

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

ORIGINAL

PRINTED: 09/08/2016
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2016 |
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| NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301 | |
| (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: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/22/16 through 8/24/16. Avera Brady Health and Rehab was found not in compliance with the following requirements: F157, F223, F226, F281, F314, F323, F514, and F520. | F 000 | *Addendums noted with an asterisk per 9/27/16 per telephone with facility administrator. DN/SDDOHIEL | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. | F 157 | 1. Resident 15 deceased. All other residents who have had a fall with injury since 8/24/16 will be reviewed by 10/13/16 to assure compliance with notification of physician and representative as outlined in the Notification of Condition Change policy revised 9/2016. Resident 7—physician notified of change in skin condition on 5/13/16. Resident 7's pressure ulcer resolved on 6/8/16 and no further pressure ulcers developed. All other residents with pressure ulcers identified on their skin ulcer assessment since 8/24/16 will be reviewed to assure compliance with notification of physician and representative. This review will be completed by 10/13/16. | 10/13/16 |

RECEIVED
SEP 19 2016
SD DOH/BOC

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

TITLE

Julie Hoffmann

Administrator

(X6) DATE

SEP 16/16

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

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| F 157 | <p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to notify the physician in a timely manner of: *The development of a pressure ulcer for one of one sampled resident (7). *An unwitnessed fall for one of one sampled resident (15) who died. Findings include:</p> <p>1. Review of resident 7's medical record revealed he had developed a stage two pressure ulcer on 5/7/16. The physician had not been notified until 5/13/16. Refer to F314, finding 1.</p> <p>Surveyor: 33488 2. Review of resident 15's medical record revealed: *She had fallen on 11/18/15 at 10:00 p.m. *Her physician or the on-call physician was not notified at the time of her fall. *At 3:00 a.m. on 11/19/15 per Provider/Family Notification LPN B contacted eLTC per phone and " Talked to ___ [name] about resident and my concern of aspiration, went over her meds and what I am doing. He stated to just cont to monitor resident at this time. " *There was no clarification of identity or credentials of the individual at eLTC. *Her local physician was not notified until after her</p> | F 157 | <p>2. Notification of Condition Changes Policy and Fall Huddle Checklist revised to include immediate physician notification for any fall with injury. Draft revisions to the Notification of Condition Changes Policy verbally reviewed with charge nurses on duty 8/29/16 and 8/30/16 and communicated through shift to shift report thereafter. Fall Huddle checklist document provided to all charge nurses on 8/29/16. Written education about notifying physician immediately of any fall with injury and within 24 hours of development of a pressure ulcer given to all nursing staff on 9/1/16. All charge nurses will be educated on Notification of Condition Change Policy, Fall Assessment Policy and the Fall Huddle Checklist at a mandatory charge nurse meeting on 9/19/16. All CNA's will be educated on the Fall Assessment Policy and Fall Huddle Checklist at mandatory CNA meetings on 9/19/16 and 9/21/16. Acute Care Policy dated March 2009 deleted as content incorporated into Notification of Condition Changes Policy.</p> | |

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| F 157 | Continued From page 2 death on 11/19/15 at 4:25 a.m. Refer to F223, finding 1. 3. Review of the provider's March 2009 Acute Care Policy revealed: *All residents were to have received timely and accurate assessments and interventions for acute care episodes, and they must have been documented. *All acute care episodes were to have been assessed by the charge nurse. *Shortness of breath assessments were to have included lung sounds each time. *Falls were to have included the assessment for the cause of the fall. | F 157 | 3. The DON or designee will conduct weekly audits on the proper notification of physicians for all residents that fall with injury and present with a pressure ulcer. The findings from these audits will be reported monthly to the QAPI committee for 6 months by the DON or designee. When the QAPI committee determines otherwise, based on compliance the audits may be decreased or discontinued. | |
| F 223 SS=G | 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review, interview, professional standard review, and policy review, the provider failed to appropriately assess, monitor, document, and intervene for one of one resident (15) after an unwitnessed fall until the time of her death. Findings include: 1. Review of resident 15's medical record | F 223 | 1. Resident #15 deceased. On 8/31/16, administrator obtained documentation of Resident #15 eLTC consult encounter from eLTC nurse manager. This documentation reflected the name of the provider and credentials were PA -C. Notification review will be completed by 10/13/16. All notifications since 8/24/16 will be reviewed to assure compliance with the Abuse and Neglect policy. 2. On 11/19/15, counseled LPN B on notification of condition changes and adherence to professional practice standards, assessment, intervention and documentation for Res. #15 and incorporated into LPN B's individual performance review process. Will | 10/13/16 |

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| F 223 | <p>Continued From page 3</p> <p>revealed:</p> <ul style="list-style-type: none"> *She had been in the facility since January 2012. *She had diagnoses of senile dementia, high blood pressure, depression, vascular disease, transient ischemic attack (TIAs), osteomyelitis in her foot, and history of a hip fracture. *Her most recent 9/21/15 Brief Interview for Mental Status (BIMS) assessment score was 8. That score reflected moderate mental impairment. *Her 9/21/15 care plan revealed: <ul style="list-style-type: none"> -She was incontinent of bladder and bowel and had frequent loose stools. She wore disposable briefs. -She was identified as a fall risk related to her diagnosis of dementia and osteoporosis. -She used an edge mattress, and her bed was to have been in a low position. -She would attempt to transfer herself at times. -She needed extensive assistance of one staff person. <p>Review of her fall record for 11/18/15 revealed the following documentation by licensed practical nurse (LPN) B:</p> <ul style="list-style-type: none"> *Her vital signs at the time of that fall were: <ul style="list-style-type: none"> -Temperature: 95.4 degrees Fahrenheit (F) (normal 97.8 F to 99.1 F). -Heart rate: 148 beats per minute (bpm) (normal 60 to 100 bpm). -Respiratory rate: 26 breathes per minute (normal 12 to 18 per minute) -Blood pressure: 168/135 millimeter of mercury (mm/hg) (normal 90/60 mm/hg to 120/80 mm/hg). *Narrative nurses notes reflected: <ul style="list-style-type: none"> -The resident was found lying on her floor positioned between her bed and the recliner. -Had a loose BM and was vomiting. -She was assisted back to bed with the | F 223 | <p>review scope and standards for nursing practice and appropriate collaboration with RN prior to returning from LOA.</p> <p>Notification of Condition Changes Policy revised to include immediate physician notification for any fall with injury. Draft revisions to the Notification of Condition Changes Policy verbally reviewed with charge nurses on duty 8/29/16 and 8/30/16 and communicated through shift to shift report thereafter. Written education on notifying physician immediately for any fall with injury given to all nursing staff on 9/1/16. Written education on the RN/LPN Scope and Standards of Nursing Practice given to all charge nurses on 9/1/16. All charge nurses will be educated at a mandatory meeting on 9/19/16: Abuse and Neglect policy, Notification of Condition Change Policy, RN and LPN Scope and Standards of Nursing Practice and INTER-ACT Care Paths to support clinical decisions and application of nursing process.</p> | | |

