed no mention</p>	S 445		7/16/15

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S 445	<p>Continued From page 85</p> <p>of falls or interventions for falls.</p> <p>*On 2/17/15 he had a fall with the following noted:</p> <ul style="list-style-type: none"> <li>-Nursing heard someone yelling for help.</li> <li>-He was found on his floor by his bed.</li> <li>-He complained of left hip pain and was unable to move his left leg.</li> <li>-He was sent by ambulance to the emergency department.</li> <li>-He was admitted to the hospital with a left hip fracture.</li> </ul> <p>Review of the provider's addendum to their final report for resident 19's 2/17/15 event revealed on 2/24/15 staff noted an obituary for him. He had died on 2/21/15.</p> <p>Surveyor: 14477</p> <p>3. Review of resident 18's closed medical record revealed:</p> <ul style="list-style-type: none"> <li>*An admission date of 7/3/14 with diagnoses of cerebral palsy, mental retardation, diabetes, and several others.</li> <li>*The 7/3/14 Fall Risk Assessment showed a score of 12 (score greater than 10 equaled high risk for falls).</li> <li>*The 7/14/14 care plan stated he had used a wheel chair for mobility (getting around) and wanted it tilted.</li> <li>*The 7/15/14 care conference note indicated the family was concerned the resident would slide out of the wheelchair. He had his own wheelchair with a seat belt. The "resident unable to release the seat belt and is thus considered a restraint."</li> <li>*A 7/15/14 faxed request from therapy to the resident's physician requested "OT, PT, and ST [Occupational Therapy, Physical Therapy, and Speech Therapy] evaluations and treatment orders to address seating safety..."</li> <li>*On 9/17/14 at 11:15 a.m. the Interdisciplinary Progress Notes stated the resident was found by</li> </ul>	S 445		7/16/15
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S 445	<p>Continued From page 86</p> <p>a certified nursing assistant (CNA) "setting on floor in room in front of assistive chair - no injury noted on assessment. Assistive chair not tilted appropriately - res [resident] slid out of chair onto floor."</p> <p>*On 9/24/14 at 1:30 p.m. the Interdisciplinary Progress Notes stated the resident's fall on 9/17/14 had been reviewed. It was noted the assistive chair was not tilted appropriately. Staff were reminded to place the assistive chair in the appropriate position. "No injuries were noted and no evidence of abuse."</p> <p>*On 3/1/15 at 10:00 a.m. a fax was sent to the physician stating the resident had a scratch to the left side of his nose. An antibiotic ointment was ordered to use on the nose, and an antibiotic via (by) the G-tube (a tube inserted directly into the stomach to provide nutrition and medication) was also ordered.</p> <p>*On 3/1/15 at 1:00 p.m. on the Interdisciplinary Progress Notes by nursing stated "Resident's sister was here and noticed bridge of nose is swollen and left eye sclera [white area of eye] is red and yellow."</p> <p>*A 3/2/15 Sanford Hospital dictation stated the patient reported a fall with bleeding. "A large scratch across the left bridge of nose and a little bit of ecchymosis [reddening] right at the corner of his eye so it suggests that there was probably a fall or injury." An X-ray showed no fracture.</p> <p>*A documented interview on 3/5/15 with the resident's sister revealed the physician had stated the resident had facial trauma. When she had asked the provider what had happened to his face the administrator and DON told her they did not know, and that they were short staffed.</p> <p>Surveyor: 32335 4. Review of resident 25's 2/11/15 care plan revealed:</p>	S 445		7/16/15

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S 445	<p>Continued From page 87</p> <p>*From 9/1/14 through 3/14/15 she had forty falls. *The following interventions had been implemented: -On 9/4/14 "Attempt to engage in activities when up," and they had obtained a floor mat to place beside her bed. -On 9/8/14 "Will do frequent observations." -On 9/21/14 "Let resident wake up on own accord in AM." -On 9/29/14 "Offer food monitor freq [frequently]." -On 10/1/14 "keep around nurse's station when out of room for easier observation, and toileting every 2 hours while awake and prn [when necessary]." -On 10/10/14 "Will ambulate with restorative [therapy to help restore function] daily." -On 10/23/14 "Toilet between 0500-0600 [5:00 a.m.-6:00 a.m.] Q [every] AM." -On 10/29/14 "New cushion for w/c [wheelchair] per O.T. [occupational therapy]." -On 11/5/14 "Will add toilet at 0001 [12:01 a.m.]. Ambulate at least two times per day and prn." -On 11/15/14 "Will start toileting program." -On 11/17/14 "Start falling stars program and toileting program. Monitor every 15 minutes." -On 11/20/14 "Trial of new voice activated bed/chair alarm." -On 1/7/15 "Pommel cushion (helps prevent forward sliding) applied to chair." -On 1/8/15 "Try music therapy with headphones." -No other interventions had been documented after 1/8/15.</p> <p>Interviews and record review revealed resident 25 had skin breakdown to her bottom due to incontinence. There was no documentation the toileting interventions above had been followed.</p> <p>Interview on 6/17/15 at 8:15 a.m. with the director of nursing revealed she did not know resident 25</p>	S 445		7/16/15

