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

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435102		08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/25/15 through 8/27/15. Sturgis Regional Senior Care was found not in compliance with the following requirements: F176, F221, F226, F241, F253, F280, F281, F311, F323, F325, F371, F431, and F441.	F 000		
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: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to secure physicians' orders or assess for the ability to safely self-administer medications for two of two residents (7 and 21) with cognitive impairment (a decline in mental functioning receiving nebulizer treatments. Findings include: 1. Observation on 8/25/15 at 4:25 p.m. of licensed practical nurse (LPN) B administering a nebulizer treatment (inhaled medication through a mouthpiece over a period of approximately fifteen minutes) to resident 21 revealed LPN B: *Set up the nebulizer machine and added the liquid medication into the chamber. *Applied the nebulizer mask to her face and	F 176	**F176** The policy has been changed to reflect that all cognitively impaired residents, including resident 21.7, need to be monitored during the course of the nebulizer treatment. Education will be given to all nurses including nurse B,E, at a staff meeting on 9/22 & 9/23,to ensure nebulizers are monitored for all cognitively impaired residents. DON or designee will do weekly check for 1 month; then monthly checks will be done until 9/30/16. Findings will be reported to the Quality Assurance Performance Improvement Committee at their monthly meetings.	9/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-18-15

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.

SEP 21 2015

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F 176	Continued From page 1 turned on the nebulizer machine at 4:25 p.m. *Instructed the resident to keep the mask on her face and left the room informing the resident she would return later. *Returned at 4:33 p.m. and turned off the resident's call light that she had turned on. *Instructed the resident to keep the mask on and left the room. *Returned to the room at 4:43, removed the mask from her face, and instructed the resident the treatment was over. Interview with LPN B at that time regarding resident 21 revealed: *She had just received the nebulizer order for her. *She had not received nebulizer medication in the past. *Her primary problem on admission was dementia (mental decline that could cause confusion and forgetfulness). *The resident often pressed her call light, and then staff would have to enter her room to turn it off. Review of resident 21's medical record revealed: *Her 7/15/15 Brief Interview for Mental Status (BIMS) (memory test) score of 5, indicated severe mental impairment. *No medication self-administration assessment had been completed. Surveyor: 35237 2. Observation on 8/25/15 at 8:00 a.m. of resident 7 during initial tour revealed: *He was laying on his right side in his bed sleeping. *There was a nebulizer (neb) mask laying on the floor next to his bed.	F 176	F176 Those residents deemed capable of self-administering will have a physician's order obtained to reflect they are cognitively intact and able to self-administer medications. With each administration of medication the resident will be asked if they feel comfortable self- administering medication. If they state no, the nurse will stay with the resident for the duration of the administration. Policy will reflect this process regarding resident choice and physician orders if needed. The DON or designee will report to QAPI Committee at their monthly meetings. MS	10-7-15

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F 176	Continued From page 2 -The nebulizer machine was on. *There were no observed staff in or around his room at that time. Review of resident 7's medical record revealed: *He had a BIMS score of 4 indicating he had severe cognitive (mental) impairment. *He had physician's orders for Albuterol (type of breathing medication) nebulizer treatments four times a day for bronchitis (inflammation of upper airway causing increased coughing). Interview on 8/26/15 at 7:50 a.m. of medication aide C revealed: *The nurses gave all the nebs in the facility. *The nurses were supposed to assess the resident before and after nebs. *She was aware the nurses generally did not stay in the room when a resident received nebs. Interview on 8/26/15 at 7:55 a.m. of LPN E revealed: *The nurses gave all the nebs in the facility. *They assessed residents before and after neb treatments. *They could leave residents alone while the neb was running if the residents were alert and oriented. *If the resident was confused the nurse should have stayed in the room for the entire treatment. *She agreed if the resident removed the neb treatment before it was completed then they would not have received the full dose as ordered by the physician. Surveyor 32332 3. Interview on 8/26/15 at 5:15 p.m. with the director of nursing regarding medication self-administration revealed:	F 176		

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F 176	Continued From page 3 *She would not expect to see any residents, including residents 7 and 21 self-administering medications. *She would not expect any residents to have a physician's order to self-administer medications, because no residents were allowed to self-administer medications. *She would not expect to have residents assessed for medication self-administration, because no residents were to self-administer medications. *Nurses were to have stayed with all residents during all medication administration including nebulizer treatments. Review of the provider's June 2013 Medication Administration policy revealed: *"Do not leave any medications at the bedside unless it is ordered to do so." *"Stay with the resident to ensure the medication had been swallowed or administered."	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, interview, record review, and policy review, the provider failed to ensure wheelchair (w/c) brakes had not been locked when staff were not in attendance for one of one randomly observed resident (13) who could not	F 221	**F221** Training will be given to all staff, at 9/22 & 9/23 staff meetings, including nurse F, who come in contact with all residents, including resident 13,regarding being a restraint free facility. The DON or designee will perform 10 restraint checks weekly for one month. If checks are adequate they will then be done monthly until 9/30/16. Findings will be reported to the QAPI Committee at monthly meetings until 9/30/16.	9/23/15

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F 221	Continued From page 4 unlock them on her own to move about in her w/c. Findings include: 1. Observation on 8/25/15 during the noon meal of resident 13 in her w/c revealed: *She had been moving around the dining room bumping into other residents' wheelchairs. *She used her feet to propel herself in the w/c. *Staff redirected her to her table several times. *She continued to leave her table and move around the dining area. *Staff placed her thickened liquids on the table and redirected her back to her table. *One randomly observed staff locked the left side of her w/c at 12:32 p.m. and left her unattended at the table. *She tried to leave the table but could not, because one side of her w/c remained locked throughout the rest of the meal. Observation on 8/25/15 at 5:29 p.m. of the evening meal of resident 13 revealed: *She was at the table with both wheelchair brakes locked. *She appeared calm. *Staff were not in attendance of her and had been serving food and helping other residents. *Her wheelchair brakes remained locked throughout the meal service even if staff had not been assisting her. *This surveyor had not been able to tell if she had tried to leave the table because her w/c had been pushed up to the table and both brakes locked. Surveyor: 35237 2. Observation and interview on 8/26/15 at 12:30 p.m. with certified nursing assistant (CNA) I who was assisting resident 13 with dining revealed: *The resident was sitting in a Broda (specialty type) wheelchair at the table with CNA I to her	F 221	F221 Sturgis Regional Senior Care Restraint policy has been changed to reflect wheelchair locks as a restraint. Ten weekly restraint checks will include wheelchair locks as well as lap trays. The DON or designee will report findings to the QAPI at their monthly meetings. MS	10-7-15

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F 221	Continued From page 5 right. *She was awake and calm. *Her wheelchair brakes were not locked. *CNA I stated the CNAs normally locked her wheelchair brakes during the meal when she was having a "busy" or more active day. *They would always unlock the brakes before they left the dining room. Observation on 8/27/15 at 7:45 a.m. of resident 13 in the dining room revealed: *She was sitting in her Broda wheelchair at the dining room table. *She was awake and calm. *There was no staff sitting by her. *Her right wheelchair brake had been locked. Review of resident 13's medical record revealed: *She had severely impaired cognition (memory and decision making ability). *Her diagnoses included Alzheimer's (memory) disease, dementia (memory disease), anxiety (nervousness), osteoarthrosis (bone disorder), osteoporosis (weak bones), history of falls, lumbago (back pain), and depression (sadness). 3. Interview on 8/26/15 at 3:05 p.m. with registered nurse F revealed: *No staff should have locked a resident's wheelchair brakes unless they were sitting with them. *They should not leave the resident alone with their wheelchair brakes locked. Interview on 8/26/15 at 4:25 p.m. with the director of nursing confirmed: *Staff should not have locked a resident's wheelchair brakes in the dining room. *There was a risk of tipping the wheelchair if the	F 221		

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F 221	Continued From page 6 brakes were locked and the resident wanted to move. Review of the provider's 1/1/10 Restraints policy revealed: *"a. A physical restraint is defined as any manual method or physical or mechanical device material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily or which restricts freedom of movement or normal access to one's body." *"l. Restraints shall not be used to limit resident mobility for convenience of the staff."	F 221		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to: *Thoroughly investigate unwitnessed falls for three of three random residents (10, 22, and 23) who had injuries. *Ensure the investigation section had been included in their policy. Findings include: 1a. Review of an incident report regarding resident 10 revealed: *She had a fall on 8/21/15 that had not been	F 226	**F226** The DON or designee will perform an investigation of all incident reports to determine interventions. These will include resident 10,22,23, as well as all other residents in the facility. Education will be provided to nursing staff at staff meetings on 9/22 & 9/23 regarding the complete charting on event reports. DON or designee will audit 10 incident reports monthly to assure completeness for 1 month; then monthly for 6 months or until 3 three consecutive months show completeness of the reports. Findings will be reported to the QAPI Committee at their monthly meetings until it is deemed no longer necessary.	9/23/15

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F 226	Continued From page 7 witnessed. *Staff heard a commotion at 7:30 p.m. and found her lying on the dining room floor. *She had hit her head and had been crying. *Under the other information category they had documented "Resident had been sitting in her w/c [wheelchair] in dining room. It is unknown what she was doing at time of fall." *There had been no documentation of where in the dining room she had been found, what was around her, what medications she had been taking, when she had last been assisted to the bathroom, who had worked with her that day, or if her care plan had been reviewed and followed. *There was no documentation of interviews conducted with staff. b. Review of an incident report regarding resident 22 revealed: *She had a fall on 8/1/15 that had not been witnessed. *A certified nursing assistant (CNA) had found her at 1:00 p.m. lying on the floor in her room. *She had hit her nose. *She was trying to go to the bathroom. *Under the other information category they had documented "Pull tab alarm was not attached." *There had been no documentation of what the environment was like in her room where she was found, what was around her, when the tab alarm had been on last, what medications she had been taking, when she had last been assisted to the bathroom, who had worked with her that day, or if her care plan had been reviewed and followed. *There was no documentation of interviews conducted with staff. c. Review of an incident report regarding resident 23 revealed:	F 226	F226 All incident reports will be investigated to try to determine the cause of the incident and to makes place interventions for future incidents as deemed appropriate. Regional Health Event Reports policy currently reflects an investigation process. Through the SD DOH a form has been devised to assist in reporting events and makes the process clear in determining the need to report. The DON or designee will report findings to the QAPI committee at their monthly meetings. MS	10-7-15

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F 226	Continued From page 8 *He had been found sitting on the floor in the dining room by a CNA. *He had an abrasion to his right elbow. *He had been confused when asked what had happened. *There had been no documentation under the other information category. *There had been no documentation of where in the dining room he had been found, what was around him, what medications he had been taking, when he had last been assisted to the bathroom, who had worked with him that day, or if his care plan had been reviewed and followed. *There was no documentation of interviews conducted with staff. d. Interview on 8/27/15 at 7:30 a.m. with the director of nursing revealed there had been no additional documentation regarding the above falls. They had not conducted a thorough investigation for any of the above mentioned falls. Review of the provider's 7/2/12 Falls policy revealed it had not addressed investigation of falls. Review of the provider's abuse and neglect policies revealed they were missing the following sections: screening, training, identification of possible incidents, investigations of incidents or allegations, and reporting to the South Dakota Department of Health. Upon follow-up with the director of nursing on 8/27/15 she was able to locate all the above mentioned sections in their abuse and neglect policies except for investigation of incidents or allegations.	F 226		