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| F 223 | <p>Continued From page 4</p> <p>assistance of 3 staff and the Hoyer mechanical lift was used. She continued to have a small emesis.</p> <p>-Vital signs and neurological checks were started "as resident could not state if she had hit her head."</p> <p>-She kept asking for staff to "help her." Her respiratory rate was again acknowledged as "fast" and oxygen saturation was 94%.</p> <p>*She was noted to be confused at the time of the fall.</p> <p>Continued review of resident 15's medical record revealed: At 10:30 p.m. per the Neuro Checks Post Injury: *She was alert and agitated. *Her Glasgow Coma Scale score was 14 (normal is 16). *She had confused conversation. *Her pupils were both non-reactive, 4 mm in size and round. *Vital signs: -Temperature: 97.4 F. -Heart rate: 136 bpm. -Respiratory rate: 26 breaths per minute. -Blood pressure: 171/95 mm/hg. -Oxygen saturation: 93% *LPN B noted "Presenting with lung sounds rales bil. all lobes."</p> <p>At 11:00 p.m.: *She was alert and awake. *She Glasgow Coma Scale score was 14. *she had confused conversation. *Her pupils were noted as: -Right pupil was non-reactive, 4 mm in size and round. -Left pupil was non-reactive, 3 mm in size and round. *Vital signs:</p> | F 223 | <p>All CNA's will be educated on the Abuse and Neglect policy during mandatory CNA meetings 9/19/16 & 9/21/16. All other facility staff will be educated on the revised Abuse and Neglect policy by 9/22/16. Mandatory Abuse prevention training is included in new associate orientation and annual training for all associates.</p> <p>3. The DON or designee will conduct weekly audits to ensure compliance with the Abuse and Neglect Policy and report findings from these audits monthly to the QAPI committee. When the QAPI committee determines otherwise, based on compliance the audits may be decreased or discontinued.</p> | | |

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| F 223 | <p>Continued From page 5</p> <ul style="list-style-type: none"> -Temperature: 96.5 F. -Heart rate: 26 bpm. -Blood pressure: 171/95 mm/hg. -Oxygen saturation: 88% and LPN B had "Turned up the oxygen level to help with Sats." <p>At 11:30 p.m.:</p> <ul style="list-style-type: none"> *Vital signs: -Temperature: 97.4 F. -Heart rate: 128 bpm. -Blood pressure: 154/78 mm/hg. -Oxygen saturation: 81% and LPN B had "Turned O2 up to 3 to help Sats up to 88 on 3 L[liters]. Lung sounds continued to be "rales" bilaterally. <p>At 2:00 a.m. on 11/19/15 LPN B documented an IV assessment (assessment of IV access site).</p> <p>At 3:00 a.m. on 11/19/15 per Provider/Family Notification LPN B contacted eLTC per phone and "Talked to ___ [name] about resident and my concern of aspiration, went over her meds and what I am doing. He stated to just cont to monitor resident at this time."</p> <ul style="list-style-type: none"> *There was no clarification of identity or credentials of the individual at eLTC. *There was no further documentation to show what information was made available to the above unidentified individual. <p>At 3:30 a.m.:</p> <ul style="list-style-type: none"> *Resident 15 was lethargic and drowsy. *Her Glasgow Coma Scale score had decreased to 10. *Her pupils were noted as: -Right pupil was non-reactive, 3 mm in size and round. -Left pupil was non-reactive, 3 mm in size and round. <ul style="list-style-type: none"> *Vital signs: -Temperature: 97.4 F. -Heart rate: 123 bpm. -Respiratory rate: 24 breaths per minute. Oxygen | F 223 | | |

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| F 223 | <p>Continued From page 6 saturation was 81%. -Blood pressure: 141/86 mm/hg. At 3:39 a.m. per a narrative note LPN B revealed: *Resident 15 "fell at 2200 on 11/18 vitals are in fall and vitals but lung sounds have been rales bil, with O2 Sats dropping." **"Questioning possible aspiration as resident did have an emesis while on the floor and while we were getting her up." **"Did a prn [as needed] Duoneb treatment that did help. O2 Sats cont to be at 81% so I called ELTC and went thru what happened, her meds, and what I had been doing." **"/ [name] stated to cont to monitor." *Resident 15 continued to have "low Sat and O2 is on 4L." *The following addendum to the above note was added on 11/19/15 at 11:39 p.m. by LPN B. -"Resident had c/o nausea after supper while getting ready for bed but had no emesis at that time. Had stated she was feeling better when I checked on her at 2000 [10:00 p.m.]. At 4:20 a.m. per Provider/Family Notification LPN B revealed a family member was contacted at that time and "Notified daughter of resident's death." At 5:20 a.m. per narrative note LPN B revealed: **"Resident found with no pulse and no respirations at 0415 [4:15 a.m.]. CNAs prepared her for the family and funeral home while I called the family and Dr. --- [name]." **"Family arrived at 0515. Resident's glasses will be sent with her to the funeral home." *The following addendum to the above note was added on 11/19/15 at 11:39 p.m. by LPN B. -"Resident did have coffee ground emesis at the time of death and another loose stool which was also coffee ground in appearance." *There was no further documentation LPN B had</p> | F 223 | | |
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| F 223 | <p>Continued From page 7</p> <p>intervened in any other way than the call placed to the unidentified eLTC individual at 3:00 a.m.</p> <p>*There was no documentation LPN B had conferred with or involved the RN on duty in the facility about the care needs of resident 15.</p> <p>Review of the staffing schedule for the night of 11/18/15 revealed:</p> <p>*LPN B was on duty on the Vasek and Brooke halls.</p> <p>-She was unavailable for interview at the time of the survey due to leave status.</p> <p>*An RN was on duty in the other half of the facility on the Harmony and Rehab halls.</p> <p>Interview and review of resident 15's record, LPN job description, and facility policies on 8/24/16 at 1:00 p.m. with the director of nursing (DON) revealed:</p> <p>*She agreed the LPN job description indicated LPNs were:</p> <ul style="list-style-type: none"> -Able to assist with an assessment. -Were to identify and communicate information to the health care team. -To adhere to professional practice standards. -To recognize critical physical assessment data, use nursing judgment, and notify the RN and/or physician. <p>*She would have expected LPN B to have documented notification to the RN had she notified her of resident 15's medical status.</p> <p>*She was not aware who the unidentified individual was at eLTC that LPN B had contacted.</p> <p>*She acknowledged they had used eLTC in addition to the local providers and had used the services in the past for urgent care needs.</p> <p>*She was not aware of all of the details of resident 15's fall and care surrounding the event.</p> <p>-Felt they had investigated and fall and event</p> | F 223 | | |
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| F 223 | <p>Continued From page 8 appropriately.</p> <p>*Following review of the record:</p> <ul style="list-style-type: none"> -She agreed there was not a thorough fall investigation. -She agreed not all of the details in the investigation report were consistent in the nurse notes. -She agreed there was a lack of documentation in the resident record to support appropriate monitoring and care interventions had occurred. <p>*Review of the following provider policies reflected:</p> <ul style="list-style-type: none"> -She agreed LPN B had not followed the intent of the Notification of Condition Changes July 2015 and Emergency Physician Care July 2007 policies. LPN B had not notified the attending physician or the physician on call for him, nor involved the RN on duty. -She agreed in completing the investigation they had not followed the intent of the Abuse Prevention July 2015 policy that included, ... Neglect was defined as "A failure, through inattentiveness, carelessness, seclusion, or omission, without a reasonable justification, to provide timely, consistent and safe services, treatment and care to a resident.".. and ..."When all sources of information have been exhausted and a conclusion has been reached, complete a final report that includes what measures will be taken to prevent reoccurrences of the same or similar event."... <p>Review of the current Administrative Rules of South Dakota 20:40:04:01 Scope and standards of nursing practice acknowledged on 08/24/16 at 2:00 p.m. with the administrator as what the provider utilized as their standard of practice policy revealed:</p> <p>""The LPN shall:</p> | F 223 | | | |