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S 445	<p>Continued From page 88</p> <p>and directed me to speak with MDS case manager X. MDS case manager X stated they put several interventions in place and referred to the care plan. All of the documentation regarding the fall interventions was requested.</p> <p>Interview and record review on 6/17/15 at 10:20 a.m. with the director of nursing after she had brought the above requested information revealed:</p> <p>*The activities documentation for resident 25 had only included information from 3/17/15 through 6/16/15.</p> <p>*There was no documentation regarding the frequent observations and monitoring every fifteen minutes.</p> <p>*There were no other interventions put in place.</p> <p>Surveyor: 35625</p> <p>5. Record review of resident 27's medical record revealed:</p> <p>*He had a Brief Interview for Mental Status (BIMS) assessment score of fifteen out of fifteen indicating no cognitive impairment.</p> <p>*Three falls had been documented since November 2014.</p> <p>*A fall occurred on 11/5/14 with the following noted:</p> <ul style="list-style-type: none"> <li>-Resident found on floor</li> <li>-He had leaned over to reach for an object and slid out of the wheelchair.</li> <li>-He was not injured in the fall.</li> <li>-Staff encouraged him to use the call light when he needed assistance.</li> <li>-No documentation was provided that indicated additional interventions were put into place to prevent future falls.</li> </ul> <p>*A fall occurred on 1/18/15 and noted:</p> <ul style="list-style-type: none"> <li>-The resident used the call light to request staff assistance after he had fallen.</li> </ul>	S 445		7/14/15

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S 445	<p>Continued From page 89</p> <ul style="list-style-type: none"> <li>-He attempted to transfer himself from the wheelchair to bed with no staff assistance.</li> <li>-He was not injured in the fall.</li> <li>-Staff encouraged the resident to ask for assistance and use the call light.</li> <li>-Follow-up documentation stated the resident would like to have physical and occupational therapy reevaluate him.</li> <li>-There was no documentation a physical or occupational therapy consultation had been ordered after it was requested.</li> <li>-No additional documentation was provided up to the end of survey that indicated additional interventions were put into place to prevent future falls.</li> <li>*A fall occurred on 4/28/15 and noted:             <ul style="list-style-type: none"> <li>-Resident was found on the floor</li> <li>-He had slid out of his wheelchair while trying to place his urinal on a table.</li> <li>-He was not injured in the fall.</li> <li>-Education was provided regarding the use of the call light for assistance.</li> <li>-No documentation was provided up to the end of the survey that indicated additional interventions were put into place to prevent future falls.</li> </ul> </li> <li>Interview on 6/16/15 at 3:50 p.m. with resident 27 regarding the above falls revealed:             <ul style="list-style-type: none"> <li>*He acknowledged he "wasn't thinking" prior to each of the falls.</li> <li>*Staff frequently reminded him to use the seatbelt on his motorized scooter.</li> <li>-He demonstrated he was able to unbuckle the belt without assistance.</li> <li>-Verbalized he had been using the seatbelt for approximately one month</li> <li>*He had a tool that allowed him to grasp objects that were out of arms reach</li> <li>-The facility had replaced the tool sometime during the winter, because the old one was</li> </ul> </li> </ul>	S 445		7/16/15

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S 445	<p>Continued From page 90</p> <p>broken. *Staff frequently reminded him to use his call light when he needed assistance while in his room.</p> <p>Interview on 6/16/15 at 4:15 p.m. with registered nurse (RN) Y revealed: *Staff had been instructed to keep items including his call light within reach. *Safety was reinforced with the resident after each fall. *Staff observed the resident more often and estimated it was at an interval of approximately every hour. *No documentation was provided to support the statement the resident had been observed at regular intervals.</p> <p>6. Review of the provider's 2001 Falls and Fall Risk Managing policy revealed: *Initial approaches could have included exercise or balance training, rearrangement of room furniture, or medication adjustments. *If falling reoccurred despite initial interventions staff should have implemented additional or different interventions or indicated why the current approach remained relevant.</p> <p>Review of the provider's revised December 2007 Falls and Fall Risk Managing policy revealed "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."</p> <p>Surveyor: 32333 D. Based on observation, interview, record review, plan of correction review from the survey on 9/11/14, job description review, and policy review, the provider failed to appropriately</p>	S 445		7/16/15