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F 241 F 241 SS=E	Continued From page 9 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, interview, and policy review, the provider failed to ensure all residents' dignity had been maintained as seen by: *Four randomly observed sampled residents (6, 11, 12, and 24) had not been assisted with feeding as needed. *Three of three observed meals had not been served in a timely manner according to their documented schedule in both dining rooms (Massa and Berry). *Two randomly observed sampled residents (3 and 12) waited a long time at a table before being served. *Food had been served at tables when residents were not there in two of two dining rooms (Massa and Berry). *Four randomly observed sampled residents (6, 11, 12, and 24) who needed assistance had been left with food in front of them for long periods of time before being assisted to eat. Findings include: 1. Observation on 8/25/15 at 12:00 noon in the Berry dining room revealed: *Two randomly observed residents had been wandering around the dining room in their	F 241 F 241	**F241** As of 9/18/15, a new policy on the resident dining experience will begin. Changes in the dining experience will take place starting 9/28/15. Menus will be posted inside the dining rooms as well as on the activity boards in hallway. Meal times will be posted inside the dining rooms as well as by the door. Open meals will take place during the following times: Breakfast 7:30am-8:30am; Lunch 11:45am-12:45pm; Supper 5:30pm-6:15pm. Meals will be based on individual needs and served individually, with appropriate condiments, following the needs for adaptive equipment, modified food textures, etc. Hot/cold beverages will be poured after the individual has been seated at the table. Once seated, individuals will be given choices for meal, server will inform food service staff and food will be plated accordingly. Meals will not be served to anyone not seated. Staff will be available to redirect individuals and encourage food/beverage intake as deemed appropriate. Staff will be educated on the importance of interaction with individuals during the meal process. Education of staff will be done by 9/24/15 The CDM will monitor at least 1 meal daily for 1 month; then at least 3 meals per week until 9/30/16. Findings will be reported to the AQPI at their monthly meetings until 9/30/16. Monitor results will consist of timeliness of meals being served, rotation of individuals being served, availability of staff to ensure all individuals are being monitored for needed assistance. The RD./DON will monitor dining rooms routinely, with no less than 6 meals per month, will document any concerns and/or ideas to improve and report findings to the QAPI Committee at their monthly meetings until 9/30/16.	10/16/15

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F 241	Continued From page 10 wheelchairs. -One of those residents bumped her wheelchair into another resident's wheelchair several times, and he used his foot to push her wheelchair away. *The first drinks had been poured at 12:25 p.m. *The first plates went out to the first table at 12:40 p.m. *There were three tables left that had not been served meals at 1:05 p.m. *The table with residents that needed dining assistance were served last. *Randomly observed staff had helped some residents eat, then got up to help other residents, and then returned to helping those first residents eat. *Lunch service should have started at noon according to staff. 2. Observation on 8/25/15 from 5:25 p.m. to 6:15 p.m. of the evening meal in the Berry dining room revealed: *Resident 11 had been wandering in and out of the dining room in his wheelchair. *At 5:45 p.m. food had been placed at resident 11's table along with another tray of food when there were no residents at the table. -An aide redirected him to his table and left him alone. *Resident 11 ate a few bites of his meal then left the dining room at 5:50 p.m. -He required assistance for dining and had not been assisted at that time. *At 6:15 p.m. a dietary aide brought resident 11 back into the dining room from the hallway to assist him with eating. -His plate of food had been sitting out uncovered for at least thirty minutes. -The aide had not offered to warm the food up.	F 241	F241 Individuals (Resident #3) will be served as they come in to the dining room, in the event most individuals are in the dining room at the start of meal service the table rotation calendar will be followed, food service will inform servers of which table is the appropriate table to start with Those individuals who need to be cued or assisted . (Resident #6 #12 &24) will be served as staff is available to work with them. A plate guard was ordered for individual (Resident #11) which worked better than lipped plate, individual is waiting to be brought into dining room, until their meal was ready to be served and staff was available to assist him. This resident has expired. The CDM or designee will be reporting monthly to the QAPI committee. MS 10-7-15	

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F 241	Continued From page 11 -The dietary aide stood when he assisted him with his meal. Observation on 8/26/15 of the 12:00 noon meal in the Berry dining room revealed: *Resident 11's food had been served at 12:31 p.m. when he was not at the table. *An aide redirected him to the table from the hallway and left him alone. *He attempted to use a knife to eat his pureed foods. *He used his fingers to eat the ground meat. *He had not been given anything to drink until 12:42 p.m. Interview on 8/26/15 at 12:50 p.m. with aide J revealed resident 11 sometimes needed assistance with eating but was mostly independent. Review of resident 11's 7/30/15 Minimum Data Set (MDS) assessment revealed he had been coded as needing extensive assistance from one person for dining. 3. Interview on 8/26/15 at 7:30 a.m. with resident 3's family member revealed: *He came to eat with the resident every day. *Sometimes it took a really long time to get served depending on who was working and that determined which table got served first. *He sometimes got a room tray for the resident, and they ate in her room. -That way she did not have to wait to get served last due to needing assistance. Surveyor: 32332 4. Review of resident 6's medical record revealed:	F 241		

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	435102		08/27/2015

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F 241	Continued From page 12 *A weight on 8/25/15 of 107.5 lb. *A weight loss of 6.1 lb in the past three months. *A weight loss of 10.3 lb in the past six months. *A request from the speech therapist for orders to evaluate and treat her for swallowing problems and possible aspiration (inhaling liquids into the lungs) had been signed and approved by the physician on 8/10/15. *The 7/18/15 MDS assessment revealed she had required supervision and meal set-up assistance. *The updated 7/30/15 care plan indicated she was to have received: -A regular diet and thin liquids. -"Offer supplement if eats less than 50% [percent] of any meal." -Neither aspiration nor dysphagia (swallowing problems) had been marked as a problem. Observation of resident 6 during the 8/26/15 supper meal revealed: *She had been served the food by the staff. *She had eaten only her dessert and drank part of her fruit juice. *No staff members had been present to supervise her intake or encourage her to eat. *No staff member had provided a supplement for her intake of below 50%. Surveyor: 32335 5. Observation on 8/25/15 from 12:00 noon through 1:10 p.m. of the noon meal in the Massa dining room revealed resident 24 had been served her meal at 12:15 p.m. Staff delivering meals would stop and remind her to eat and then would return to delivering meals. She was not alert and had not been eating. Staff who had been assisting residents eat at another table got up and left those residents twice to come over to	F 241		

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F 241	Continued From page 13 her and cue her to eat. She had not eaten her meal due to her sleeping at the table. Observation on 8/25/15 from 5:30 p.m. through 6:15 p.m. during the evening meal in the Massa dining room revealed: *Resident 24 had been served her dessert at 5:35 p.m. *Staff had stopped at her table, moved the cake closer, and cued her to eat. *They had cued her at the table three different times. Review of resident 24's 6/8/15 MDS assessment revealed she required supervision with eating. 6. Observation on the same date and time as above revealed: *Resident 12 had been sitting at the table at 5:30 p.m. *She had been served beverages that she drank immediately. *She proceeded to lick her empty plate several times without staff intervening. *She was not served her food until 6:15 p.m. *She had not attempted to eat her food. *There were no staff at her table to assist. Review of resident 12's 5/28/15 MDS assessment revealed she was to have had assistance from one staff person with eating. They had not provided that assistance during the above meal. Surveyor: 23059 7. Observation on 8/25/15 beginning at 12:05 p.m. of the noon meal in the Massa dining room revealed there were thirteen residents seated at tables at that time. That meal was scheduled to begin at 12:00 noon. Observation of that meal	F 241		

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F 241	Continued From page 14 revealed: *At 12:10 p.m. desserts were being served to all residents. *Drinks began being served at 12:12 p.m. Those desserts and drinks were served to all place settings even if the resident was not present. *Service of the main meal began at 12:20 p.m. The food was served family style with portions being dished up for all residents at a table. Some of those tables did not have all residents present. *At 12:22 p.m. food was dished for two random residents requiring feeding assistance. Those two residents did not receive assistance to begin eating until 12:35 p.m. That food had not been covered to preserve temperature while waiting for staff assistance. *Also at 12:22 p.m. food was dished up for two random residents who were not currently at the table. -One resident arrived at 12:45 p.m. and was assisted to eat her meal. That food had not been reheated. -The other resident had not arrived by 1:00 p.m. when the observation ended. Her food remained uncovered that entire time. 8. Observation on 8/25/15 beginning at 5:45 p.m. in the Massa dining room revealed the evening meal service had been scheduled to start at 5:30 p.m. At that time desserts were being served. Aides began serving soup to residents' tables at 5:53 p.m. Soup was served to several places where residents were not yet present. Observation of that meal revealed: *Plates of food began being served at 6:01 p.m. family style. Food was served to all place settings at each table even if residents were not present. *Observation of two random residents requiring feeding assistance revealed there food had been	F 241		

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F 241	Continued From page 15 dished up at 6:05 p.m. Assistance for those two residents was not provided until 6:15 p.m. Those plates of food had not been covered to preserve temperature while waiting for staff to assist them. *At 6:12 p.m. covers were placed on two plates of food where residents had not been seated. That food sat uncovered for eleven minutes. Surveyor: 35237 9a. Observation of meal service on 8/25/15 from 11:55 a.m. through 1:15 p.m. in the Berry dining room revealed: *Residents had been sitting in the dining room ready to eat at 11:55 a.m. *The meal started to be served at 12:38 p.m. *The last meal was served was at 1:15 p.m. b. Observation of meal service on 8/25/15 from 5:15 p.m. through 6:10 p.m. in the Massa dining room revealed: *Residents had been sitting in the dining room ready to eat at 5:15 p.m. *The meal started to be served at 5:50 p.m. *The last meal was served at 6:10 p.m. c. Review of the provider's scheduled meal times revealed: *Breakfast was from 7:30 a.m. through 9:00 a.m. *Lunch was served at 12:00 noon. *Supper was served at 5:30 p.m. Surveyor: 32332 d. Interview on 8/25/15 at 3:30 p.m. in a confidential meeting with random residents revealed: *Dietary staff sometimes plated food during the meal service and left the plated food at some residents tables when the resident was not present.	F 241		

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F 241	Continued From page 16 *The staff sometimes left the plated food at some tables where the residents required assistance with eating, and there were staff members present to assist them. *Several residents had agreed the meal service took much longer at some meals, and the meals did not always start on time. 10. Interview on 8/26/15 at 9:00 a.m. with the certified dietary manager revealed: *Normally it took approximately thirty minutes to serve the meals in both dining rooms, Massa and Berry. *Staff rotated which table was served first each day according to a calendar that was located in each kitchenette. *Dietary staff should have gone to the kitchenette about thirty minutes before serving to set-up and have been ready to serve on time. *Family style dining was started about four years ago and was recommended by the director of nursing (DON) at that time. -That DON felt family style dining was more homelike for the residents. *She stated they had been talking about changing to restaurant style dining in the future. *She was not aware of any concerns from the residents regarding family style dining. *Staff should not have served residents that were not at their table. *Residents' that required assistance should not have been served until staff were able to help them. *She agreed meals and dining were a large part of the resident's day, and she expected that experience to be good for them. Interview on 8/26/15 at 3:10 p.m. with certified	F 241		

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F 241	Continued From page 17 nursing assistant G revealed: *Usually it took about thirty minutes for meals to be served in the dining room. *Residents who required assistance should not have been served until nursing staff were able to help them. *She thought family style dining was time consuming. *She felt the residents did not care either way if it was served family style or not. Interview on 8/26/15 at 4:25 p.m. with the DON revealed: *She was aware there were some concerns with meal services. *She stated normally it took about thirty minutes to serve the meals in both dining rooms. *Family style dining was not working well lately. *There had been a lot of new dietary staff recently. *They wanted to change from family style dining to restaurant style dining in the future. *Breakfast was open style dining from 7:30 a.m. to 9:00 a.m., and that worked well for the residents and staff. *She stated it could have been more efficient if they changed from family style dining. *She agreed staff should not have left food at the table for residents that were not there yet. *She agreed residents that required assistance should not have been served until staff were able to help them. *Meal service was a "work in progress." Review of the provider's 2010 Dining Experience policy revealed: *"1. Staff will treat all customers [residents] with dignity and respect. Socialization includes staff to individual contact. Focus on the individual - listen	F 241		

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F 241	Continued From page 18 and pay attention. Communicate with the individual (not with other staff)." *"2. Staff will provide service that will help to make dining a special "event" that customers will look forward to and that will create lasting memories." Review of the provider's 2010 Dining Room Service policy revealed: *"1. Meals are distributed promptly to maintain adequate temperature and appearance." *"5. There should be enough available staff in the dining areas to assist those who need help and to handle any situation that may arise." Review of the provider's 2010 Family Style Dining policy revealed: *"1. Food placed in bowls or on platters and delivered to dining tables for family style dining will: -Be covered if necessary. -Be at the appropriate and required temperature for service. -Have the appropriate size serving utensil according to the planned menu." *"3. A staff member will: -Oversee the passing of food as needed. -Encourage appropriate portion size. Assist those who need help. -Monitor for any unsafe food handling practices during the meal. -If a food item is considered contaminated, the food will be removed from the table and a replacement obtained."	F 241		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and	F 253		