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| F 223 | <p>Continued From page 9</p> <ul style="list-style-type: none"> -Contribute to the nursing assessment. -Participate in care planning and nursing interventions. -Contribute to nursing interventions. *They may practice as follows: <ul style="list-style-type: none"> -With at least minimal supervision when providing supervision in a stable nursing situation. -With direct supervision when providing supervision when providing care in a complex nursing situation. *Consult with an RN or other health team members and seek guidance as necessary and shall obtain instruction and supervision as necessary."... <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 279, regarding clinical decisions revealed: *"Your ability to make clinical decisions depends on application of the nursing process." *"When you begin a patient [resident] assessment, the first activity involves a focused but complete assessment of the patient's condition so you are able to make an accurate judgment about his or her nursing diagnosis and collaborative health problem." *"You develop a plan of care, implement nursing interventions, and evaluate patient outcomes." *"The process requires clinical decision making using a critical thinking approach." *"If you do not make accurate clinical decisions about a patient, undesirable outcomes will probably occur."</p> | F 223 | | |
| F 226 SS=E | <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit</p> | F 226 | <p>1. Resident #15 deceased. For residents #10, #6, #7 and all other residents who have fallen since 8/24/16, the internal notification will be updated to reflect a completed</p> | 10/13/16 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2016 |
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| NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301 |
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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 |
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| F 226 | <p>Continued From page 10 mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate falls for the potential of abuse and neglect for four of four sampled residents (6, 7, 10, and 15). Findings include:</p> <p>1. Review of resident 10's medical record revealed he had a fall on 7/9/16 that resulted in a fracture to his right elbow. There was no documentation to support a thorough investigation had been done. Refer to F323, finding 1.</p> <p>2. Review of resident 6's medical record revealed he had the following falls: *1/10/16 with a minor injury. *1/22/16 with a minor injury. *2/6/16 with no injury. *2/7/16 with a minor injury. *6/8/16 with a minor injury. *8/3/16 with a minor injury. *There was no documentation to support a thorough investigation had been done for each of the above falls. Refer to F323, finding 2.</p> <p>3. Review of resident 7's medical record revealed he: *Had the following falls: *3/17/16 with a minor injury. *4/8/16 with no injury. *4/11/16 with no injury.</p> | F 226 | <p>investigation by 10/13/16.</p> <p>2. Notification of Condition Changes Policy and Fall Huddle Checklist revised to include immediate physician notification for any fall with injury and notification completed by RN. Draft revisions to the Notification of Condition Changes Policy verbally reviewed with charge nurses on duty 8/29/16 and 8/30/16 and communicated through shift to shift report thereafter. Fall Huddle Checklist document provided to all charge nurses on 8/29/16. Written education about notifying physician immediately of any fall with injury given to all nursing staff on 9/1/16. All charge nurses will be educated on Notification of Condition Change Policy, Fall Assessment Policy, Fall Huddle Checklist and Alleged Victim & Abuse Prevention policy at a mandatory charge nurse meeting on 9/19/16. All CNA's will be educated on the Fall Assessment Policy, Fall Huddle Checklist and Alleged Victim Abuse and Abuse Prevention Policy at mandatory CNA meeting on 9/19/16 and 9/21/16. Abuse prevention training is included in new associate</p> | |
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| NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301 | | |
| (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) | (X6) COMPLETION DATE |
| F 226 | <p>Continued From page 11 *7/19/16 with minor injury. *8/5/16 with no injury. *8/13/16 with no injury.</p> <p>Review of the internal notification forms for resident 7 revealed there was no documentation that a thorough investigation had been completed for each of the above falls. That form was not a part of the resident's medical record. There was no documentation in the chart an investigation for each fall had been conducted.</p> <p>4. Interview on 8/24/16 at 10:35 a.m. with the assistant director of nursing and the director of nursing regarding the investigation into the falls for the above residents revealed: *The only investigation they had was an internal notification form that went to staff. -That form was not part of the medical record. *There had been no other documentation regarding the investigations in the residents' medical charts.</p> <p>Surveyor: 33488</p> <p>5. Review of the Review of the Incident/Fall Investigation report for resident 15 regarding her fall on 11/18/15 revealed: *A report filed to the South Dakota Department of Health on behalf of the provider, gave a brief description of the events surrounding the incident. *Those details were: -"The resident reported nausea after supper. -No emesis at that time. -At 2000 [8:00 p.m.] resident reports feeling better. -Resident noted to fall at 2200 [10:00 p.m.]. -When resident was found on the floor, also noted emesis and loose BM on the floor.</p> | F 226 | <p>orientation and annual training for all associates which is mandatory.</p> <p>3. DON or designee will review all internal notifications to ensure a thorough investigation is completed and report findings from these audits monthly to the QAPI committee. When the QAPI committee determines otherwise, based on compliance the audits may be decreased or discontinued.</p> | |

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| F 226 | <p>Continued From page 12</p> <ul style="list-style-type: none"> -She continued to have further emesis after assisted back to bed with a total lift. -Family notified of fall... -No injury noted from fall. -The resident did have her call light within reach but did not use it. -She also had a low bed in place with the bed in the lowest position. -Staff had last been in the room with her 45 min prior to the fall. -Unsure if resident hit her head as she was unable to verbalize so initiated neuro checks which remained unchanged throughout the night. -Checked respiratory status throughout the night-Noted decreased O2 [oxygen] saturations so resident's oxygen increased as needed. -Lung sounds noted to be congested. -PRN [as needed] nebulizer treatment given. -At 0300 [3:00 a.m.] ELTC called and provider [person licensed practical nurse (LPN) B spoke with] was notified of situation and concern for aspiration during emesis. -No new orders recieved and instructed just to monitor. -At 0529 [5:29 a.m.] resident noted to be without respirations/heartbeat. -Noted coffee ground emesis and loose stool of same appearance at time of death." *Details of the above information conflicted with the information located in the resident's chart documented by LPN B. Refer to F223, finding 1. <p>6. Interview and review of the provider's July 2015 Abuse prevention policy on 8/24/16 at 1:00 p.m. with the DON revealed: **Neglect was defined as "A failure, through inattentiveness, carelessness, seclusion, or omission, without a reasonable justification, to</p> | F 226 | | |
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| F 226 | Continued From page 13 provide timely, consistent and safe services, treatment and care to a resident." **"Under administrative direction, the DON and/or others initiates further investigation of the event." **"When all sources of information have been exhausted and a conclusion has been reached, complete a final report that includes what measures will be taken to prevent reoccurrences of the same or similar event." **"Physical abuse- Evidence from Care plan/Patient History: prolonged time between illness/injury and medical care." **"Physical Neglect-Physical Indicators-General Body Features: Not receiving medical care/untreated medical condition." **"Physical Neglect-Untreated Injuries or Medical Conditions: -Vomiting. -Blood in excretion. -Shortness of breath. -Falling. -Prolonged interval between treatment and injury." *She agreed with the above policy and definitions of abuse and neglect. *She agreed the final report of the investigation had not included documentation of all sources of information or measures to prevent reoccurrences. There was no additional investigative report information that could be provided by the director of nursing (DON) or the assistant DON prior to exit by this surveyor. | F 226 | | | |
| F 281 SS=E | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility | F 281 | 1. Resident 14 and 15 deceased. All other resident deaths since 8/29/16 will be reviewed to ensure compliance with notification to physician immediately | 10/13/16 | |