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S 445	<p>Continued From page 91</p> <p>identify, notify, assess, provide treatment, and care plan a pressure ulcer (injury to skin/tissue from pressure usually over a bony area) for one of one sampled resident (2) who was at risk for pressure ulcers. Findings include:</p> <p>1. Review of resident 2's complete medical record revealed:                      *She was admitted on 11/16/10.                      *There were multiple documentation entries of pressure ulcers since her admission.                      *There was multiple conflicting documentation of pressure ulcers on different areas of her body.                      *Her most recent documented pressure ulcer had been identified on 3/12/15.                      *On 5/21/15 there was a nursing note that the area was healed.                      *There was no way to know if the resident had a pressure ulcer currently or not because of the conflicting documentation.</p> <p>Random observations on 6/9/15 of resident 2 from 8:45 a.m. through 10:33 a.m. while she was seated in the center dining room revealed:                      *At 8:45 a.m. she was sitting in her wheelchair at the dining room table with her breakfast in front of her on the table.                      *At 9:49 a.m. she was seated at the dining room table in her wheelchair with her head down.                      *At 10:00 a.m. she called out "Someone help me please" several times with no staff response.                      *At 10:10 a.m. she called out "I need to use the toilet" with no staff response.                      *At 10:33 a.m. she was still seated in her wheelchair at the dining room table with her head down.                      *Dietary staff had been in and out of the dining room while she was calling for help.                      *No nursing staff were present in the dining room.</p>	S 445		7/16/15

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S 445	<p>Continued From page 92</p> <p>Observation on 6/9/15 at 10:45 a.m. of resident 2 in her room revealed certified nursing assistant (CNA) EE and FF were helping her use the toilet.</p> <p>Interview on 6/9/15 at 10:55 a.m. with resident 2 while she was in her recliner in her room revealed: *The questions asked were written due to her hearing impairment with some of her answers being verbal. *She stated "I have a sore on my bottom [left buttock] and it hurts." *When asked if she was toileted enough she wrote on a piece of paper "It depends on who is working."</p> <p>Interview on 6/9/15 at 11:15 a.m. with CNA EE regarding resident 2 revealed: *After meals they were supposed to toilet the resident and lay her down. *She had a reddened area on her bottom, but it was not opened. *She complained her bottom was sore when she was toileted.</p> <p>Interview on 6/9/15 at 11:15 a.m. with CNA FF regarding resident 2 revealed there were no reddened areas on her bottom.</p> <p>Interview on 6/9/15 at 11:20 a.m with registered nurse (RN) BB revealed she had not heard that resident 2 had a sore on her bottom. Nor had she heard of any reddened areas on her bottom.</p> <p>Review of resident 2's 6/7/15-6/9/15 bowel and bladder detail report revealed: *On 6/7/15 she was toileted at: -12:31 a.m. -10:18 a.m. -2:51 p.m.</p>	S 445		7/14/15

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S 445	<p>Continued From page 93</p> <p>*On 6/8/15 she was toileted at: -12:48 a.m. -1:41 p.m. -8:48 p.m.</p> <p>*On 6/9/15 she was toileted at: -11:52 p.m. -9:47 a.m. (The observation of resident 2 being toileted was 10:45 a.m. on this date). -9:30 p.m.</p> <p>Record review on 6/10/15 of resident 2's medical record revealed no documentation regarding her 6/9/15 complaints of a sore on her bottom or a pain assessment.</p> <p>Observation and interview on 6/10/15 at 9:00 a.m. while CNA EE toileted resident 2 revealed: *She had a reddened area on her left buttock (bottom). *The CNA stated she would notify the nurse on duty.</p> <p>Observation and interview on 6/10/15 at 11:00 a.m. with MDS case manager X and HH of resident 2's left buttock revealed: *A reddened area with several pinpoint open areas. *A scant amount of blood was noted on her incontinence (loss of bowel and bladder control) brief. *They stated they were unsure if it was a pressure ulcer or an incontinence ulcer. *The resident did sit in her chair a lot.</p> <p>Interview on 6/10/15 at 11:25 a.m. with the director of nursing (DON) and licensed practical nurse (LPN) O regarding resident 2's left buttock assessment revealed: *LPN O stated "Its just red" when asked if she had assessed the resident's bottom.</p>	S 445		7/16/15