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F 253	Continued From page 19 maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, interview, and policy review, the provider failed to ensure two randomly observed resident use areas had been maintained in a sanitary manner (the courtyard and the laundry room): *The courtyard surfaces had a lot of bird droppings on them. *The laundry room had some unfinished and uncleanable surfaces. Findings include: 1. Observation on 8/25/15 at 11:00 a.m. of the courtyard revealed: *Sidewalks and the concrete patio under the two trees in the courtyard were covered in a large amount of bird droppings. *Handrails had bird droppings on the top where residents would put their hands. *A metal picnic table had bird droppings on it's top. *The benches around the patio area had droppings on the backs and seats. *A dead bird laying on the concrete was decomposed to a skeleton and feathers. 2. Observation on 8/26/15 at 7:25 a.m. in the laundry room revealed: *A small board had been cut to fit over a hole in the floor that held piping for the washing machines. *There was dirt on the board, and the finish had been worn away creating an uncleanable surface.	F 253	**F253** On 9/15/15 Plant Operations staff was in-serviced by Plant Operations manager. Laundry floor grout will be repaired by 10/16/15 Drain covers repaired 9/9/15 by plant operations manager. MS 10-7-15 Court ~~Years~~ Yard will be monitored on daily rounds with check list for bird droppings by plant operations staff. The maintenance PM schedule will include monthly inspections of cleanable surfaces in laundry and outdoor courtyards. The maintenance PM schedule is performed by plant operations staff, monitored by the plant operations manager, and reported to the QAPI at their monthly meetings. F 253 Plant Operations staff in-serviced on 9/16/15 by Plant Operations Manager. Laundry floor grout will be repaired by 10/16/15. Drain covers repaired 9/9/15 by Plant Operations Manager. The maintenance PM schedule will include monthly inspections of cleanable surfaces in laundry and outdoor courtyards. The maintenance PM schedule is performed by maintenance personnel, monitored by Plant Operations Manager or designee and reported to the Quality Assurance Performance Improvement Committee at monthly meeting. Courtyards will be monitored on daily rounds and reported on check list by Plant Operations personnel for Bird droppings. Plant Operations Manager or designee will monitor check list weekly and report findings and actions to Quality Assurance Performance Improvement Committee at monthly meeting. MS 10-7-15	10/16/15

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F 253	Continued From page 20 *Lint and dirt were stuck around the edges of that board. *Grout in-between some of the tiles on the floor near the washing machines had been missing creating an uncleanable surface. 3. Interview on 8/26/15 at 9:15 a.m. with the maintenance manager revealed: *Maintenance staff were only responsible for mowing the grass in the courtyard. *Activities staff had been responsible for any other cleaning of the courtyard. *He had been unaware of the bird droppings that had been observed. *He had been unaware of the uncleanable surfaces in the laundry room. Interview on 8/26/15 at 9:45 a.m. with the activities director revealed: *She had been unaware of activities responsibility to clean the concrete in the courtyard. *She hosed off the tables and benches before resident activities. *She had hosed off the tables and benches on Sunday (8/23/15). *She agreed it needed to be kept clean, and a better cleaner than just water from the hose should have been used on surfaces residents touched. *She had been unsure of how to keep the courtyard clean, because there were a large amount of birds in the courtyard at times. There had been no policy or maintenance schedule for cleaning the courtyard available from the maintenance manager or activities director.	F 253		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=E	Continued From page 21 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 each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to update care plans to reflect the current status for: *Two of thirteen sampled residents (5 and 10) with falls with no interventions for prevention. *Two of thirteen sampled residents (8 and 11) with specialized equipment. *One of thirteen sampled residents (13) with skin integrity concerns. Findings include: 1. Review of resident 5's medical record revealed	F 280	**F280** Brown CRA sheets will be discontinued. Education will be given to all staff at a staff meeting on 9/22 & 9/23 and will be instructed on the use of Point Click Care care plans which will be kept up to date for all residents, including residents 5,8,10,11,13. F280 Sturgis Regional Senior Care policy currently reflects immediate update for all care needs including resident 5&10, which would update regarding falls. Resident 8&11 will be updated for specialized equipment and resident 13 for skin integrity concerns. Anyone in direct patient care may update the care plans. MDS coordinator will update quarterly as well. Care plan monitoring is completed by the MDS coordinator in direct relation with daily cares and daily physician orders. DON or designee will report to the QAPI at their monthly meetings. Currently, QAPI has a project for Care plan updating completed by MDS coordinators. MS	9/23/15 10-7-15

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F 280	Continued From page 22 he had a fall on 6/30/15. Review of resident 5's undated CRA (certified resident assistant [CNA]) care plan revealed it had not included his most recent fall, being at risk for falls, or interventions used to prevent falls. 2. Review of resident 10's medical record revealed she had a fall on 8/21/15 where she had hit her head. Review of resident 10's undated CRA care plan used by the CNAs revealed it had not included her most recent fall, being at risk for falls, or interventions used to prevent falls. 3. Interview on 8/27/15 at 7:30 a.m. with the director of nursing (DON) revealed the falls and interventions should have been on the CRA care plans. They had care plans developed from the Minimum Data Set (MDS) assessment, but those care plans were not used by the CNAs. They were only used by the MDS nurses. Surveyor: 32573 4. Review of resident 11's 7/23/15 physician's orders revealed an order to receive a lipped (edge to keep food on it) plate during mealtime to increase his independence with eating. Review of resident 11's current complete care plan and the undated CRA care plan sheet used by staff for his care revealed his need for a lipped plate had not been included on either care plan. Interview on 8/27/15 at 8:05 a.m. with the DON revealed the lipped plate should have been included on both of the care plans. The CRA care plan was what staff should have been using to	F 280		

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F 280	Continued From page 23 determine what care to provide resident 11. She agreed those care plans were not working as well as they should have been. Surveyor: 35237 5. Observation on 8/26/15 at 12:30 p.m. of resident 13 revealed she was sitting in a Broda (special type) wheelchair in the dining room. Review of her 8/4/15 CRA care plan revealed it had not indicated she had a Broda chair. For locomotion (moving around) it listed a wheelchair that she could have self propelled (moved) or had staff assistance to move. Review of her last reviewed 8/10/15 care plan revealed she used a wheelchair for most locomotion. She was able to self propel her wheelchair and needed staff assistance at times. That area had last been revised on 1/14/13. Interview on 8/26/15 at 3:40 p.m. with registered nurse (RN) F regarding resident 13 confirmed: *The Broda chair had not been updated on the CRA or the other care plan. *The resident had been changed to the Broda chair from a regular wheelchair following a fall on 7/31/15. *It should have been listed on her care plans. Interview on 8/26/15 at 4:25 p.m. with the DON revealed: *She had been aware of resident 13's change from a wheelchair to a Broda wheelchair following a fall. *She agreed it was not on either of her care plans, and it should have been. Surveyor: 23059	F 280		

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F 280	Continued From page 24 6. Review of resident 8's 7/22/15 physician's orders revealed she had a reddened area to her groin that had been treated with miconazole (antifungal) cream for a yeast infection. Review of her 8/21/15 notification to the physician revealed that area had not healed. The physician replied on that date she would need to see it to determine the next steps for treatment. Additional review of her 8/21/15 notification to the physician revealed she had a red nonblanchable (no color change with pressure) area to her right heel. The physician had ordered that day heel boots to have been applied while she was in bed. Review of resident 8's current Minimum Data Set (MDS) assessment focused care plan with an initiation date of 7/31/15 revealed: *She had a focus area of having potential for impaired skin integrity (open areas) due to loss of bowel/bladder control. *Her goal was to be free from pressure related skin breakdown with current interventions through 9/29/15. *There was no mention of her current skin concerns as noted above. *There were no interventions listed for the current yeast infection or pressure area to her right heel. Review of resident 8's undated CRA care plan revealed under the area for skin care: *Routine peri (private area) care. *Barrier cream (to prevent moisture from causing skin irritation). *There was no mention of the use of miconazole cream for the yeast infection. *There was no mention of the skin concern on her right heel or the need for the use of heel boots while she was in bed.	F 280		

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	435102		08/27/2015

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F 280	Continued From page 25 7. Interview on 8/25/15 at 4:30 p.m. with the DON revealed: *The CRA care plan was the day-to-day care plan that outlined each resident's care. *The MDS care plan was developed from the MDS assessment but was not used to indicate a resident's daily care. *Both care plans should have been updated immediately when a concern arose. *If the care plan was not updated accurately important care for the resident could be missed. *Every nurse had the responsibility to make changes to the care plan when the resident's status had changed. *The nurses should not have waited for the MDS coordinator to make updates. *The provider did not have a policy for how care plans were to have been maintained including updating to reflect the current status of residents.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, interview, and policy review, the provider failed to follow physician's orders for 2 of 13 residents (8 and 11). Findings include: 1. Observation on 8/25/15 at 5:30 p.m. during the evening meal revealed resident 11 had a lipped (edge to keep food on it) plate.	F 281	**F281** Education to all staff, including, CNA M, working with the residents, including resident 8&11, to instruct them on professional standards and following of physician orders. The DON or designee will audit 10 physician orders weekly for one month; then monthly until 9/30/16 to ensure high quality care and physician order compliance. Findings will be reported to the QAPI Committee meeting at their monthly meetings until 9/30/16. MS 10-7-15	10/16/15

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F 281	Continued From page 26 Observation on 8/26/15 at the 12:00 noon meal revealed: *Resident 11 had a standard plate sitting at his place at the table. *At 12:31 p.m. his food was placed on that standard plate. *A lipped plate had not been used. Observation on 8/27/15 at 7:50 a.m. of the breakfast meal revealed: *Resident 11 had a standard plate sitting at his place at the table. *Some of his food had been left in single serving dishes on the plate. *A lipped plate had not been used Review of resident 11's 7/23/15 physician's orders revealed an order for him to receive a lipped plate during mealtime to increase his independence with eating. Review of resident 11's 7/9/15 CRA care plan used by staff to provide care revealed a lipped plate had not been written in as a dietary assistance requirement. Interview on 8/27/15 at 8:05 a.m. with the director of nursing (DON) revealed: *Resident 11 should have gotten a lipped plate at every meal per physician's orders. *The lipped plate should have been mentioned on the CRA care plan staff used for determining his care. Surveyor: 23059 2. Observation on 8/25/15 at 10:25 a.m. revealed	F 281	F281 Resident 11 received the lipped plate but has since passed away. Education has been completed for all staff regarding physician orders and completion as well as following them. Resident 8's boots have been clarified that they are to be on any time in bed not just at HS. DON is auditing 10 physician orders to ensure completion of process as well as those orders being followed. DON or designee will report to the QAPI at their monthly meetings. MS	10-7-15

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F 281	Continued From page 27 resident 8 was wearing heel boots (foam protected cushioning) while she was in bed. Review of her 8/21/15 notification to the physician revealed she had a reddened area to her right heel. The physician had responded that same day with an order for "Heel lift boots applied when resident is in bed." Random observations on 8/26/15 from 7:15 a.m. through 5:30 p.m. revealed resident 8 never had the heel boots on while she was in bed. Those heel boots stored on the top of the resident's armoire (closet storage) throughout that day. Interview on 8/26/15 at 10:05 a.m. with certified nursing assistant M revealed she was aware the heel boots were to have been worn by resident 8 whenever she was in bed. She stated "We try to keep them on her, but she kicks them off." She confirmed the resident was in bed and not currently wearing the heel boots. She was not aware if anyone had tried to put the heel boots on her. Interview on 8/27/15 at 8:30 a.m. with the DON revealed resident 8's heel boots should have been on whenever she was in bed. She confirmed the physician's orders were not being followed consistently. 3. Review of the provider's Physician's Orders policy revised 4/8/10 revealed nursing staff had been responsible for ensuring physician's orders had been carried out and completed. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 306, revealed "Nurses follow	F 281		