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| F 281 | <p>Continued From page 14 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 A Based on record review, interview, professional standard review, and policy review, the provider failed to ensure one of one licensed practical nurse (LPN) B followed facility policies and practiced within her scope of nursing practice when providing care for one of one resident (15) after a fall and later death. Findings include:</p> <p>1. Review of resident 15's record revealed: *She had been in the facility since January 2012. *She had a fall on 11/18/15 and died 11/19/15. Refer to F223.</p> <p>2. Review of the provider's March 2009 Acute Care Policy revealed: *All residents were to have received timely and accurate assessments and interventions for acute care episodes, and they must have been documented. *All acute care episodes were to have been assessed by the charge nurse. *Shortness of breath assessments were to have included lung sounds each time. *Falls were to have included the assessment for the cause of the fall.</p> <p>Review of the current Administrative Rules of South Dakota 20:40:04:01 Scope and standards of nursing practice acknowledged on 08/24/16 at 2:00 p.m. with the administrator as what the provider utilized as their standard of practice policy revealed: *The RN shall:</p> | F 281 | <p>once resident presents with no respirations and no pulse for pronouncement of death and order for release of body to mortician.</p> <p>2. LPN B counseled on notification of condition changes and adherence to professional practice standards, assessment, intervention and documentation for Resident #15 on 11/19/15. Will incorporate into individual performance review process. Will review scope and standards for nursing practice and when collaboration with RN is needed prior to returning from LOA.</p> <p>Care of Deceased Policy revised to include notify physician immediately of no respirations and no pulse. Death Checklist revised to include step 1 as calling the physician to inform of absence of respirations and pulse for death pronouncement and obtain order to release body to mortician. Draft revisions to the Care of the Deceased policy verbally reviewed with charge nurses on duty 8/29/16 and 8/30/16 and communicated through shift to shift report thereafter. Written education on Revised Care of Deceased Policy given to all charge nurses 9/1/16.</p> <p>Notification of Condition Changes</p> | | |

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| NAME OF PROVIDER OR SUPPLIER avera brady health and rehab | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301 | | |
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| F 281 | <p>Continued From page 15</p> <ul style="list-style-type: none"> -Make nursing assessments regarding the health status of a client. -Implement nursing care. -Evaluate responses to nursing interventions. -Recognize the legal implications of delegation and supervision. -Delegate to another only those interventions which that person is prepared or qualified to perform. -Provide minimal or direct supervision to others whom nursing interventions are delegated." *The LPN shall: <ul style="list-style-type: none"> -Contribute to the nursing assessment. -Participate in care planning and nursing interventions. -Contribute to nursing interventions. *They may practice as follows: <ul style="list-style-type: none"> -With at least minimal supervision when providing supervision in a stable nursing situation. -With direct supervision when providing supervision when providing care in a complex nursing situation. *Consult with a RN or other health team members and seek guidance as necessary and shall obtain instruction and supervision as necessary. *A nurse must exercise professional judgement when a physician transmits orders through a third party, who may or may not be unlicensed, via telephone or otherwise. *If an order is transmitted through third party, all persons, including the thirds party, must be identified by name and title before the order may be implemented." <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 279, regarding clinical decisions, revealed: **"Your ability to make clinical decisions depends</p> | F 281 | <p>Policy and Fall Huddle Checklist revised to include immediate physician notification for any fall with injury.</p> <p>Draft revisions to the Notification of Condition Changes Policy and Fall Huddle Checklist verbally reviewed with charge nurses on duty 8/29/16 and 8/30/16 and communicated through shift to shift report thereafter. Written education about notifying physician immediately of any fall with injury and within 24 hours of development of a pressure ulcer given to all nursing staff on 9/1/16. Written education regarding RN/LPN Scope and Standard of Practice given to all charge nurses on 9/1/16.</p> <p>All charge nurses will be educated on the revised Care of the Deceased policy, Abuse Prevention and Alleged Victim Abuse Policies, Notification of Condition Changes Policy, Fall Assessment Policy, Fall Huddle Checklist, RN and LPN Scope and Standards of Practice, Interact Care Paths to support clinical decisions and application of The</p> | | |

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| F 281 | <p>Continued From page 16</p> <p>on application of the nursing process." **"When you begin a patient assessment, the first activity involves a focused but complete assessment of the patient's condition so you are able to make an accurate judgement about his or her nursing diagnosis and collaborative health problem." **"You develop a plan of care, implement nursing interventions, and evaluate patient outcomes." **"The process requires clinical decision making using a critical thinking approach." **"If you do not make accurate clinical decisions about a patient, undesirable outcomes will probably occur."</p> <p>Review of the above reference, pages 488 and 511, regarding physical examinations, revealed: **Physical examinations are conducted: -As part of an initial evaluation in triage for emergency care. -To admit a patient to a hospital. *After considering their current condition, a nurse selects a focused physical exam or area." *Observe the pupils for size, shape equality, accommodation, and reaction to light. They are normally black, round, regular, and equal in size." *Any abnormality along the nerve pathways may have altered the ability of the pupils to have reacted to light. *Changes in intracranial pressure, and trauma may have altered pupillary reaction."</p> <p>Interview on 8/24/16 at 2:00 p.m. with the administrator revealed they had no policy regarding documentation.</p> <p>Surveyor: 35625</p> | F 281 | <p>DON or designee will review all resident deaths to ensure nursing process at a mandatory charge nurse meeting on 9/19/16.</p> <p>3. The DON or designee will review all resident deaths to ensure physician has pronounced death and order was received for release of body. The findings from these audits will be reported monthly to the QAPI committee for six months by the DON or designee. When the QAPI committee determines otherwise, based on compliance the audits may be decreased or discontinued.</p> | | |