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S 445	<p>Continued From page 94</p> <p>*LPN O had not documented the assessment yet. *There was no wound care nurse at the facility, however MDS coordinator HH used to be the wound care nurse. *LPN O had asked the CNAs to apply a barrier cream on her.</p> <p>Review of the following documentation on 6/11/15 regarding resident 2 revealed: *A nursing note on 6/10/15 at 7:30 p.m. stated "New skin concern on bottom see NPSCR [Non-pressure skin condition report]." *NPSCR: -Left buttock redness. -The size was documented as pinpoint. -Provon (skin barrier cream) was placed. *Review of resident 2's 6/10/15 skin assessment report revealed: -The location of the new skin concern was on the left buttock. -The contributing factor was incontinence. -The skin concern was redness and a pinpoint area open. *Review of resident 2's 6/10/15 interdisciplinary progress (IDP) notes revealed "New skin concern found on left side of residents bottom. There is one pinpoint area on bottom that is open, the rest of her cheek is red with no other open areas noted at this time. PCP [primary care provider] faxed r/t [related to] this reoccurring skin issue. Family notified of skin concern. CNA instructed to put on Provon for time being until PCP faxes back with treatment. No other skin concerns at this time. Call light within reach. Will continue to monitor."</p> <p>Interview on 6/10/15 at 3:55 p.m. with MDS coordinator HH regarding the above noted IDP note revealed: *It was not how she would have documented the</p>	S 445		7/16/15

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHRIDGE HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900S NORTON AVENUE SIOUX FALLS, SD 57105</b>		
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S 445	<p>Continued From page 95</p> <p>assessment of what she observed resident 2's skin concern. * She would have measured the reddened area. *Resident 2's "cheek [entire left buttocks]" was not all reddened. *LPN O should have assessed the resident for pain and documented it. *She confirmed the assessment was inaccurate.</p> <p>Review of resident 2's entire medical record revealed: *There was no documentation on 6/9/15 of her complaint of the sore on her bottom or her complaints of pain. *There had been no pain assessment documented. *There had been no accurate measurement of her reddened area on her left buttock. *The only documentation for measurement stated "pinpoint."</p> <p>Review of resident 2's skin assessment report faxed to the physician on 6/10/15 and then physician response on 6/11/15 revealed it was okay to start with barrier cream and to keep it as clean as possible.</p> <p>Review of a fax sent to the physician on 6/11/15 to clarify the above order revealed: *RN Y asked the physician "Do you want the barrier cream as a PRN [as needed] order or daily? Please clarify." *The physicians response was "If incontinent daily."</p> <p>Review of resident 2's bowel and bladder detail report from 6/12/15 through 6/16/15 revealed she had been incontinent on: *6/12/15 at 12:51 p.m. and 7:54 p.m. *6/13/15 at 12:24 a.m. and 8:05 p.m.</p>	S 445		7/16/15

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S 445	<p>Continued From page 96</p> <p>*6/14/15 at 12:19 a.m. and 4:40 p.m. *6/15/15 at 10:09 a.m. and 3:35 a.m. *6/16/15 at 12:44 a.m.</p> <p>Review on 6/16/15 of resident 2's June 2015 treatment administration record revealed: *6/12/15 Barrier cream to area on buttocks if incontinent daily. *The time listed to apply the barrier cream was "PRN." *There was no documentation the barrier cream had been applied.</p> <p>Interview on 6/16/15 at 9:50 a.m. with RN Y regarding resident 2 revealed: *She was incontinent more than usual. *The nurse should have been putting on the barrier cream.</p> <p>Interview on 6/16/15 at 10:05 a.m. with CNAs TT and UU regarding resident 2 revealed: *She was always incontinent. *She had been incontinent that day at 9:45 a.m.</p> <p>Review of resident 2's care plan revealed: *Two focus areas documented as pressure ulcers. *One of the pressure ulcer focus areas updated 3/12/15 was the following: -She was at risk for pressure ulcers, because she was frequently incontinent of urine and she had edema (swelling). -During care observe skin and notify the nurse if there were any areas of concern. -Notify the nurse, family and physician with any areas that were reddened, opened, or with any unexplained bruising. -Remind the resident to reposition when sitting or lying in one place. -On 3/12/15 her care plan was updated "Area to</p>	S 445		7/16/15