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F 281	Continued From page 28 health care provider's orders unless they believe the orders are in error or harm patients."	F 281		
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: 32335 Based on observation, record review, and interview, the provider failed to consistently follow the restorative walk-to-dine program for one of one sampled resident (10). Findings include: 1. Random observations on 8/25/15 from 11:15 a.m. through 12:15 p.m. of resident 10 revealed she had been sitting in her wheelchair in the dining room. She had not been walked to the dining room for lunch (confirmed by an interview on 8/26/15 with certified nursing assistant (CNA) O). Observation on 8/25/15 at 5:35 p.m. of resident 10 revealed she had been brought into the dining room in her wheelchair. Review of resident 10's undated care plan revealed she was on a walk-to-dine program. Interview on 8/26/15 at 12:45 p.m. with restorative aide N revealed: *There were two restorative aides for the whole facility. *The CNAs would assist with the walk-to-dine	F 311		

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F 311	Continued From page 29 program when they could. *The residents on the walk-to-dine program should have been walked to all three meals. -It sometimes did not get done if they were short staffed. *She was unsure if resident 10 had been walked to lunch that day. *She thought maybe CNA O had walked resident 10. Interview on 8/26/15 at 12:48 p.m. with CNA O revealed she had not walked resident 10 to lunch. Review of the restorative documentation from 8/17/15 through 8/25/15 regarding resident 10 revealed: *Residents were supposed to have been walked to and from all meals. *Staff were supposed to initial if completed, write U for unsafe, S for sleeping, R for refused, NA for not available, and F for forgot to offer. *There had been documentation for only ten out of fifty-four times. *There was no documentation for forty-four out of fifty-four times. Interview on 8/26/15 at 12:50 p.m. with the Minimum Data Set (MDS) assessment coordinator and the director of nursing revealed: *They agreed the documentation for the walk-to-dine program had not been complete for resident 10. *Resident 10 had been started on the program around the beginning of July 2015, but they did have have the actual date. *They had no policy for the walk-to-dine program.	F 311	**F311** The restorative program staffing will ensure the ability to perform restorative programs for all residents in need of such programs, including resident 10. Education will be given to all staff including, CRA D, to ensure knowledge of the program and proper charting of each program. MDS coordinator will monitor resident progress and assure proper programs for all resident including #10. She will assure proper charting on all residents including resident 10 and will Report to PI monthly until 9/30/2016. F311 MDS coordinator will work daily with the restorative program aides to ensure proper documentation and proper programs for each resident on the restorative program are written. MDS coordinator will report to QAPI monthly regarding restorative numbers. MS	10/16/15 10-7-15
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 30 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: 32332 Surveyor: 32573 Based on observation, interview, and policy review, the provider failed to ensure areas with hazardous chemicals and dangerous items had been locked to prevent resident access for one of one tub room undergoing construction (Berry unit). Findings include: Surveyor: 32332 1. Observation on 8/25/15 at 7:50 a.m. of the tub room located on the west hallway of the Berry unit revealed: *The door was unlocked. *A large trash can containing used insulation and pieces of tile. *The shower wall tile had been removed leaving insulation exposed. *A spray can of silicone lubricant at waist level. *A spray bottle marked 'bleach water' at waist level. Surveyor: 32573 Observation on 8/25/15 at 11:20 a.m. in the east west hallway of the Berry unit revealed the tub room had been undergoing construction and	F 323	**F323** Plant Operations staff were in-serviced on 9/16/15 by plant operations manager. All construction areas will be locked and appropriate signage displayed while unattended by plant operations personnel. The plant operations manager will monitor all construction projects for compliance and report any issues to the QAPI Committee at their monthly meetings. F323 Plant Operations staff in-serviced on 9/16/15 by Plant Operations Manager. All construction areas will be locked and appropriate signage displayed while unattended by maintenance personnel. Shower room was locked the day of findings (8-25-15) until room was complete (9-4-15). Plant Operations Manager or designee will monitor all future construction projects daily for compliance and report to Quality Assurance Performance Improvement Committee at monthly meeting. MS	9/16/15 10-7-15

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F 323	Continued From page 31 revealed the following: *Two putty knives (metal flat scraping tool) had been sitting on a ledge about four feet off the floor. *A spray bottle with "bleach and water" written on it with liquid in it was sitting on that ledge. *A spray can of silicone lubricant with the warning "harmful or fatal if swallowed" had been sitting on that ledge. *A serrated drywall knife was sitting on the opposite ledge of the same height. *Tiles had been removed from the shower wall and were in a bucket on the floor. *The tiles had rough sharp edges. *There was exposed insulation in the wall from where the tiles had been removed. *The door to this room was unlocked from initial tour on 8/25/15 until the morning on 8/26/15. *Residents had been observed to pass by that room many times while it was unlocked. Interview on 8/26/15 at 9:15 a.m. with the maintenance manager revealed the above door should have been unlocked at all times. He agreed it was unsafe to keep it unlocked while under construction when residents could access the above items. Review of the Hazardous Chemicals and Waste Management policy revised February 2015 revealed all chemicals designated as being hazardous should have been handled according to federal, state, and local laws and regulations.	F 323		
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	F 325		

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F 325	Continued From page 32 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 nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, interview, record review, and policy review, the provider failed to ensure nutritional interventions were put in place or followed to prevent significant or gradual weight loss for four of seven sampled residents (6, 7, 11, and 13) with weight loss. Findings include: 1. a. Review of resident 11's weight summary from 7/3/15 to 8/25/15 revealed: *7/3/15- 144 pounds (lb). *7/6/15- 141.6 lb. *8/4/15- 132 lb. -That had been a 6.8% decrease from 7/6/15. *8/11/15- 127.6 lbs. -That had been a 17.5% decrease from 7/14/15. *8/25/15- 124.4 lbs. -That had been a 13.6% decrease from 7/3/15. *The significant weight changes had been automatically noted on the weight summary. Review of resident 11's nurses progress notes from 8/4/15 through 8/25/15 revealed: *On 8/4/15 the resident had weight loss and would be reweighed the next day. *On 8/5/15 he had greater than 5% unplanned	F 325	**F325** Policies for nutritional snacks, nutritional supplements, and nutritional risks were revised/ updated. The Weight Change Protocol and Unintended Weight Change Assessment Form have been revised. Re-establish the Nutritional Risk Committee to include, but not limited to: Nursing Services, Food/Nutrition Services, Nutritional Support, Therapies, and Pharmacy. Minimum of 2 Committee meetings in per month will be held. (One unit per meeting). Staff will be education on policy revisions/ updated by 9/24/15. Snack offering, nutritional supplement offerings, and weight changes will be monitored monthly and findings reported to QAPI at their monthly meetings until 9/30/16. For snack offerings and nutritional supplement offerings 6 residents will be monitored weekly for one month; then 12 residents will be monitored monthly until 9/30/16.	10/16/15

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F 325	Continued From page 33 weight loss in the past month, and the physician had been notified that day. *The only other mention of weight loss had been a weight change noted from the dietician on 8/21/15 stating nursing would continue to monitor his weight loss. *A charting note on 8/24/15 stated he required total to partial assistance with meals. b. Observation on 8/25/15 at the noon meal of resident 11 in the Berry dining room revealed: *He moved around the dining room and out into the hallway in his wheelchair (w/c) throughout the meal service. *Staff brought him back to the dining room when his food was served. *He ate a few bites of his meal (less than 20%) and continued wandering in his w/c out of the dining room. *No staff had assisted him when they first brought him his food. *A lipped (edges to keep food on the plate) plate had been used to serve his food. Observation on 8/25/15 from 5:25 p.m. to 6:15 p.m. of resident 11 at the evening meal in the Berry dining room revealed: *He had been wandering in and out of the dining room in his wheelchair. *At 5:45 p.m. food had been placed on resident 11's table along with another tray of food when there were no residents at the table. -An aide redirected him to the table and left him alone. -His food had been served on a standard plate. *He ate a few bites of his meal then left the dining room at 5:50 p.m. *At 6:15 p.m. a dietary aide brought him back into the dining room from the hallway to assist him	F 325	F325 Policies have been revised to reflect changes interventions. Resident 6's weight, meal intake and snack intake information reviewed. Resident does not accept assistance with eating. At times, can be cued to take additional bites of food. A medication review was completed by Pharmacy. Recommend a morning snack. Resident 7's weight, meal intake, snack intake, and blood glucose monitoring information reviewed. Recommend a scheduled nutritional supplement. Resident 11's weight, meal intake and snack intake information reviewed. Resident experienced increased mouth secretions and spitting. Discussed increased secretions and spitting with SLP. Resident is a DNR; aggressive nutrition therapy (i.e. tube feeding) was not warranted. Resident has expired and continued monitoring is not warranted. Resident 13's weight, meal intake, and supplement acceptance were reviewed. Resident is currently receiving a scheduled nutritional supplement. The recommendation was made to increase the amount at each scheduled offering. The weekly, then monthly monitoring for nutrition supplement offerings, snack offering, and weight changes will be completed by the RD. The RD or designee will report the findings to QAPI. MS	10-7-15

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F 325	Continued From page 34 with eating. -His plate of food had been sitting out uncovered for at least twenty-five minutes. -The aide had not offered to warm up the food and the resident would not have been able to ask *The resident did eat some food with assistance. Observation on 8/26/15 at the 12:00 noon meal with resident 11 in the Berry dining room revealed: *His food had been served at 12:31 p.m. when he was not at the table. -His food had been served on a standard plate. *An aide redirected him to the table from the hallway and left him alone. *He attempted to use a knife to eat his pureed foods and it spilled off the knife. *He used his fingers to eat the ground meat. *He ate about 20% of his food and then left the dining room again. *An aide redirected him back to the dining room and saw he had not gotten anything to drink. *The aide got him something to drink at 12:42 p.m. and tried to cue (remind) him to drink. *He only drank a little thickened juice. Interview on 8/26/15 at 12:50 p.m. with aide J revealed resident 11 was mostly independent and sometimes needed cueing. Observation on 8/27/15 at 7:50 a.m. of resident 11 in the Berry dining room revealed: *His food had been served on a standard plate. *There had been no one assisting him with his food. *He was trying to use utensils to get a packet of jelly open, and squeezed it into his mouth when he couldn't get it open with the utensils.	F 325		

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F 325	Continued From page 35 Review of resident 11's complete medical record revealed: *The 7/23/15 Minimum Data Set (MDS) (an assessment of current resident status) revealed he needed extensive assistance of one person for dining. *His current CRA [certified resident assistant] care plan staff used as a reference had not mentioned he needed a lipped plate or how much help he needed for meals. *His 7/23/15 physician's orders were a lipped plate was to be used to encourage his independence with eating. *His current undated care plan had not mentioned the order for a lipped plate. c. Review of resident 11's meal intake and supplement intake forms from 7/28/15 through 8/26/15 revealed: *He ate 25% or less of his meals or refused them thirty-two out of ninety meals. -A supplement had been checked as not applicable twenty-one of those thirty-two times when one should have been offered. *He ate 26 to 50% of his meals nineteen out of ninety meals. The intake forms had not specified if the % had been less than 50%. *There would have been no way to know if a supplement should have been offered at those meals. d. Review of resident 11's fluid intake forms from 7/28/15 through 8/26/15 revealed: *Fluid intake had been monitored three times a day. *He had not met his fluid intake goals from his care plan during the above date range. e. Review of resident 11's eating support provided	F 325		

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F 325	Continued From page 36 forms from 7/28/15 through 8/21/15 revealed: *Set-up help only had been provided for fifty-one of ninety meals. *He had extensive assistance from staff or total dependence on staff thirty-two of ninety meals. *He had supervision (oversight, encouragement, or cueing) or had no help from staff fifty-two of ninety meals. f. Review of resident 11's current undated care plan revealed: *A 8/20/15 focus area of potential for a nutritional problem of undernutrition related to limited food and fluid intake. *Interventions included: -"Monitor/record/report to medical doctor as needed signs and symptoms of malnutrition or significant weight loss." -"Assist and encourage fluids at meals and offer during cares and activities." -A fluid intake goal of 1719 to 2063 milliliters in 24 hours. -"Occupational therapy [OT] to provide adaptive equipment for feeding as needed." -"Please offer alternative food/fluid choices and/or a nutritional supplement when my meal intake is 50 percent or less. Monitor intake and record with meal." *A 7/31/15 focus area of self care performance deficit related to limited mobility (getting around), confusion, dementia (memory problems), and inability to communicate his needs at times. *Interventions included: -Eating required extensive assistance from a staff member/participation to eat. -Finger foods were to have been provided when he had difficulty using utensils. -Milkshakes or liquid food supplements were to have been offered when he refused a meal or ate	F 325		