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| F 281 | <p>Continued From page 17</p> <p>B. Based on closed record review the provider failed to ensure there was appropriate conclusionary documentation by the nurse at the time of death and care of or release of the body for two of two residents (14 and 15.) Findings include:</p> <p>1. Review of the closed medical record for resident 14 revealed: *She died on 11/21/15 at 2:18 a.m. with her family at the bedside. *Her body was released to the funeral home at 6:15 a.m. *The primary care provider was notified by fax at 6:27 a.m. *No documentation was found that indicated registered nurse (RN) A had notified the physician in a timely manner that respirations and pulse had ceased. *An physician's order to release the body to the funeral home was not found.</p> <p>Interview on 8/24/16 at 1:30 p.m. and at 1:45 p.m. with the director of nursing regarding resident 14's death revealed: *It was usual procedure to notify the physician by fax during the night or by a phone call in the morning if a resident had passed away. *She felt RN A followed the procedure during the above resident's death. *When a resident died a death record note was printed from the electronic medical record. -It was signed by the funeral home personnel and the nurse on duty. -A copy of the signed document was kept in the resident's medical record. *There was no order from the physician to release the body to the funeral home.</p> | F 281 | | |
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| F 281 | <p>Continued From page 18</p> <p>Review of the provider's April 2016 Death Checklist revealed the funeral home was notified and would have picked up the body before the physician was notified.</p> <p>Review of the provider's May 2011 Care of the Deceased policy revealed: *"Notify the physician and on-call administrator when death occurs. Can call in early AM if death occurs through night." *It did not address notifying the physician to: -Let them know pulse and respirations had ceased, so they could pronounce death. -Obtain an order for the release of body to the funeral home.</p> <p>Surveyor 33488 2. Review of resident 15's closed medical record revealed: *She had died on 11/19/15 at 4:15 a.m. *The nurse on duty "Notified daughter of resident's death" at 4:20 a.m. *At 4:25 a.m. the physician was notified of her death. *The funeral home was notified at 5:40 a.m.</p> <p>3. Interview, record review, and April 2016 Death Checklist policy review on 8/24/16 at 1:00 p.m. with the director of nursing (DON) revealed she: *Agreed the nurse should not have pronounced death. *That was not within her nursing scope of practice. *Agreed the order of the Death Checklist the nurses were to have followed listed the family was to have been called first. *Agreed step #10 on the Death Checklist, labeled "Notify physician" needed to be changed to step #1.</p> | F 281 | | |
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| F 281 | <p>Continued From page 19</p> <p>*With that change the physician would pronounce death and give the order to release the body to the funeral home.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 724, revealed, documentation of end of life included the name of the health care provider who certified death.</p> <p>Review of South Dakota Codified Law 34-25-18 and 34-25-18.1 revealed: *The signing of the death certificate was a medical act by a physician, physician's assistant, or nurse practitioner. **"Since the Legislature did not provide that the act was delegable to anyone else the South Dakota Board of Nursing did not believe a licensed nurse could officially pronounce death."</p> | F 281 | | |
| F 314 SS=G | <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to obtain treatment</p> | F 314 | <ol style="list-style-type: none"> 1. Physician notified of pressure area for Resident #7 on 5/13/16. All pressure ulcers identified since 8/24/16 will be reviewed to ensure appropriate physician notification. This will be completed by 10/13/16. 2. Notification of Condition Change Policy revised 9/2016 to include physician notification of skin ulcer. Wound and Skin Care Policy revised 9/2016 to incorporate the Preventative Skin Care policy and Wound and Skin Guidelines. Clinical coordinators will assess pressure areas weekly with charge nurse. | 10/13/16 |

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| F 314 | <p>Continued From page 20</p> <p>orders in a timely manner and implement interventions for one of one sampled resident (7) who developed a pressure ulcer. Findings include:</p> <p>1. Record review and interview on 8/23/16 at 2:30 p.m. with the director of nursing (DON) and clinical coordinator D regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *He had developed a stage two pressure ulcer on 5/7/16. -The measurements had been length 0.4 centimeters (cm) x width 1.0 cm with no depth documented. -An opti foam dressing had been applied. *The nurses were required to complete weekly wound measurements. *They would also document in the chart if they looked at it or if a dressing was changed. *On 5/9/16 measurements had been length 1.8 cm x width 1.3 cm x depth 0.1 cm. -The area had been cleaned and Tena barrier cream applied. -It was left open to air. *Interventions listed had included: <ul style="list-style-type: none"> -A gel cushion in his recliner and a honeycomb cushion in his wheelchair. -A pressure redistribution mattress on his bed. *On 5/10/16 length 1.8 cm x width 1.8 cm with no depth documented. -It had been left open to air. -A barrier cream had been applied. *On 5/11/16 there had been no measurements documented, but it stated it had been left open to air and a barrier cream applied. *On 5/13/16, 5/14/16, 5/15/16, and 5/16/16 there had been no measurements documented, but it stated it had been left open to air and calmoseptine applied. | F 314 | <p>Draft revision to the Notification of Condition Changes Policy and Wound and Skin Care Policy verbally reviewed with charge nurses on duty 8/29/16 and 8/30/16 and communicated through shift to shift report thereafter. Written education about notification of condition changes and wound and skin care given to all nursing staff on 9/1/16. All charge nurses will be educated on revised Notification of Condition Change Policy and Wound and Skin Care policies at a mandatory charge nurse meeting on 9/19/16. All CNA's will be educated on the Wound and Skin Care policy at mandatory CNA meetings on 9/19/16 and 9/21/16.</p> <p>3. The DON or designee will conduct weekly audits to ensure compliance with the revised Wound and Skin Care Policy and Notification of Condition Change and report findings from these audits monthly to the QAPI committee. When the QAPI committee determines otherwise, based on compliance the audits may be decreased or discontinued.</p> | |
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| F 314 | <p>Continued From page 21</p> <p>*On 5/17/16 length 0.4 cm x width 0.3 cm x depth 0.0 cm. -It had been left open to air and calmoseptine applied. -A new intervention had included staff were to assist the resident into his bed and lay him on his side.</p> <p>*On 5/18/16, 5/19/16, 5/20/16, 5/21/16, 5/22/16, and 5/23/16 there had been no measurements documented, but it stated it had been left open to air and calmoseptine applied.</p> <p>*On 5/24/16 length 0.1 cm x width 0.1 cm. with no depth documented. -It had been left open to air and a barrier cream had been applied.</p> <p>*On 5/25/16, 5/26/16, 5/27/16, 5/28/16, 5/29/16, 5/30/16, 5/31/16, 6/1/16, 6/2/16, 6/4/16, 6/5/16, and 6/6/16 there had been no measurements documented, but it stated it had been left open to air and calmoseptine applied. -There had been no documentation for 6/3/16.</p> <p>*On 6/7/16 it was open, but there had been no measurements. *On 6/8/16 it was intact. *There was no notification to the physician until 5/13/16 after it had gotten bigger. *They had been unsure if they had standing orders for pressure ulcer treatment.</p> <p>Review of the physician's standing orders and interview on 8/24/16 at 8:50 a.m. with registered nurse E (RN) regarding the standing orders for resident 7 revealed there were no standing orders for pressure ulcer treatment.</p> <p>Review of the physician's orders and notifications from 5/3/16 through 6/21/16 for resident 7 revealed on 5/13/16 they had notified the physician of the stage two pressure ulcer to his</p> | F 314 | | |

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| F 314 | <p>Continued From page 22</p> <p>coccyx. They had asked for an order for calmoseptine two times per day until resolved. The physician had marked yes as a reply to the calmoseptine request. On 6/21/16 they had notified the physician by fax the area on the coccyx was healed. That had been fourteen days after the documentation in the chart stated it had been intact. The notification to the physician and request for treatment had been six days after the pressure ulcer had developed.</p> <p>Review of the provider's July 2015 Notification of Condition Changes policy revealed: *The charge nurse was responsible for notifying the attending physician when a change occurred in the resident's condition. *Those changes would have included significant changes in physical, mental, or psycho-social status as well as any accident that had resulted in injury. *The charge nurse should have documented the notification of the physician in the resident's medical record.</p> | F 314 | | |
| F 323 SS=G | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237</p> | F 323 | <ol style="list-style-type: none"> For residents #10 and #6 and all other residents who have fallen since 8/24/16, internal notifications will be updated to reflect a completed investigation. This will be completed by 10/13/16. Fall Assessment policy and Fall Huddle Checklist revised to include initiation of Fall Huddle Checklist and internal notification. Revised Fall Assessment Policy and Fall Huddle Checklist verbally reviewed with charge nurses on duty 8/29/16 and 8/30/16 and communicated | 10/13/16 |