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S 445	<p>Continued From page 97</p> <p>buttock crease open again." -3/12/15 was the last time her care plan had been updated. *Another focus area documented as pressure ulcers updated on May 2015 revealed the following: -"I have a pressure ulcer." , -Progress toward the healing of the residents pressure ulcer. -If there were no changes to wound in two weeks seek a different treatment. -If there were no changes in four weeks, seek a consult to the wound clinic. *She had a focus area for pain with the following interventions: -Nursing should assess pain and document it. -Encourage the resident to change positions if she is in the same position for more than two hours.</p> <p>Her care plan had not been updated to reflect when her pressure ulcer identified on 3/12/14 had been healed. Review of her care plan on 6/16/15 revealed it had not been updated to include her new skin concern. * A May 2015 focus area of urinary incontinence. -"Please take me to the toilet when I get up in the morning, before and after meals, at bedtime and PRN." -"Please take me every couple hours at night as well." -"I take a diuretic that makes me have to go often"</p> <p>Review of resident 2's pocket care plan revealed CNAs were to check skin daily.</p> <p>Interview on 6/16/15 at 2:45 p.m. with the DON and administrator regarding resident 2 revealed:</p>	S 445		7/16/15

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S 445	<p>Continued From page 98</p> <ul style="list-style-type: none"> <li>*The nursing staff should have assessed her for her complaints of a sore on her bottom and pain.</li> <li>*They would have expected the physician's orders to have been followed.</li> <li>*They would have expected the nurse to have done accurate measurements and accurate assessments of the resident's impaired skin integrity (skin break down).</li> <li>*They would have expected the resident's care plan to have been updated.</li> <li>*The DON would not expect toileting to be real time (actual time it was done).</li> <li>*The DON agreed there was no was know way to know when the resident was being toileted.</li> <li>*The administrator asked the DON during this interview to have nursing staff go do an accurate assessment to get a baseline of the resident's impaired skin integrity.</li> </ul> <p>Review on 6/17/15 of resident 2's requested by the administrator skin assessment revealed a stage II pressure ulcer (open sore) measuring 2 centimeters by 0.8 centimeters.</p> <p>Review of the provider's 9/11/14 last survey results revealed the provider failed to appropriately assess, intervene, and care plan for three of four residents with pressure ulcers.</p> <p>Review of the provider's plan of correction for their 9/11/14 recertification survey regarding pressure ulcers revealed:</p> <ul style="list-style-type: none"> <li>*All nursing staff would be re-educated on pressure ulcer prevention, care planning, and treatment including contributing factors.</li> <li>*A certified wound care nurse would be hired within the next sixty days.</li> <li>*A weekly wound care committee was started to include the MDS case managers, DON, the certified wound care nurse, and the consultant</li> </ul>	S 445		7/16/15

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S 445	<p>Continued From page 99</p> <p>registered dietician to review all residents at risk for weight loss and or wound management needs.</p> <p>*At monthly quality assurance and performance improvement meetings, the certified wound care nurse would provide a report, on a continuous basis, on pressure ulcer incidence, and effectiveness of current treatments and prevention program.</p> <p>Surveyor: 33488 Interview on 6/17/15 at 8:15 a.m. with the administrator regarding audits performed as part of the plan of correction from the 9/11/14 survey related to pressure ulcer prevention revealed: **A certified wound care nurse will be hired within the next sixty days." *There was no certified wound care nurse hired as directed. *He was unsure why that had not been done. *He agreed they had not followed the plan of correction as stated by hiring a certified wound care nurse.</p> <p>Surveyor: 32333 Review of the provider's revised March 2013 CNA's job description revealed: **"Provides, completes and documents, if applicable, resident care as assigned in a timely and accurate manner." *Examples of resident care included provides personal care in eating, dressing, hair and body care, communication, toileting, bathing, and oral care. **"Reports changes in resident's condition immediately to the Staff Nurse." **"Responds to request from residents for assistance in a respectful and timely fashion. Answers call lights promptly." **"Communicates suggestions or concerns from</p>	S 445		7/16/15