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F 325	Continued From page 37 less than 50% of any meal. The amount taken and/or any refusals was to have been documented. Interview on 8/27/15 at 8:05 a.m. with the director of nursing (DON) regarding resident 11 revealed: *She had been aware of the weight issues with the resident. *Dietary staff had mentioned the problem with charting supplements as "not applicable." -Training had been provided but must have needed to be done again. *She expected staff to have been offering snacks and supplements when the resident ate less than 50% of his meals. *She expected a lipped plate to be used at every meal as the physician had ordered. -That lipped plate should have been documented on the CRA care plan sheet staff used to reference resident care needs. *She expected the resident to have been getting staff assistance at every meal as it had been stated on his regular care plan. *She believed the CRA care plan sheets the staff used to provide care had not been working as well as hoped for. Surveyor: 32332 2. Review of resident 6's medical record revealed: *A weight on 8/25/15 of 107.5 lb. *A weight loss of 4.7 lb (4.2%) in thirty days (7/25/15-8/25/15). *A weight loss of 10.3 lb ((8.7%) in 180 days (2/27/15-8/25/15). *An open wound on her buttocks had healed on 7/22/15. *A request from the speech therapist for orders to	F 325		

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F 325	Continued From page 38 evaluate and treat her for swallowing problems and possible aspiration (inhaling liquids into the lungs) had been signed and approved by the physician on 8/10/15. *The 7/18/15 MDS revealed: -She had required supervision and meal set-up assistance. -She had required supervision and meal set-up assistance. Review of the updated 7/30/15 CRA care plan indicated she was to have received: *A regular diet and thin liquids. *"Offer supplement if eats less than 50 % [percent] of any meal." *Neither aspiration nor dysphagia (swallowing problems) had been marked as a problem. The 7/28/15 Minimum Data Set (MDS) care plan revealed: *"Monitor and assist me as needed." *"I eat slowly as at times I tend to choke." *"Provide milkshakes or liquid food supplements when I refuse or have difficulty with solid food or provide nutritious foods that can be taken from a cup or mug." The last dietitian documentation had been recorded on 4/24/15 and indicated a weight of 114.8 lb prior to the skin breakdown. Recommendations at that time were to continue with the current regular diet and give supplements for intake below 50%. Interview on 8/26/15 at 8:45 a.m. with registered nurse (RN) F regarding speech therapy orders for treating resident 6 for swallowing problems and possible aspiration revealed: *She had not been aware of swallowing problems	F 325		

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F 325	Continued From page 39 or aspiration concerns. *She had not recalled having noted and signed off the speech therapy evaluation/treatment order on 8/11/15, but her signature was on the order. *She was not sure who had voiced the concerns that triggered a therapy order. Interview on 8/26/15 at 8:55 a.m. with the dietitian regarding resident 6 revealed: *She had not been made aware of orders for the speech therapist to evaluate and treat. *She had not known of any swallowing concerns. *She was not aware of the continued weight loss. *She stated the last note in the electronic medical record (EMR) had indicated the resident was not above a 10% weight loss, so it would not have been a significant weight loss. *If the weight loss had not flagged in the EMR, she would not have been notified of the continued weight loss. *She was behind in documenting in the medical record, so had not entered her last assessment into the record. *Her last assessment had been on 7/28/15, and had indicated: -Average weekly meal intakes of 32 to 42%. -A weight loss of 2.5% in 30 days and 8.8% in 180 days. -Staff were to have offered encouragement and assistance during meals, as well as alternative food choices or a supplement. *She had recently initiated an Unintended Weight Change Assessment Form for the nurses to use to notify her if there were weight changes or other dietary concerns such as swallowing problems, poor intake, or skin issues. *She stated she had not educated the nursing staff well enough, so they had not effectively utilized the new tool.	F 325		

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F 325	Continued From page 40 *She completed the dietary assessments and attended the care conferences when they were held. *The dietary manager was not involved with the resident changes or care conferences. Review of resident 6's 8/13/15 through 8/26/15 meal intake records revealed: *She ate less than 50% for twenty-three of thirty-nine meals. *She refused supplements for ten of thirty-nine meals. *A box labeled not applicable had been checked thirty times. *The above intake record had no recorded documentation of having received supplements. Interview on 8/26/15 at 12:25 p.m. with RN F regarding resident 6 revealed: *The not applicable box should have indicated the resident's intake of a supplement. *Not applicable would have indicated no follow-through with supplement. *Refusal would have indicated the supplemented was offered, but the resident refused. *She would agree the resident had no dietary supplement intake. Interview on 8/26/15 at 12:30 p.m. with the speech therapist regarding the speech therapy order regarding resident 6 revealed: *He had received a consultation request from the nursing department after the resident had a care conference on 7/31/15. *The resident's daughter had verbalized concern that her mother was having more coughing, swallowing difficulties, and difficulty with food textures. *The order had been received in the therapy	F 325		

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F 325	Continued From page 41 department on 8/11/15. *He started working with her on 8/25/15. *When asked why he waited to begin therapy more than three weeks after the order he stated sometimes it took time for the family to call with approval before he could begin therapy. Observation of resident 6 during the 8/26/15 supper meal revealed: *She had been served the food by the staff. *She had eaten only her dessert and part of her fruit juice. *No staff members had been present to supervise her intake or encourage her to eat. *There was no milkshake or supplement at her place at the table. *There was coffee in her cup. *No staff member had provided a supplement for her intake of below 50%. Interview on 8/26/15 at 4:50 p.m. with the dietary manager revealed: *The speech therapist would only notify the dietary department if diet changes were necessary. *She did not attend care conferences, but she did attend resident rounds every Monday. *She had not been contacted about any concerns for the resident. Interview on 8/26/25 at 5:15 p.m. with the director of nursing revealed: *There had been communication issues between the nursing and dietary department. *There had been a recent change to flag for significant weight changes percentages rather than loss in weight/pounds. *No one had been flagged unless significant losses were noted.	F 325		

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F 325	Continued From page 42 Surveyor: 35237 3. Observation and interview of certified nursing assistant (CNA) I on 8/26/15 at 12:27 p.m. who was assisting resident 13 revealed: *The resident was sitting in a Broda (special type) wheelchair at the table in the Berry dining room. *She was served pureed (blended) food and had thickened liquids. *Sometimes the resident fed herself and sometimes she did not. Review of resident 13's medical record revealed: *She was admitted on 5/9/14. *Her diagnoses included Alzheimer's (impaired memory) disease, dementia (impaired memory) with behaviors, kidney disease, osteoarthrosis (bone disorder), anxiety (nervousness), contractures (stiffness) of lower legs, muscle weakness, lumbago (back pain), constipation, osteoporosis (weak bones), depressive disorder (sadness), history of falls, and low potassium blood levels. *Her 7/4/15 signed physician's orders stated she had a regular diet, NDD1 texture(pureed/blended)", nectar consistency liquids. -There was no mention of weight loss or interventions for weight loss. *Her August 2015 medication administration record had Med Pass 2.0 (liquid nutrition supplement) that was given two times a day with an order date of 7/18/14 for health maintenance. *There were Unintended Weight Change Assessment Forms done by nursing for 7/28/15 and 8/12/15. Review of resident 13's weight summary from August 2014 through 8/25/15 revealed her weight	F 325		

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F 325	Continued From page 43 in pounds (lb) was: *8/4/14 - 117.2. *5/18/15 - 116. *5/25/15 - 103.6. *6/1/15 - 103. *8/25/15 - 103.3. *Her weight had been stable from 8/4/14 through 5/25/15 and ranged from 114 to 121 lb. *The first weight warning was on 5/25/15 and stated it was an 11.6 % decrease from 4/27/15 and a 11.1 % decrease from 12/8/14. *Following the 5/25/15 weight warning there were weight warnings for sixteen of the next twenty-four documented weights. Review of resident 13's dietary progress notes by the registered dietitian (RD) revealed: *The RD had documented on 8/29/14, 11/19/14, 2/18/15, and 8/5/15. -Those notes had been related to her quarterly assessments. *There were no additional notes in May 2015 related to the sudden weight loss from 116 lb to 103.6 lb. *Recommendations on 8/5/15 were to: -"Continue current diet order, with snacks PRN [as needed]. -Offer, encourage, and provide fluids with meals and throughout the day. -Staff to offer encouragement and assistance during meals and snack passes; while honoring [resident's name] choice to accept or refuse food/fluid offerings. -When meal intake is 50% or less, offer alternate food choices and/or a nutritional supplement to increase caloric and fluid intakes. -Continue to track food/fluid intake, weight, and labs [laboratory test results] - as available. -Will continue to monitor."	F 325		

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F 325	Continued From page 44 *There was no mention of any additional interventions added or changed related to her weight loss in May. Review of resident 13's 8/4/15 CRA (certified resident assistant [CNA]) care plan revealed: *To encourage fluids and do intake/output. *There was no mention of her weight loss or interventions for that. Review of resident 13's last reviewed 8/10/15 Minimum Data Set (MDS) care plan revealed: *A focus area for her needing assistance with activities of daily living that included eating. *Interventions for eating last revised on 5/30/14 included: -"At times, I am able to feed myself after set up." -"I do need cueing and assistance at times as well to remain on task." -"Family feels that [resident's name] is overweight so please offer small portions at meals." *A focus area for potential for nutritional problem and recent weight loss. *Interventions for nutrition included: -"Provide and serve supplements as ordered per facility protocol. I am not on any scheduled supplements." That intervention was last revised on 8/20/13. -"Provide, serve diet as ordered. Monitor intake and record q [every] meal. My current diet order is Regular, NDD1 textures, nectar consistency, regular size nosey [cut out area for nose] cup at all meals, avoid grapefruit juice due to medication interaction. Med Pass 2.0 two times a day for health maintenance. At times, I do sleep-in, please offer me something to eat and drink after rising." That intervention was last revised 8/5/15. Interview on 8/26/15 at 3:05 p.m. and again at	F 325		

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F 325	Continued From page 45 3:40 p.m. with RN F revealed: *Resident 13: -Had a significant weight loss in May 2015. -Had received a supplement twice a day from the medication aides that had been started in July 2014. *She agreed the significant weight loss in May for resident 13 had not been addressed, and no new interventions had been started. *It was a standard for staff to give a supplement to any resident who ate less than 50 percent of their meal. *Nursing staff weighed the residents on their bath day. *A weight would trigger or be a warning in their electronic medical record (EMR) if it was a loss or gain of 5 % in one month or 10 % in six months. *If a weight was entered and triggered nursing would have re-weighed the resident the next day. *If the reweigh was triggered nursing would notify the registered dietitian (RD) and the physician. *If the weight entered into the EMR did not have a warning nothing else would happen. 4. Observation on 8/25/15 at 1:25 p.m. of resident 7 in the Massa dining room revealed: *He was sitting in a wheelchair at the table feeding himself. *He had ground meat, cabbage, cut up sweet potatoes, cheesecake, and a vanilla Ensure (protein supplement). *He had eaten about 50 % of his food. Observation on 8/25/15 at 6:20 p.m. of resident 7 in the Massa dining room revealed: *He was sitting in a wheelchair at the table feeding himself. *He had a tuna melt with no crust on the bread, applesauce, wax beans, and a potato stick.	F 325		

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F 325	Continued From page 46 Review of resident 7's medical record revealed: *He was admitted on 1/14/14. *His diagnoses included depressive disorder (sadness), Psoriasis (skin disorder), anxiety (nervousness), diabetes (abnormal blood sugar levels), kidney disease, Alzheimer's disease, insomnia (unable to sleep), lumbago, muscle weakness, congestive heart failure (heart not working properly), Parkinson's (affecting nerves and muscles) disease, and high blood pressure. *His 7/14/15 signed physician's orders stated he had a regular diet, NDD2 texture (soft and ground foods), and thin consistency. -There was no mention of weight loss and interventions for weight loss. *There were no Unintended Weight Change Assessment forms in his record. Review of resident 7's weight summary form from 8/28/14 through 8/26/15 revealed his weight in pounds was: *188.8 on 8/28/14 and 167.9 on 8/24/15. -He had lost 20.9 lb in 1 year. *There were weight warnings for twenty-one of the fifty documented weights. *The last weight warning was on 4/27/15 and stated it was a 5.5 % increase since 3/30/15. Review of resident 7's dietary progress notes by the RD revealed: *The RD had documented on 10/16/14, 1/6/15, 4/3/15, and 6/24/15. -Those notes had been related to his quarterly assessments. *There were no additional notes after June 2015 by the RD. *Recommendations in the note from 6/24/15 were to:	F 325		