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| F 323 | <p>Continued From page 23</p> <p>Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to: *Follow the plan of care and have appropriate documentation for one of one sampled resident (10) that resulted in a major injury. *Implement or change interventions for one of one sampled resident (6) who had multiple falls that resulted in minor injury. Findings include:</p> <p>Surveyor: 35237 1. Interview on 8/23/16 at 3:45 p.m. with resident 10's family member revealed: *He had transferred from an assisted living to long term care on 3/17/16, because he had dementia and had needed more assistance with activities of daily living. *On 7/9/16 he had fallen, had hit his head, and had fractured his elbow. *She was concerned, because since that fall he had required more care and assistance from staff.</p> <p>Surveyor: 32335 Review of resident 10's 7/9/16 initial fall report revealed: *The fall had occurred at 6:40 p.m. *There was an injury, but it was not major. *He had been identified to be at risk for falls. *The trauma event was listed as "Resident ambulated with walker to the bathroom. The CNA [certified nursing assistant] assisted him with pulling down his slacks. As the resident went to sit down, he fell over onto the floor. Stated, 'I think I passed out.' Resident was lifted from the floor with a Hoyer and 4 staff. Assisted into the recliner. Ice and pressure applied to his head and</p> | F 323 | <p>through shift to shift report there-after. Fall Huddle checklist document provided to all charge nurses on 8/29/16. All charge nurses will be educated on revised Fall Assessment Policy, revised Fall Huddle Checklist and Abuse Prevention & Alleged Victim Abuse Policy at a mandatory charge nurse meeting on 9/19/16. All CNA's will be educated on the Fall Assessment Policy, Fall Huddle Checklist and Abuse Prevention and Alleged Victim Abuse policy at mandatory CNA meetings on 9/19/16 and 9/21/16. Abuse prevention training is included in new associate orientation and annual training for all associates which is mandatory. Fall risk assessment policy incorporated into the revised 9/2016 Fall Assessment Policy.</p> <p>3. DON or designee will review all internal fall notifications to ensure a thorough investigation of falls was completed. The DON or designee will conduct weekly audits to ensure investigations were complete. The findings from these audits will be reported monthly to the QAPI committee. When the QAPI committee determines otherwise, based on <i>*Compliance</i> the audits may be decreased or discontinued. <i>DW/SDOHT/EL</i></p> | |
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| F 323 | <p>Continued From page 24</p> <p>nose."</p> <p>*Under range of motion it had "new limitation." *He had a new onset of pain. -The pain limited functional activity. *There was a new condition of swelling. *He had hit his head. *Under the section "What can be done in the future to prevent another fall" it had "remain with resident during cares." *There was no other documentation regarding what the limitation in his range of motion was, where the pain was, or where the swelling was.</p> <p>Review of the 7/9/16 internal notification form for resident 10 revealed there was no documentation a thorough investigation had been completed. That form was not a part of the resident's medical record per interview on 8/24/16 at 10:35 a.m. with the assistant director of nursing and the director of nursing.</p> <p>Review of the 7/9/16 initial and final investigation fall report sent to the South Dakota Department of Health regarding resident 10 revealed: *"Resident was ambulating with his walker into the bathroom. *The CNA was with him and assisted him to pull his slacks down. *Resident was going to sit down on the toilet, he lost his balance, and fell to the floor. *CNA had just left the room and went back into the bathroom to find the resident on the floor. *The resident stated that he felt like he had passed out. *Resident was seen by eLTC and it was recommended that he go to the emergency room. -That information had not been included in the nurses notes or assessments in his medical record.</p> | F 323 | | |
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| F 323 | <p>Continued From page 25</p> <p>*At the emergency room, an X-ray of the right elbow was completed and resident has a likely humeral fracture.</p> <p>*He had also bumped his head as he fell forward.</p> <p>*He was admitted to the hospital due to a possible fracture and head injury as resident is on Coumadin and his INR was 3.8."</p> <p>*There had been no documentation of interviews with staff.</p> <p>*The CNA had not been identified.</p> <p>Review of resident 10's medical record revealed:</p> <p>*He had been admitted on 3/17/16.</p> <p>*There had been no documentation regarding the new limitation in his range of motion.</p> <p>*There had been no pain assessment completed.</p> <p>Review of the 7/9/16 eLTC report revealed:</p> <p>*The time of service had been 7:00 p.m.</p> <p>*Under comments it was noted: "Nurse called to request that patient be transferred via ambulance per family request. Patient fell and has nose bleeding, and face/head bruising in the resident's bathroom."</p> <p>*There had been no mention of pain, the range of motion limitation, or the possibility of a fracture.</p> <p>Review of resident 10's 6/13/16 Minimum Data Set (MDS) assessment revealed he required extensive assistance from one staff person to use the bathroom.</p> <p>Review of resident 10's 6/21/16 MDS note revealed he received extensive assistance of one staff person with bed mobility, transfers, ambulation with walker in his room, dressing, toileting, bathing, locomotion on the unit, and personal hygiene.</p> | F 323 | | | |

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| F 323 | <p>Continued From page 26</p> <p>Review of resident 10's 6/14/16 care plan revealed he required extensive assistance of two staff to go to the bathroom.</p> <p>Interview on 8/24/16 at 10:35 a.m. with the assistant director of nursing and the director of nursing regarding the investigation into the 7/9/16 fall for resident 10 revealed:</p> <ul style="list-style-type: none"> *The initial and final report sent to the state was the whole investigation. *There had been no other documentation in the medical chart. *There was no documentation of the interviews with staff. *They agreed extensive assistance of one staff person would include helping the resident sit on the toilet. *They were not sure why the CNA had left the room. *They stated sometimes he did not like help but had no documentation to confirm that was why the CNA had left the room. *They had not considered abuse or neglect even though she had not followed his care plan. *They were not sure why the fall report stated the injury was not major. *He had been sent to the ER on 7/10/16 based on the family request and not the nursing assessment per the documentation. *He returned to the facility on 7/11/16 with a cast and sling applied to his right arm. <p>2. Review of resident 6's medical record revealed:</p> <ul style="list-style-type: none"> *He had an admission date of 3/18/15. *He had falls on the following days: <ul style="list-style-type: none"> -1/10/16 with a minor injury. -1/22/16 with a minor injury. -2/6/16 with no injury. | F 323 | | |
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| F 323 | <p>Continued From page 27</p> <p>-2/7/16 with a minor injury. -6/8/16 with a minor injury. -8/3/16 with a minor injury.</p> <p>*The only intervention listed on the fall follow-up forms was "remind to use call light." *Fall risk assessments had been done on 3/14/16 and 6/16/16. *There had been no documentation of investigations into the above mentioned falls.</p> <p>Review of resident 6's 12/15/15, 3/16/16, and 6/13/16 care plans revealed: *He was at high risk for falls. *"Encourage/remind to use call light and the one closest to him" was the only intervention listed on all three care plans.</p> <p>Interview on 8/24/16 at 10:05 a.m. with the director of nursing, clinical coordinator F, and licensed social worker G revealed: *They were unable to provide interventions that had been attempted prior to or after each fall. *They only completed an internal investigation for falls.</p> <p>Review of the 1/10/16, 1/22/16, 2/6/16, 2/7/16, 6/8/16, and 8/3/16 internal notification forms for resident 6 revealed there was no documentation thorough investigations had been completed. Those forms were not a part of the resident's medical record.</p> <p>3. Review of the provider's Fall Risk Assessment policy revealed recommendations for changes in resident care should have appropriate documentation completed.</p> | F 323 | | |
| F 514 SS=E | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB | F 514 | 1. Physician notified of pressure area for | 10/13/16 |