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S 445	<p>Continued From page 100</p> <p>residents, other staff, visitors or others to the Staff Nurse in a timely, factual and accurate manner."</p> <p>Review of the provider's undated LPN job description revealed: **Assesses, plans, implements, evaluates plan of care for residents." **"Make changes on the plan of care as necessary."</p> <p>Review of the provider's undated RN job description revealed "Assesses, plans, implements, evaluates plan of care for residents.</p> <p>Review of the provider's September 2011 Standard Operating Procedure Skin Assessments revealed: **"To monitor residents known to have history of or be at risk of pressure ulcers or have skin breakdown." **"All staff are aware of need to notify a nurse concerning any resident's skin concerns." **"Staff nurse will perform skin assessments with measurements on a weekly basis."</p> <p>Surveyor: 33265 E. Based on observation, interview, record review, and policy review, the provider failed to ensure freedom of movement for one of one sampled resident (10). Findings include:</p> <p>1. Observation and interview on 6/10/15 from 12:40 p.m. to 1:00 p.m. in the east wing, far east hallway revealed: *At 12:40 p.m. resident 10 was seated in his wheelchair, his knees were up against the bed, and his head was down. *At 12:45 p.m. resident 10 put his call light on. It stayed on for several minutes, and then went into</p>	S 445		7/10/15

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S 445	Continued From page 101  a faster beeping and flashing mode. The resident made his way into the hall with his wheelchair and stayed just outside of his doorway. *At 12:53 p.m. three certified nursing assistants (CNA) came to answer the call light. The resident was pushed back into his room, the television was turned on, and one CNA asked him if the channel was okay. No response was heard from the resident. *At 12:55 p.m. the resident turned his light on again and went out into the hallway in his wheelchair. *Two of the above three CNAs returned to his room. CNAs II and JJ pushed him backwards into his room. CNA II told him he needed to wait ten more minutes, and then they would move him into his recliner. They then closed the door to his room. *When the two CNAs were asked why the resident had to wait ten minutes. CNA II responded he wanted to know his weight, and they had not had time to get it.  *This surveyor had previously identified the door to his room stuck and was difficult to open. *On previous random observations when the resident had been in his recliner and watching television, the door had been left open a few inches and the resident could have been seen in the recliner.  After the CNAs had closed the resident's door and left the following occurred: *The resident was heard trying to open the door. *The door knob was moving, but it was not opening. *After knocking on the door, this surveyor opened it slowly to find the resident was right in front of the door. *He motioned with his hands he wanted to move	S 445		7/16/15

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S 445	Continued From page 102  to the recliner. -His call light was not seen. *At 1:00 p.m. the resident's light was back on. *The two CNAs returned with an EZ Stand (device to assist in lifting a person into the standing position) to move the resident.  Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing (DON) and the administrator, revealed they were: *Unaware of the event. *Wanting to know if the event needed to be reported to the South Dakota Department of Health office in Pierre at this time.  Review of the provider's June 2014 Reporting Abuse to Facility Management policy revealed: *Involuntary seclusion was listed as a type of abuse. *The definition for involuntary seclusion included a resident being confined to his room against his will. *Employees, facility consultants, and or attending physicians were to report abuse or suspected abuse to the administrator or DON.  Surveyor: 14477 F. Based on observation, interview, and record review, the provider failed to ensure accurate weights were consistently monitored and recorded in a central document and the dietary team was notified of significant weight changes for two of two sampled residents (1 and 10) with weight concerns. Findings include:  1. Review of resident 1's entire medical record revealed: *An admission date of 5/19/15. *He was receiving tube feedings (receiving	S 445		7/16/15

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S 445	<p>Continued From page 103</p> <p>nutrition and medication directly through a tube inserted into the stomach). *He was NPO (could have nothing by mouth).</p> <p>Review of the following weight logs revealed his weight in pounds: *May/2015: -140.6 on 5/20 (day after admission). -150.2 on 5/26. -149.6 on 5/27. -151.8 on 5/30. *June 2015: -152.7 on 6/1. -153.8 on 6/2. -154.1 on 6/3. -154.6 on 6/4. -156.2 on 6/5. -155.2 on 6/6. -156.2 on 6/7. -157.4 on 6/8.</p> <p>Observation on 6/9/15 at 9:50 a.m. of resident 1 being weighed revealed his weight in his wheelchair with peddles on was 218.4 pounds. The weight sheet indicated the wheelchair weight was 61.2 pounds with peddles on. The recorded weight was 156 pounds on the weight log sheet. The correct weight on the log sheet should have been 157.2 pounds.</p> <p>Review of resident 1's 6/9/15 swallow study revealed he had been allowed to start taking foods by mouth that day. His weights following that study were: *159.2 on 6/10. *160.0 on 6/11. *161.0 on 6/12. *No weight had been documented on 6/13. *168.0 on 6/14. *172.4 on 6/15.</p>	S 445		7/16/15