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F 325	Continued From page 47 -"Continue current diet order, with snacks PRN [as needed]. -Offer, encourage, and provide fluids with meals and throughout the day. -Staff to offer encouragement and assistance during meals and snack passes; while honoring [resident's name] choice to accept or refuse food/fluid offerings. -When meal intake is 50% or less, offer alternate food choices and/or a nutritional supplement to increase caloric and fluid intakes. -Continue to track food/fluid intake, weight, and labs - as available. -Will continue to monitor." *There was no mention of any additional interventions added or changed related to his weight loss. Review of resident 7's 7/2/15 CRA care plan revealed: *To encourage fluids and do intake/output. *There was no mention of his weight loss or interventions for that. Review of resident 7's last reviewed 7/3/15 MDS care plan revealed: *A focus area for his needing assistance with activities of daily living that included eating. *Interventions for eating last revised on 1/27/14 included: -"I am able to eat independently after assistance from staff with set up." -"Provide finger foods when I have difficulty using utensils. Speech to evaluate as needed." *A focus area for potential for nutritional problem and weight loss. *Interventions for nutrition included: -"Monitor/record/report to MD [physician] PRN [as needed] s/sx [signs/symptoms] of malnutrition:	F 325		

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F 325	Continued From page 48 Emaciation (extreme weight loss caused from not taking in enough food to function normally), muscle wasting, significant weight loss: 5% in 1 month, or 10% in 6 months." That intervention was last revised on 1/6/15. -"Provide, serve diet as ordered. My current diet order is Regular, NDD2 textures, thin consistency, exception of regular grain products. Offer alternate food choices and/or a nutritional supplement when meal intake is < [less than] 50 %. Encourage and offer fluids with meals and throughout the day. Monitor intake and record q [every] meal." That area was last revised 10/16/14. -RD to evaluate and make diet change recommendations PRN. *There was no mention of his gradual weight loss or changes in interventions related to that. 5. Interview at 8/26/15 at 12:00 noon with the CDM and the RD revealed: *The RD worked full time for the long term care facility, the hospital, and outpatient services. -She also filled in as a dietary aide when needed. *The CDM stated she rarely did documentation; the RD did all the documentation in the EMR. *The RD typically did documentation for residents only with their Minimum Data Set (MDS) assessments. -If there was an unintended weight loss for a resident she would have documented that in-between assessments. *They stated there had been a problem with the residents' weight system in the facility for a long time. *They had recently been updating the weight policies. *Before the EMR all the residents' weights were signed off by the nurses daily.	F 325		

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F 325	Continued From page 49 *Since the EMR started the CNAs entered residents' weights. *Standard practice was to offer a resident a supplement if they ate less than 50% for their meal. *Nursing staff completed an Unintended Weight Change Assessment form on any resident with a 5% weight change in one month or 10% weight change in six months. That form: -Would have been given the the RD. -Was new as of March 2015. -Was not up and running smoothly yet. -Was not the only way of notification to the RD but was usually how she first became aware of residents' weight changes. *Now when nursing entered resident weights into the EMR and it triggered a warning they would have: -Re-weighed the resident that day or within twenty-four hours. -Done the Unintended Weight Change form -Gave the form to the RD and the physician for follow-up. *The RD agreed: -Resident 7 had a gradual weight loss. -They had not made any changes or added other interventions related to his weight loss. -She had not documented on him other than his quarterly assessments. -Residents with gradual weight loss would not have triggered in their system, therefore would not have been alerted to staff. Interview on 8/26/15 with the DON regarding weights and weight loss revealed: *She was aware resident 13 had a significant weight loss. *She was aware resident 7 had a gradual weight loss.	F 325		

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F 325	Continued From page 50 *They were currently working on updating and changing the weight policy. *They now went by percentages of weight loss/gain instead of three to five pound changes. *If a warning triggered when nursing entered a resident's weight they would have let the RD know. *Nursing had not been hearing back from the RD related to the forms. *She knew the RD would have updated the pharmacist related to weight loss for them to do a medication review. *She confirmed there were additional interventions they could have tried for resident's with weight loss including increasing calories, changing diets, and adding supplements. *She agreed nursing and dietary should have worked together, and it should have been a collaborative effort. *She stated more could have been done with residents with weight loss, and they needed to change their policy. *She agreed someone with a gradual weight loss would not have triggered in their system, but they should have been monitoring those residents and updating their interventions too. Review of the provider's 1/1/10 Weight policy revealed: *Significant weight change was 5% in one month or 10% in six months. Greater than that was considered severe. *"If the resident's weight shows a significant/severe change:" -"a. Reweigh to verify the results and document in the "Weights and Vitals" section in Point Click Care. -b. If the results still show a change, reweigh the resident in 24 hours.	F 325		

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F 325	Continued From page 51 -c. If the results still show a change, complete the Unintended Weight Change Assessment Form to notify the dietitian and provider. Nursing to also contact resident's family or POC." Review of the provider's revised 8/4/15 Weight Change Protocol policy revealed: *Nurse Responsibilities included: -"1. Review resident weights per bath schedule or per provider ordered schedule. -2. Document review in Point Click Care under the nursing note type of "Weight Review Note." *Dietitians Responsibilities included: -"1. Reviews the "Unintended Weight Change Assessment Form" in a timely manner. -2. Conducts further inquiries as needed. -3. Documents recommendations/findings in Point Click Care. -4. Notifies appropriate services for further review as needed. -a. Consultant pharmacist -b. Speech Therapy. -Reviews "Weights & Vitals Exceptions Report" on a monthly basis and compares with received referral forms and reports to Long Term Care Performance Improvement Committee." Review of the provider's 6/7/13 Nutrition at Risk Management Program revealed: *"The dietary staff and nursing staff unite to comprise a team prepared to offer nutritionally adequate food to the residents and manage those residents determined to be at moderate or high risk for malnutrition. The team will strive to eliminate protein-caloric malnutrition as a complication of morbidity and cause of mortality." *"7. The causes and concerns for the weight loss/gain, which will be assessed and provided to, and discusses with the physician, to include, but	F 325		

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F 325	Continued From page 52 not limited to: -a. Depression/Mood/Behavior. -b. Functional limitations. -c. Cultural/ethnic preferences. -d. Environment. -e. Pain. -f. Constipation or Fecal Impaction [severe constipation]. -g. Food texture. -h. Oral/Dental Issues. -i. Swallowing Difficulties/Therapy Screen if indicated. -j. Hydration vs. Dehydration. -k. Medications, polypharmacy [many medications], medications that significantly increase or decrease appetite. Consult Pharmacist. -l. Consider an appetite stimulating medication for residents with weight loss. -m. Acute clinical conditions/signs and symptoms of an infection. -n. Skin/Wound conditions. -o. Psychological [mental/emotional state] stressors, wandering, tremors, agitation, dementia. -p. Exacerbation [make worse] of chronic physiological [normal healthy operation of the body] or psychological conditions." *"10. Consider a med pass supplement and/or caloric dense foods (food fortification, e.g. added protein, fat and/or carbohydrate to foods such as hot cereal, mashed potatoes, casseroles, and desserts." *"13. Document the plan of care and communicate/coordinate interventions with appropriate health care team members." *"17. Provide additional snacks/fluids during activities or during resident contacts." *"20. Complete, concise documentation of the	F 325		

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F 325	Continued From page 53 assessment, discussions and decisions with resident and/or family, physician, dietitian and other appropriate members of the clinical team. This documentation will be a progress note, placed in the dietary section of the resident's medical record."	F 325		
F 371 SS=D	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 This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to: *Monitor and maintain appropriate refrigerator temperatures in two of two kitchenettes (Massa and Berry). *Maintain sanitary conditions in two of two kitchenettes (Massa and Berry). *Ensure appropriate hand hygiene occurred during one of two meal observations by one of three dietary aides (H). Findings include: 1a. Observation on 8/25/15 at 10:20 a.m. of the Massa kitchenette revealed: *There were two refrigerators.	F 371		

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

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F 371	Continued From page 54 -One for staff items. -One for resident items. *The resident refrigerator had items such as juices, supplements, desserts, milk, and cheese. *The thermometer in the resident refrigerator was at 21 degrees Fahrenheit (F). *Items appeared to be cold but not frozen. Observation and interview on 8/25/15 on 10:50 a.m. of dietary aide H in the Massa kitchenette revealed: *He agreed the temperature at that time appeared to be at 24 degrees F according to the thermometer in the refrigerator. *The temperature should have been lower than 40 degrees F. *He agreed below 32 degrees F would have been considered freezing. *The items in the refrigerator did not appear to be frozen. *Dietary staff would have written down refrigerator temperatures every day. *He would have just written down the temperature and not done anything else specifically when the temperature was below 32 F. *The dietary manager reviewed the temperature logs at the end of the month. Further observation and interview on 8/25/15 at 5:45 p.m. with dietary aide K in the Massa kitchenette revealed: *The temperature in the refrigerator appeared to be 28 degrees F. *She thought there might be something wrong with the thermometer. *The temperatures had been that way a long time. *Dietary staff wrote down the temperatures on a log sheet.	F 371	**F371** On 8/28/15, the certified dietary manager (CDM) replaced the thermometers in the Massa and Berry Units. The CDM has revamped the refrigeration temperature log (attached) to reflect the need to take action when temperatures are not within designated range. The CDM will educate staff on 9/18/15 as to proper action and written documentation. The CDM will monitor weekly for a month; then continue monthly and report results to the QAPI Committee at their monthly meetings until 9/30/16. The CDM will educate staff on the importance of keeping the kitchenettes clean and free of debris at a meeting on 9/18/15.The CDM will add the cupboards to the Massa & Berry Unit weekly/monthly cleaning schedule(attached). The cupboards were cleaned in part on9/4/15 and will be completed by 9/18/15. These will be monitored weekly for 2 months; then monthly until 9/30/16. Results will be reported to the QAPI Committee at their monthly meetings until 9/30/16. Food service staff will be educated on 9/18/15 on the appropriate hand washing guidelines to include washing hands before serving on the Massa and Berry Units. The current hand washing policy will be updated to reflect washing of hands prior to serving food. The staff will complete required hand hygiene information and test by 9/22/15. The CDM will monitor hand hygiene on a routine of no less than 4 times weekly for 2 months varying between Units and meals; then weekly until 9/30/16. Results will be reported to the QAPI Committee at their monthly meetings until 9/30/16.	10/16/15

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F 371	Continued From page 55 *She stated nothing in the refrigerator appeared frozen but agreed the temperature would be at freezing. Review of the August 2015 Food/Refrigeration Temp sheet from the Massa kitchenette revealed: *For lunch there were nine documented temperatures. -Those temperatures ranged from 21 to 38 degrees F. *For supper there were eight documented temperatures. -Those temperatures ranged from 14 to 40 degrees F. Review of the August 2015 Food Service Temperature Documentation Form from the Massa kitchenette revealed three documented temperatures. Those temperatures were 20, 34, and 40 degrees F. b. Observation on 8/25/15 at 10:25 a.m. of the Berry kitchenette revealed: *There was one refrigerator that had items such as juices, supplements, desserts, milk, and cheese. *The thermometer in that refrigerator was at 14 degrees F. *Items appeared to be cold but not frozen. Interview on 8/25/15 at 10:30 a.m. of certified nursing assistant (CNA) J in the Berry kitchenette revealed: *She confirmed the thermometer in the refrigerator appeared to say 14 degrees F. *That temperature was not accurate, because things in the refrigerator were not frozen. *She thought the dietary staff reviewed and documented temperatures of the refrigerators	F 371	F371 Refrigeration thermometers were replaced in the refrigerator & freezers units in the Massa and Berry dining room kitchenettes on 8/28/15. The Food Storage policy has been updated to reflect the action plan for when the temperatures are not within the set guide line this includes documentation of the steps taken. Education of staff took place on 9/18/15 which included what to do if the temperatures in the refrigeration units are not with in set guide lines. Each staff was given a copy of the up dated version of the temperature log with highlighted area of what to do in case the temperature is out of range. Monitor of the temperature logs will be done by the CDM . The CDM or designee will report the results to the QAPI Team. The cleanliness of the kitchenettes will be monitored weekly for 2 months and the monthly by the CDM. The CDM will report results of the monitor to the QAPI Team. On 9/18 each staff member was given updated hand washing and glove use policy focusing on what is considered to be contaminated surfaces, each employee was given a quiz to test knowledge of information given them. Employee H has been monitored by the CDM on three occasions. Employee H used appropriate hand washing times and techniques. The CDM or designee will continue to monitor employee H as well has the rest of the staff for appropriate hand hygiene. The CDM or designee will monitor and report results to the QAPI Team. MS	10-7-15