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| F 514 | <p>Continued From page 28 LE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to ensure complete and accurate medical information was documented in the medical records regarding care for 4 of 15 sampled residents (6, 7, 10, and 15). Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 6's medical record revealed there was a lack of documentation for several falls. Refer to F323, finding 2. 2. Review of resident 7's medical record revealed there was lack of documentation regarding a pressure ulcer that had developed. Refer to F314, finding 1. <p>There was lack of documentation in his medical record regarding investigations into his falls. Refer to F226, finding 3.</p> | F 514 | <p>Resident # 7 on 5/13/16 and internal notifications will be updated to reflect a completed investigation. These reviews will be completed by 10/13/16. All pressure ulcers identified since 8/24/16 will be reviewed to ensure physician notification. For resident #10 and #6 and all other residents who have fallen since 8/24/16, internal notifications will be updated to reflect a completed investigation. These reviews will be completed by 10/13/16. Resident #15 deceased. All face to face resident eLTC encounters since 8/24/16 will be reviewed to ensure documentation is in medical record. This will be completed by 10/13/16. Counseled LPN B on notification of condition changes and adherence to professional practice standards, assessment, intervention and documentation for Res. #15 on 11/19/15. Will incorporate into individual performance review process. Will review scope and standards for nursing practice and when collaboration with RN is needed prior to returning from LOA.</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 08/24/2016 |
|---|--|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301 | | |
| (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 514 | <p>Continued From page 29</p> <p>3. Review of resident 10's medical record revealed there was lack of documentation in the medical chart regarding a fall that had resulted in a major injury. Refer to F323, finding 1.</p> <p>Surveyor: 33488</p> <p>4. Review of the medical record for resident 15 revealed there was a lack of documentation related to her fall on 11/18/15. The events thereafter leading up until the time of her death on 11/19/15. Refer to F223, finding 1.</p> <p>5. Interview and review of the provider's July 2015 Abuse prevention policy on 8/24/16 at 1:00 p.m. with the director of nursing (DON) revealed: ***Neglect was defined as "A failure, through inattentiveness, carelessness, seclusion, or omission, without a reasonable justification, to provide timely, consistent and safe services, treatment and care to a resident." ***Under administrative direction, the DON and/or others initiates further investigation of the event." ***When all sources of information have been exhausted and a conclusion has been reached, complete a final report that includes what measures will be taken to prevent reoccurrences of the same or similar event." ***Physical abuse- Evidence from Care plan/Patient History: prolonged time between illness/injury and medical care." ***Physical Neglect-Physical Indicators-General Body Features: Not receiving medical care/untreated medical condition." ***Physical Neglect-Untreated Injuries or Medical Conditions: -Vomiting. -Blood in excretion. -Shortness of breath. -Falling.</p> | F 514 | <p>2. Draft revisions of the Wound and Skin Care Policy, draft revision of Fall Assessment and Fall Huddle checklist, Notification of Condition reviewed verbally with charge nurses on duty 8/29/16 and 8/30/16 and communicated through shift to shift report thereafter. Written education given to all charge nurses on 9/1/16 regarding: Notification of Condition Changes, Wound and Skin policy, RN/LPN scope of practice. All charge nurses will be educated at a mandatory charge nurse meeting on 9/19/16 regarding: revised Notification of Condition Change Policy, revised Wound and Skin Care policy, revised Fall Assessment policy and Fall Huddle checklist, Abuse Prevention and Alleged Victim Abuse and RN and LPN scope and standards of practice, Interact Care Paths to support clinical decision and application of nursing process and timely and accurate documentation in the medical record.</p> | | |

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

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| NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301 | | |
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| F 514 | <p>Continued From page 30</p> <p>-Prolonged interval between treatment and injury."</p> <p>*She agreed with the above policy and definitions of abuse and neglect.</p> <p>*She agreed the final report of the investigation had not included documentation of all sources of information or measures to prevent reoccurrences.</p> <p>Interview on 8/24/16 at 2:00 p.m. with the administrator revealed they had no policy regarding documentation.</p> <p>Review of the current Administrative Rules of South Dakota 20:40:04:01 Scope and standards of nursing practice acknowledged on 08/24/16 at 2:00 p.m. with the administrator as what the provider utilized as their standard of practice policy revealed:</p> <p>***A nurse must exercise professional judgement when a physician transmits orders through a third party, who may or may not be unlicensed, via telephone or otherwise.</p> <p>*If an order is transmitted through third party, all persons, including the thirds party, must be identified by name and title before the order may be implemented."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 279, regarding clinical decisions, revealed:</p> <p>***Your ability to make clinical decisions depends on application of the nursing process."</p> <p>***When you begin a patient assessment, the first activity involves a focused but complete assessment of the patient's condition so you are able to make an accurate judgement about his or her nursing diagnosis and collaborative health</p> | F 514 | <p>3. The DON or designee will conduct weekly audits to ensure compliance with the Fall Assessment Policy, Wound and Skin Care Policy, Notification of Changes policy, Abuse and Neglect policy. The findings from these audits will be reported monthly to the QAPI committee by the DON or designee. When the QAPI committee determines otherwise, based on compliance the audits may be decreased or discontinued.</p> | | |

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| F 514 | Continued From page 31 problem." **"You develop a plan of care, implement nursing interventions, and evaluate patient outcomes." **"The process requires clinical decision making using a critical thinking approach." **"If you do not make accurate clinical decisions about a patient, undesirable outcomes will probably occur." | F 514 | | | |
| F 520 SS=E | 483.75(o)(1) QAA' COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced | F 520 | 1. Administrative/QI meetings where DON, Medical Director, Administrator, ADON and 2 additional staff members present were held on: 8/18/15, 11/24/15, 3/7/16. Meeting for 8/24/16 rescheduled to 9/22/16 due to survey process in facility. • 8/18/15—Quality indicators monitored included door alarms, side rails, falls, pressure ulcers, call light response, infection surveillance. Updated action plans for areas not meeting goals—falls and pressure ulcers and will continue to monitor effect of changes. Implemented changes included: Daily rounding with focus on fall and pressure ulcer prevention. Reviewed new strategies regarding readmissions. Reviewed daily rounding with all LTC neighborhoods to identify performance improvement opportunities for resident within 30 days of admission. | 10/13/16 | |