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S 445	<p>Continued From page 104</p> <p>*178.4 on 6/16.</p> <p>Review of the weight log sheet instructions stated "if the weight differs by 5# [pounds], please re-weigh."</p> <p>Review of the provider's policy Tracking Weight Changes revealed under Procedure 5: "The RD [registered dietician] or designee will be notified of any individual with an unplanned significant weight change of 5% [percent] in one month, 7.5% in three months, or 10% in six months."</p> <p>Review of resident 1's weight records revealed he had a greater than 10% weight gain in twenty-eight days. No documentation was found regarding: *Any reweights done for differing weights of greater than five pounds. *If the RD had been notified of the 6/9/15 change from NPO to eating by mouth in addition to the tube feeding.</p> <p>Surveyor: 33265 2. Review of resident 10's complete medical record revealed: *Four different documents on which weights were to have been recorded. -Daily weights were to have been written in by hand for a month at a time. -Weekly weights were to have been written in by hand for an entire year. -Monthly weights were to have been written in by hand for a two year period. The day of the month the weight was to have been done was not recorded. -A computer print out form of weights had been entered into the computer documentation system. *The resident had weights recorded on all four types of weight records. None of the forms were</p>	S 445		7/16/15

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S 445	<p>Continued From page 105</p> <p>complete.</p> <p>*On the daily weight form for February 2015 there was a notation the resident was to "start daily weights on 2/13/15."</p> <p>-There were three daily weights missing for that month.</p> <p>*The daily weight form for March 2015 had not had the month or year filled in. There were:</p> <p>-Three weights documented for the entire month and twenty-eight daily weights missing.</p> <p>*The daily weight form for April 2015 also had "daily wts [weights]" written in on the form.</p> <p>-Seven days had no weight recorded.</p> <p>*The daily weight form for May 2015 had seven daily weights missing for the month.</p> <p>*Daily weights were listed on the June 2015 Treatment Administration Record. The first two days of the month were blank.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the DON and the administrator revealed the DON:</p> <p>*Believed the daily weights had been discontinued.</p> <p>*Had not known of the existence of one of the four different weight documents.</p> <p>Continued review of the weight documentation revealed:</p> <p>*There was a ten pound weight loss between 3/24/15 and 4/2/15. No re-weight was noted.</p> <p>*There was an eight pound weight loss between 5/15/15 and 5/16/15 with the note "reweigh" written after the 5/16/15 weight. No weight was done for the next two days.</p> <p>Review of the provider's 11/10/09 Weight and Height Policy and Procedure revealed a reweigh was to have been done for any five pound weight change from the previous weight.</p>	S 445		7/16/15

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S 445	Continued From page 106  Surveyor: 16385 G. Based on observation and interview, the provider failed to maintain a homelike environment for all residents for the following: *The memory care unit (Memory Lane) dining/common area laminate floor was visibly scratched and worn. *Four doors were hard to open and/or close (room 317, center tub room, center soiled utility room, and east shower room). *Plates, cups, and silverware were left on trays instead of being placed on the table for two of two meals observed in Memory Lane. Findings include:  1. Random observations from 6/8/15 through 6/11/15 revealed the Memory Lane dining/common area laminate floor had large areas where the finish was scratched or worn off. That created an uncleanable surface.  Interview on 6/11/15 at 8:30 a.m. with the administrator confirmed he was aware of the worn laminate floors in Memory Lane. He revealed he and the owner had toured the area and noted the floor was worn. No immediate plans were in place to replace the floor.  Surveyor: 33265 2. Random observations throughout 6/9/15 and 6/10/15 revealed: *The center wing tub room door was difficult to open and would not close completely. It would not lock as it should when closed. *The center soiled utility room door was difficult to open. *The east shower room door would stick and was difficult to get into and out of. *Resident room 317's door would stick and was	S 445		7/16/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10682</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
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S 445	<p>Continued From page 107</p> <p>hard to move or close.</p> <p>Interview and record review including surveyor 32331 on 6/16/15 at 5:00 p.m. with the director of nursing and the administrator revealed they: *Were not aware resident room 317's door was sticking and difficult to open and close. *Wanted a list of the doors not working properly.</p> <p>Surveyor: 32335</p> <p>3. Observation on 6/9/15 at 11:50 a.m. and at 5:50 p.m. of the meal service in Memory Lane revealed the staff left the plates, cups, and silverware on the trays when they served the residents.</p> <p>Interview on 6/10/15 at 1:30 p.m. with certified nursing assistant MM revealed she was not sure if they were supposed to leave the trays on the table or not during meals.</p> <p>4. Interview on 6/10/15 at 9:35 a.m. with the dietary manager and registered dietitian revealed staff should not have left the plates, cups, and silverware on the trays when serving meals. They should have taken those items off and set them on the table. Staff should have used regular cups not the soft plastic ones for snacks and all meals.</p> <p>A homelike environment policy had been requested but had not been provided before the team exited the facility on 6/17/15.</p>	S 445		7/16/15
S 446	<p>44:04:17:10 Grievances</p> <p>A resident may voice grievances without discrimination or reprisal. A resident's grievance may be in writing or oral and may relate to</p>	S 446		