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F 371	Continued From page 56 every day. Further observation on 8/25/15 at 11:55 a.m. in the Berry kitchenette revealed the temperature in the refrigerator was 12 degrees F. Review of the August 2015 Food/Refrigeration Temp sheet from the Berry kitchenette revealed: *For lunch there were five documented temperatures. -Those temperatures ranged from 18 to 29 degrees F. *For supper there were two documented temperatures of 34 and 36 degrees F. Review of the August 2015 Food Service Temperature Documentation Form from the Berry kitchenette revealed three documented temperatures. Those temperatures were 20, 20, and 16 degrees F. c. Review of the Maintenance Work Order log in the kitchen from 3/9/15 through 8/20/15 revealed no documentation maintenance had been updated on the refrigerator temperatures being below 32 degrees F in the Massa and Berry kitchenettes. Interview on 8/26/15 at 9:00 a.m. with the certified dietary manager (CDM) revealed: *She was not aware of a problem with the refrigerator temperatures in the Berry and Massa kitchenettes. *She confirmed below 32 degrees F was considered freezing. *She stated the dietary staff probably needed more education regarding the refrigerator temperature process.	F 371		

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F 371	Continued From page 57 Review of the provider's 2010 Food Storage policy for Refrigerated Food revealed: *"a. All refrigerator units are kept clean and in good working condition at all times. *b. PHF/TCS [potentially hazardous food] foods must be maintained at or below 41 [degrees] F unless otherwise specified by law. Periodically take temperatures of refrigerated foods to assure temperatures are maintained at or below 41 [degrees] F. Temperatures for refrigerators should be between 35-39 [degrees] F. Thermometers should be checked at least two times each day. Check for proper functioning of the unit at the same time." 2a. Observation on 8/25/15 at 10:20 a.m. of the Massa kitchenette revealed an upper cupboard in the corner had several white particles, crumbs, and contained the following items: -Electrical power strip. -Pepper shaker. -Coffee pitcher. -Paper cup. -Seasoning container. -Toothpicks in paper wrappers. Interview on 8/25/15 at 10:50 a.m. with dietary aide H in the Massa kitchenette revealed dietary staff had assigned cleaning duties. Those sheets were kept in the dietary office. b. Observation on 8/25/15 at 10:25 a.m. of the Berry dining room and kitchenette revealed: *At the far end of the dining room: -A microwave with some dried food splatters inside. -Two counter tops by the sink area that had some dark spots that appeared to be from food spills. *In the kitchenette:	F 371		

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F 371	Continued From page 58 -A cabinet that had several water pitchers had a dark sticky residue inside the front edge on the bottom with a dust-like material. -Several drawers had dust and debris inside them and had resident items such as hot cocoa packets, lids, plates, and bowls. Further observation on 8/26/15 at 12:30 p.m. of the Berry dining room and kitchenette confirmed the areas appeared the same as the above observation. c. Interview on 8/25/15 at 5:25 p.m. with dietary aide K revealed: *Cleaning of the kitchenettes was a cooperative effort of the nursing and dietary staff. *She thought the cupboards and drawer cleaning would have been assigned to someone in dietary. Review of the August 2015 Weekly Cleaning Schedule revealed: *Several cleaning tasks were not initialed by staff as completed. *There was no mention of cleaning drawers, cupboards, or counter tops in the Massa or Berry kitchenettes or dining rooms. Review of the August 2015 Monthly Cleaning Schedule revealed: *Several cleaning tasks were not initialed by staff as completed. *There was no mention of cleaning drawers, cupboards, or counter tops in the Massa or Berry kitchenettes or dining rooms. Interview on 8/26/15 at 9:00 a.m. with the CDM revealed: *She agreed if a kitchen/kitchenette surface contacted resident items, such as food or dishes,	F 371		

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F 371	Continued From page 59 it should have been kept clean and sanitary. *She confirmed the drawers, cupboards, and counter tops in Massa and Berry were not on the cleaning schedules. -She needed to adjust the cleaning schedules for them to be included. Review of the provider's 2010 General Sanitation of Kitchen policy revealed: *"1. Cleaning and sanitation tasks for the kitchen will be recorded. *2. Tasks will be assigned to be the responsibility of specific positions. *3. Tasks will be addressed as to frequency of cleaning." Review of the provider's 2010 Cleaning Instructions: Cabinets and Drawers policy revealed "Cabinets and drawers will be free of food particles and dirt. They should be cleaned at least twice a month." 3. Observation and interview on 8/25/15 from 11:55 a.m. through 1:15 p.m. of dietary aide H in the Berry kitchenette during meal service revealed: *He assisted another dietary aide with dishing up and serving residents' food onto trays for the nursing staff to take to the tables. *He had to exit the kitchenette area several times for more supplies. *Upon re-entry to the kitchenette: -He entered a code into the key pad to unlock the door. -Then re-started helping serving residents' food. -Each time he re-entered the serving area he did not perform hand hygiene prior to serving food. *He agreed the key pad and door knob to enter the kitchenette were not clean surfaces.	F 371		

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F 371	Continued From page 60 *He agreed he had not washed his hands and should have each time he had entered the kitchenette. Interview on 8/26/15 at 9:00 a.m. with the CDM confirmed staff should have washed their hands each time they entered the kitchenette prior to working with residents' food. Review of the provider's 6/11/13 Proper Handwashing for Food Service policy revealed: *"Clean hands and exposed portions of arms immediately before engaging in food preparation including working with exposed food. *1. When to wash hands: -After handling soiled equipment or utensils. -During food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. -After engaging in other activities that contaminate the hands." Review of the provider's 6/11/13 Proper Glove Usage policy revealed "Hands are to be washed when entering the kitchen."	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		

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F 431	Continued From page 61 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to: *Have a system in place for secure storage of all new narcotic (for controlling pain) medications awaiting destruction in the absence of the director of nursing (DON). *Provide clean storage for the separation of internal medications such as oral (by mouth), injectable (through the skin), inhaled (through the lungs), and eye drops away from external/topical (applied onto skin or wounds) medications for two of two observed treatment carts.	F 431	**F431** All controlled medications awaiting destruction will be kept in the medication cart and continued to be counted until they can be hand delivered to the DON who will then place them in a locked drawer in her desk until the pharmacist is scheduled to destroy them. This way assuring they are kept in an area with a double lock. Medications stored in the medication carts will be by internal and external delivery methods. Education will be given to all employees, including med-aide C, at a staff meeting on 9/22 & 9/23,regarding controlled medications and separation of meds in the med cart. Med carts will be checked weekly by DON or designee for compliance for one month; then monthly until 9/30/16. Results will be reported at the QAPI Committee monthly meetings until 9/30/16. **F431** Policy has been updated to reflect current practice of narcotic handling. The DON or designee will report to the QAPI at their monthly meetings. MS	9/23/15 10-7-15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 62 Findings include: 1. Observation on 8/26/15 from 2:30 p.m. through 4:30 p.m. during the medication room/medication cart review of the Massa and Berry units revealed secured double-locked storage areas for narcotics in both medication rooms and medication carts. Interview on 8/16/15 at 3:00 with the resident care coordinator revealed: *When a narcotic medication was discontinued or was up for destruction the nurse removed it from the medication cart, stapled it to the medication count record, and placed it in the DON's office until it could be destroyed when the pharmacist was in the building. *There was a locked cabinet in the DON's office for secured narcotic storage. *Only the DON and the resident care coordinator had a key to her office. *The DON was the only person with a key to the locked storage in her office. *When the DON was not present the narcotic medication was placed under her door until the DON returned to work. *The narcotic medication placed under the door was only secured by one lock. *She was aware narcotic medication required double-locked security. Interview on 8/26/15 at 3:30 p.m. with medication aide C confirmed the narcotics awaiting destruction in the absence of the DON were stapled to the narcotic sheet, and they were then placed under the DON's door until she returned to work. 2. Observation on 8/26/15 between 2:30 p.m.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435102		08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 63 through 4:30 p.m. of the treatment carts on the Massa and Berry units revealed several drawers on both carts contained multiple internal medications stored beside external medications. there was no barrier in place to separate the medications. 3. Interview on 8/26/15 at 5:15 p.m. with the DON revealed: *She was aware the narcotic medications up for destruction in her absence should have been double-locked. *Internal medications and external medications should not have been stored together without a barrier separating them. 4. Review of the provider's June 2013 Medication Administration policy revealed "All class II, III, & IV medications [would include narcotics] are to be checked and accounted for every shift by two licensed nurses. No controlled substance will be surrendered to any person for any reason, including physicians."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and 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	**F441** On 9/22 & 9/23 education regarding proper glove use will be provided to all staff, including RN-D, LPN-E, in regards to all residents, including resident 7, 19,18,20, for proper compliance in hand hygiene policy and in accordance with procedure involved. Monitoring will be completed by DON or designee daily for one week; then weekly for 4 weeks; then monthly thereafter until 9/30/16 to assure compliance. Findings will be reported to the QAPI Committee at their monthly meetings until 9/30/16.	9/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435102		08/27/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 64 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: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure sanitary conditions had been followed for hand hygiene and glove use for: *One of two random residents and one of thirteen sampled residents (11 and 18) receiving wound care. *Three of three randomly observed residents (7, 19, and 20) receiving glucose meter (device to check blood sugar levels) checks. *One of thirteen sampled residents (7) receiving	F 441	F441 Regional Health as a whole has changed the hand hygiene policy and monitoring practices. Infection control and DON provided education regarding hand hygiene which included wound care, glucometer usage, personal cares for all residents, including residents 7,18,19,20. Education was completed through a mandatory on-line education session that required employee to demonstrate understanding by taking a test. DON or designee will report the results to the QAPI at their monthly meetings. MS	10-7-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

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F 441	Continued From page 65 personal care. Findings include: 1. Observation on 8/25/15 at 10:15 a.m. of registered nurse (RN) D providing wound care to resident 18 revealed she used alcohol gel to cleanse her hands and then put on gloves. With her gloved hands she: *Opened the treatment cart and obtained ointment and gauze pads (a type of dressing). *Locked the treatment cart. *Knocked on the resident's door and entered the resident's room. *Assisted another resident in that room who required help sitting back in her chair. *Removed those gloves, applied alcohol gel, then removed another pair of gloves from her pocket, and applied those gloves. *With those gloves she: -Pulled down resident D's clothing. -Used a tongue blade to apply ointment to her buttocks wound. With the same gloves she: -Reapplied the brief and pulled up her pants. -Adjusted her boot. -Pulled up the bed linens to cover her. At that time she removed those gloves and cleansed her hands with alcohol. 2. Observation on 8/25/15 at 10:55 a.m. of RN D obtaining a blood sugar test for resident 19 using a glucose meter revealed she applied alcohol gel to cleanse her hands. She put on gloves, and then: *Opened the drawer and removed glucose testing equipment from the treatment cart. *Locked the cart. *Located the resident and cleansed her skin with an alcohol pad. *Set-up the glucose meter.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435102		08/27/2015

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STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