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| F 520 | <p>Continued From page 32</p> <p>by: Surveyor: 32335</p> <p>Based on interview and record review, the provider failed to have an effective quality assurance (QA) program in place to identify concerns, develop action plans, and implement appropriate interventions to improve performance measures for their facility. Findings include:</p> <p>1. Review of the recertification survey on 9/30/15 revealed the following deficiencies had been cited: F281 and F514.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*): F157, F223, F226, F281*, F314, F323, F514* and F520.</p> <p>Review of the provider's 4/1/16 through 6/30/16 quality improvement report revealed they had collected data on falls, medication notification, infections, newly acquired pressure areas, hand washing percentage, call light response, and readmission rate. No action plans or interventions had been documented for those issues.</p> <p>Interview on 8/24/16 at 1:35 p.m. with the assistant director of nursing revealed the quality improvement committee met quarterly and reviewed the data mentioned above. They had a separate committee that met two times per month that had addressed falls. The medical director was not part of the separate committee meetings. She could not identify any other areas of concern the quality improvement committee had addressed and created an action plan for.</p> | F 520 | <ul style="list-style-type: none"> 11/24/15—Quality indicators monitored included: Pharmaceuticals (including insulin, antipsychotics and Omeprazole), End of Life Care & Documentation, door alarms, side rails, falls infection surveillance, pressure ulcers, call lights and report of audits related to survey findings. Improvement noted in MAR/TAR audits (continue to monitor as electronic eMAR transition occurs), falls, infections, call lights, antipsychotics. Reviewed action plans for Pressure Sores—7 this quarter—most at end of life, currently treating 2. 3/7/16—Quality indicators monitored included: Pharmaceuticals (including insulin, antipsychotics and Omeprazole), continue to monitor eMAR, End of Life & Documentation, Door Alarms, Side Rails, Falls. Improvement sustained and monitors discontinued for side rails and door alarms. Side rails have been in compliance as well for the same period of time. It was discussed and approved by the committee to stop auditing and reporting this. | |
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| F 520 | <p>Continued From page 32</p> <p>by: Surveyor: 32335</p> <p>Based on interview and record review, the provider failed to have an effective quality assurance (QA) program in place to identify concerns, develop action plans, and implement appropriate interventions to improve performance measures for their facility. Findings include:</p> <p>1. Review of the recertification survey on 9/30/15 revealed the following deficiencies had been cited: F281 and F514.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*): F157, F223, F226, F281*, F314, F323, F514* and F520.</p> <p>Review of the provider's 4/1/16 through 6/30/16 quality improvement report revealed they had collected data on falls, medication notification, infections, newly acquired pressure areas, hand washing percentage, call light response, and readmission rate. No action plans or interventions had been documented for those issues.</p> <p>Interview on 8/24/16 at 1:35 p.m. with the assistant director of nursing revealed the quality improvement committee met quarterly and reviewed the data mentioned above. They had a separate committee that met two times per month that had addressed falls. The medical director was not part of the separate committee meetings. She could not identify any other areas of concern the quality improvement committee had addressed and created an action plan for.</p> | F 520 | <p>cont. of F 520</p> <ul style="list-style-type: none"> • QAPI committee meeting scheduled 9/22/16 will introduce the CMS QAPI at a Glance Toolkit to structure meeting framework and performance improvement plan. Participant in the Great Plains Quality Innovation Network Nursing Home Quality Care Collaborative since July 2014. Participant in the Clostridium difficile Reporting and Reduction Project since 7/201 2. Will utilize the CMS QAPI at a Glance Toolkit to structure meeting framework and performance improvement plan. QAPI meeting will be schedule monthly. Medical director will be in attendance a minimum of quarterly. QAPI plan will be revised by 10/13/16. Establish performance improvement projects for any area identified by the QAPI team based on quality indicators/performance outcomes/trends. Members of QAPI team will review Avera Performance Improvement 101 education module by 10/13/16. 3. Administrator will audit all QAPI meeting minutes to identify issues | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| NAME OF PROVIDER OR SUPPLIER AVERA BRADY HEALTH AND REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 500 S OHLMAN MITCHELL, SD 57301 |
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| F 520 | <p>Continued From page 32</p> <p>by: Surveyor: 32335</p> <p>Based on interview and record review, the provider failed to have an effective quality assurance (QA) program in place to identify concerns, develop action plans, and implement appropriate interventions to improve performance measures for their facility. Findings include:</p> <p>1. Review of the recertification survey on 9/30/15 revealed the following deficiencies had been cited: F281 and F514.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*): F157, F223, F226, F281*, F314, F323, F514* and F520.</p> <p>Review of the provider's 4/1/16 through 6/30/16 quality improvement report revealed they had collected data on falls, medication notification, infections, newly acquired pressure areas, hand washing percentage, call light response, and readmission rate. No action plans or interventions had been documented for those issues.</p> <p>Interview on 8/24/16 at 1:35 p.m. with the assistant director of nursing revealed the quality improvement committee met quarterly and reviewed the data mentioned above. They had a separate committee that met two times per month that had addressed falls. The medical director was not part of the separate committee meetings. She could not identify any other areas of concern the quality improvement committee had addressed and created an action plan for.</p> | F 520 | <p>cont. of F 520</p> <p>with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality performance indicators. Monitoring will occur monthly for six months or when the QAPI committee determines otherwise, based on compliance the audits may be decreased or discontinued.</p> | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 08/23/2016 |
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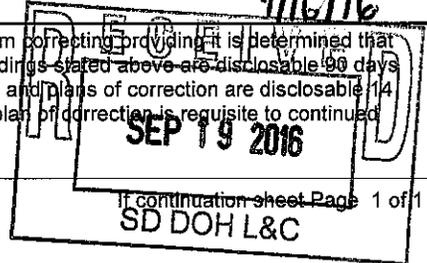
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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/23/16. Avera Brady Health and Rehab (original building, building 01) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julie Hoffmann</i> | TITLE <i>Administrator</i> | (X8) DATE <i>9/16/16</i> |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

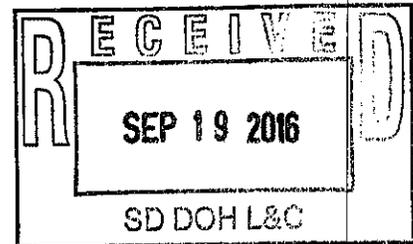


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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/23/16. Avera Brady Health and Rehab (center addition, building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Julie Hoffmann TITLE Administrator (X6) DATE 9/16/16

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

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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 8/23/16. Avera Brady Health and Rehab (north addition, building 03) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Julie Hoffmann* TITLE *Administrator* (X6) DATE *9/16/16*

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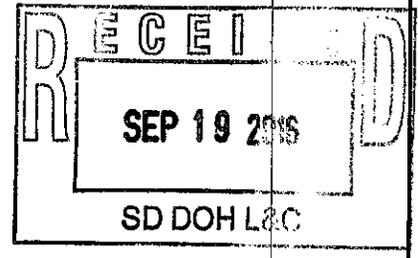
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South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10652 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 08/24/2016 |
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| S 000 | Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/22/16 through 8/24/16. Avera Brady Health and Rehab was found in compliance. | S 000 | | |
| S 000 | Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/22/16 through 8/24/16. Avera Brady Health and Rehab was found in compliance. | S 000 | | |



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

TITLE

(X6) DATE

Julie Hoffmann

Administrator

9/16/16