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S 446	Continued From page 108  treatment furnished, treatment that has not been furnished, the behavior of other residents, and infringement of the resident's rights. A facility must adopt a grievance process and make the process known to each resident and to the resident's immediate family. The grievance process must include the facility's efforts to resolve the grievance, documentation of: (1) The grievance; (2) The names of the persons involved; (3) The disposition of the matter; and (4) The date of disposition.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one randomly observed resident (44) and a random group of fifteen residents had been notified of doctors' appointments in a timely manner. Findings include:  Surveyor: 33265 1. Observation on 6/9/15 at 12:09 p.m. in the east wing dining room revealed: *Licensed practical nurse (LPN) KK told resident 44 she needed to go to see the physician right away. *The resident stated she knew nothing about having a physician's appointment. *She had not received her meal. *Her meal was quickly brought to her, and she was told to hurry and eat. *She finished most of her meal and was wheeled out before dessert was served.  Surveyor: 32333 2. Group interview on 6/9/15 at 3:15 p.m. with	S 446	This deficient practice could affect all residents. The Department of Medical Records informs residents and family for regularly scheduled appointments by mail. Charge nurses will notify residents and/or family about upcoming appointments by each Friday for the following week. The charge nurse will enter an IPN (Interdisciplinary Progress Note) note in the EMR about the notification of the upcoming medical appointment. The Social Services department will ask every resident or resident representative by July 13, 2015 the questions listed on the Quality of Care rounds sheet which asks if the resident is receiving enough notice for their medical appointments. Responses that indicate a problem will be entered as a grievance or reported to the Department of Health if the criteria are met. All staff will be inserviced between July 13-15, 2015 about the medical appointment process. The charge nurses will review the transportation log daily to review if there are medical appointments for the day and remind the resident of the appointment 1/2 sheet of paper. All grievances mentioned in the Resident Council will be entered in a Resident Grievance Complaint Log by the Activities Director and the Grievance given to the appropriate department in accordance with the Grievance Policy and Procedure. The Clinical Coordinators will choose 5 random residents that had medical appointments for the calendar month. The Clinical Coordinators will ask the resident or Responsible party if they were notified timely of the appointment.	7/16/15

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S 446	<p>Continued From page 109</p> <p>fifteen residents in attendance revealed it was the group consensus:                      *They were not being notified of doctor's appointments in a timely manner.                      *A staff member would notify them of a doctor's appointment minutes before they were scheduled.                      *They had brought that to the facility's attention several times in the past.                      *That grievance was not being followed-up on nor resolved.</p> <p>Review of the resident council meeting minutes from January 2015 through June 2015 revealed:                      *1/5/15 New business: "Some residents expressed concern in not receiving appointment reminder sheets."                      *2/2/15 Old business: "Residents are not getting their announcements of doctor's appointments."                      *3/2/15 Old business: "Residents are not getting their announcements of doctor's appointments."                      *4/13/15 There was no follow-up mentioned for the above stated concerns.                      *5/13/15 There was no follow-up mentioned for the above stated concerns.                      *6/1/15 New business: "[Resident name] said they are not being notified about appointments."</p> <p>Interview on 6/16/15 at 2:25 p.m. with the administrator and director of nursing revealed they would have expected follow-up and resolution with resident council grievances.</p> <p>Surveyor: 33265                      Review of the provider's 11/8/12 Grievance/Complaints policy and procedure revealed anyone who complained had a right to request and receive a written response to the complaint within a reasonable period of time.</p>	S 446	<p>The Social Services Department will follow-up with all grievances brought forth in resident council using the grievance procedure. The Clinical Coordinators will report the findings of the Medical Appointment audit and Social Workers will report results of any grievances for the month to the QAPI committee for a period of 1 year and then as deemed necessary by the QAPI committee.</p>	7/16/15