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F 441	Continued From page 66 *Pricked the resident's finger with a disposable device to obtain blood. *Wiped the blood from her finger, and then obtained a blood sample for the test. *Obtained the test result. *Only at that time did she remove her gloves and cleanse her hands. 3. Observation on 8/25/15 at 11:00 a.m. of RN D obtaining a blood sugar test for resident 20 using a glucose meter revealed she applied alcohol get to cleanse her hands and put on gloves. With those glove on she then: *Opened the drawer and removed testing equipment from the treatment cart. *Locked the cart. *Knocked on the resident's door and opened it. *Opened the bathroom door. With those same gloves on she: *Cleansed the resident's finger with an alcohol wipe. *Pricked her finger with a disposable device to obtain blood. *Wiped the blood from her finger and obtained a blood sample for the test. *Obtained the test result. *Only then did she remove the gloves, put the glucose meter away, and cleansed her hands. 4. Observation on 8/26/15 at 9:15 a.m. of licensed practical nurse (LPN) C obtaining a blood sugar test using a glucose meter for resident 7 revealed she applied alcohol to cleanse her hands. She then gathered the glucose meter equipment and put on her gloves. With these gloves on, she: *Locked the treatment cart. *Carried the equipment to the resident's room. *Opened the door to the room, and with the same	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

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F 441	Continued From page 67 gloves she: *Cleansed the resident's finger with an alcohol wipe. *Pricked his finger to obtain blood. *Wiped the blood from his finger and obtained a blood sample for the test. *Obtained the test result. *Only then did she remove her gloves and cleanse her hands with alcohol. 5. Interview on 8/26/15 at 5:15 p.m. with the DON revealed: *She would have expected the nurses to apply fresh gloves after they had touched doors, drawers, equipment, and prior to performing invasive (entered the body through the skin or body opening) procedures. *She would have expected staff to apply clean gloves after performing resident wound care and before touching the resident's clothing and environment. *She believed the staff required more education on proper glove use. Surveyor: 32573 5. Observation on 8/26/15 at 12:10 p.m. of resident 11 revealed: *He had wheeled himself in his wheelchair out of the dining room. *Nurse L had moved him into the library. *She put on gloves. *She reached into her pocket and took out an alcohol wipe. *She wiped off an open wound on the resident's face. *She then wheeled the resident back into the hallway wearing those same gloves with the used alcohol wipe in one hand touching the right handle of his wheelchair.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 68 *She removed the gloves. *She did not wash her hands after removing the gloves. *She used hand sanitizer and continued to work. Surveyor: 35237 6. Observation and interview on 8/26/15 at 9:40 a.m. of resident 7's personal care with CNA G revealed: *He was in bed, and she was getting him up for breakfast. *She assisted him with personal care including private area care, mouth care, hair brushing, and dressing. *She performed hand hygiene and put on gloves then she: -Used wet disposable cloths to wipe the resident's buttocks (bottom area) since he had been incontinent (unable to control bowel movements). -Ran out of wipes. -Went to a dresser and opened the drawer to get more disposable wipes. -Went to the sink and turned on the faucet. -Wet the wipes with water. -Sprayed perineal (private area) wash onto the wipes. -Returned to the resident and continued to wipe his buttocks. -Pulled up his disposable brief and pants. -Then removed her gloves and threw them in the trash. *CNA G confirmed the above was her usual practice. *She agreed there was a risk of contamination to the surfaces she had touched with those dirty gloves. Interview on 8/26/15 at 4:25 p.m. with the DON confirmed she would expected infection control	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435102		08/27/2015

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F 441	Continued From page 69 practices to have been maintained. She agreed there was a potential to contaminate other surfaces if they had been touched with dirty gloves. 7. Review of the provider's August 2010 Hand Hygiene Policy revealed: *"1. Indications for hand hygiene: -a. When hands are visibly dirty or contaminated with proteinaceous [containing proteins/germs] material or are visibly soiled with blood or other body fluids, wash hands with either and antimicrobial [kills germs] soap and water or a non-antimicrobial soap and water. -b. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. If alcohol-based hand rub in not available, wash hand with an antimicrobial soap and water." *"c. DECONTAMINATION OF HANDS should take place in the following conditions:" -"a. Before having direct contact with patients/residents." -"e. After contact with a patient's/resident's intact skin." -"f. After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressing if hands are not visibly soiled." -"g. When moving from a contaminated body site to a clean body site during patient/resident care." -"h. After contact with inanimate objects including medical equipment, in the immediate vicinity of the patient/resident." -"i. After removing gloves." Review of the provider's revised May 2015 Exposure Control Plan policy revealed: *"1. The use of gloves will vary according to the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 70 procedure involved. The use of disposable gloves is indicated for procedures where body fluids are handled and includes the following: -if it can be reasonably anticipated that the employee's hands will come in contact with blood or body fluids [saliva, urine, bowel movements, sweat], excretions [expel waste], secretions [substance produced by the body], mucous membranes [mucus from the body], or other potentially infectious materials while performing the procedure; -if the employee has any cuts, scrapes, wounds, chapped skin, dermatitis, etc., on his/her hands; -when handling soiled linen or contaminated items or touching contaminated surfaces; -when cleaning up spills or splashes of blood or body fluids and decontaminating procedures; and whenever in doubt. *2. Surgical or examination gloves shall not be washed or disinfected for reuse. They shall be used only once and discarded into appropriate receptacle located in the room. *3. Disposable (single use) gloves must be replaced as soon as practical when contaminated or as soon as feasible if they are torn or punctured and when they exhibit signs of deterioration or when their ability to function as a barrier is compromised." *"5. Hand washing is necessary when gloves are removed."	F 441		

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

ORIGINAL

PRINTED: 09/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MASSA B. WING	(X3) DATE SURVEY COMPLETED
	435102		08/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/25/15. Sturgis Regional Senior Care building 1 (Massa) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 9-18-15

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.

SEP 21 2015

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

ORIGINAL

PRINTED: 09/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02 - BERRY** B. WING	(X3) DATE SURVEY COMPLETED
	435102		**08/25/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	**949 HARMON STREET** **STURGIS, SD 57785**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
	Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/25/15. Sturgis Regional Senior Care building 2 (Berry) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K038, K045, and K047 in conjunction with the provider's commitment to continued compliance with the fire safety standards.			
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	**K045** Light fixtures in the Berry Unit stairway will be installed by approved vendor by 10/16/15. Plant Operations Manager will notify DON & QAPI Committee, at their monthly meeting, when work is complete.	10/16/15
	This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain adequate illumination of the means of egress in both stair enclosures (northwest and east) from the basement of the Berry unit. Only one fixture was installed in each of the stair enclosures. Findings include: 1. Observation at 8:15 a.m. on 8/25/15 revealed the light fixture in the northwest exit stair enclosure from the basement of the Berry unit			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9-8-15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BERRY B. WING	(X3) DATE SURVEY COMPLETED
	435102		08/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

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K 045	Continued From page 1 was only a single bulb fixture. Further observation at 8:30 a.m. revealed the east stair enclosure from the basement of the Berry unit had a single light fixture (dual lamp flourescent fixture) installed overhead. Those areas would be left in darkness in an egress emergency if the fixtures were to fail. Interview with the operating manager of plant operations confirmed those conditions. The deficiency affected one of several requirements for the illumination of the means of egress.	K 045		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to furnish exit signs to ensure the path of egress to exits were identified (Berry unit basement and the dining room to the corridor system). Findings include: 1. Observation at 8:20 a.m. on 8/25/15 revealed the Berry unit basement was not equipped with exit signs with continuous illumination served by the emergency lighting system to the stair enclosures. 2. Observation at 8:35 a.m. on 8/25/15 revealed the Berry unit dining room had two exterior doors	K 047	**K047** Exit signage will be installed in the Berry Unit basement and Berry Unit dining area to insure proper signage by approved vendor by 10/16/15. Plant Operations Manager will notify DON & QAPI Committee, at their mónthly meeting, when work is complete.	10/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING 02 - BERRY B. WING _____	08/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

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K 047	Continued From page 2 in close proximity to each other marked as exits in the north wall. The doors to the corridor system were not marked with an exit sign with continuous illumination served by the emergency lighting system. 3. Interview with the operating manager of plant operations at the time of the observation confirmed those findings. The deficiency had the potential to affect occupants of the basement and residents occupying the dining room.	K 047		

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

ORIGINAL

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435102	MULTIPLE CONSTRUCTION A. BUILDING: 02 - BERRY B. WING _____	DATE SURVEY COMPLETE: 8/25/2015
NAME OF PROVIDER OR SUPPLIER STURGIS REGIONAL SENIOR CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 949 HARMON STREET STURGIS, SD		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 038	NFPA 101 LIFE SAFETY CODE STANDARD

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1

This STANDARD is not met as evidenced by:
Surveyor: 18087
Based on observation and interview, the provider failed to ensure the door at one randomly observed location (exterior door for the Berry unit dining room) was readily accessible at all times. Findings include:

1. Observation and interview beginning at 9:30 a.m. on 8/25/15 revealed the east exterior exit door for the Berry dining room was obstructed with a chair and two stools on wheels The chair and stools were directly in front of the marked exit door. Interview with the operating manager of plant operations at the time of the observation confirmed the finding. He indicated the floor could be marked to show an area to be kept clear. The chair and stools were relocated during the survey.

The deficiency had the potential to affect all residents in the dining room area in an emergency situation.

K038
Floor tape marking was placed 9/15/15 by Plant Operations manager to indicate clear exit of area. Weekly checks for obstruction will be performed by Plant Operations manager or designee for one month; then quarterly thereafter through the plant operations preventative maintenance program. Any finding will be reported to DON and Quality Assurance Performance Improvement Committee at their monthly meeting.

9/23/15

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

The above isolated deficiencies pose no actual harm to the residents

SEP 21 2015

031099

Event ID: PLCI21

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

ORIGINAL

PRINTED: 09/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - ADMIN** B. WING _____	(X3) DATE SURVEY COMPLETED
	435102		**08/25/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	**949 HARMON STREET** **STURGIS, SD 57785**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/25/15. Sturgis Regional Senior Care Building 3 (Administration) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 9-18-15

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.

ORIGINAL

PRINTED: 09/09/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10693		08/27/2015

NAME OF PROVIDER OR SUPPLIER: STURGIS REGIONAL SENIOR CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 949 HARMON ST, STURGIS, SD 57785

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/25/15 through 8/27/15. Sturgis Regional Senior Care was found not in compliance with the following requirement: S360.	S 000		
S 360	44:04:13:01 Application of chapter This chapter applies to all new facilities and to renovations, additions, and changes in space use of currently approved existing facilities. Accessible and usable accommodations must be available to the public, staff, and...residents with disabilities. Minimum requirements, except as noted in this chapter are those in "ADA Accessibility Guidelines for Buildings and Facilities." 28 C.F.R., Part 36, Appendix A, as published in 56 Fed. Reg. 35605 to 35690, inclusive (July 26, 1991), http://www.usdoj.gov/crt/ada/req3a.html#Anchor-Appendix-52467. Facilities must comply with NFPA 101 Life Safety Code, 2000 edition. Facilities must also comply with the building construction standards of the International Building Code, 2000 edition. Facilities providing off-site services must comply with "Business Occupancy standards or other occupancies standards as applicable for the use of the facility from "NFPA 101 Life Safety Code, 2000 edition, and construction standards of the International Building Code, 2000 edition for the buildings where these services are offered.	S 360	**S360** Handicapped restroom sinks will be raised to regulation height by 10/16/15. The Plant Operations Manager will notify the DON and QAPI Committee, at their monthly meeting, when the work is complete.	10/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Administrator

(X6) DATE: 9-18-15

SEP 21 2015

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	10693		08/27/2015

NAME OF PROVIDER OR SUPPLIER: STURGIS REGIONAL SENIOR CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 949 HARMON ST, STURGIS, SD 57785

(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 360	Continued From page 1 This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain accessibility requirements at one randomly observed toilet room identified as handicap accessible (men's public toilet room). Findings include: 1. Observation of the men's public toilet room at 8:00 a.m. on 8/25/15 revealed the men's public toilet room located at the Berry unit nurse station was identified with signage designating the toilet room as handicap accessible. Further observation within the toilet room revealed the following item did not conform to accessibility requirements. The bottom of the leading edge of the lavatory measured 26-1/2 inches above the finished floor. The minimum clearance from the finished floor to the bottom of the front edge of the lavatory must not be less than 29 inches (the top edge of the lavatory rim or counter surface must not be more than 34 inches above the finished floor). Interview with the operating manager of plant operations at the time of the observation confirmed that finding. He was unaware the toilet room did not meet accessibility requirements.	S 360		