

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

ORIGINAL

PRINTED: 07/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/07/2016
NAME OF PROVIDER OR SUPPLIER avera prince of peace			STREET ADDRESS, CITY, STATE, ZIP CODE 4513 SOUTH PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103	
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F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/5/16 through 7/7/16. Avera Prince of Peace was found not in compliance with the following requirements: F176, F221, F280, F281, F309, F323, F329, F332, F371, F386, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/5/16 through 7/7/16. Areas surveyed included accidents, resident/patient/client abuse, and nursing services. Avera Prince of Peace was found not in compliance with the following requirements: F223, F226, and F250.	F 000	*Addendums noted with an asterisk per 8/08/16 per onsite visit with facility administrator. PE/SDDOTHEL	
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: 35625 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (5) who self-administered a nebulizer medication had been assessed for her capability to self-administer medication. Findings include: 1. Review of the medical record for resident 5	F 176		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator (X6) DATE 7-29-16

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

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F 176	<p>Continued From page 1</p> <p>revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 6/1/15. *She received two medications via her nebulizer. -The first medication was administered twice a day. -The second medication was administered three times a day. *On 3/21/16 her primary care physician had ordered she could self-administer her nebulizer medications after nurse set-up. *There was no documentation an initial or subsequent self-administration of medication assessment had been completed. *Her plan of care had not included self-administration of her nebulizer medications. <p>Interview on 7/7/16 at 11:20 a.m. with registered nurse coordinator G regarding resident 5 confirmed:</p> <ul style="list-style-type: none"> *No initial or quarterly self-administration of medication assessments had been done at the instruction of the former director of nursing. *Staff allowed the resident to self-administer her nebulizer medications after set-up. *Staff had been educated that without a self-administration of medication assessment the resident could not be left alone, but it continued to occur. <p>Interview on 7/7/16 at 3:20 p.m. with resident 5 revealed the staff often left the room after they had started her nebulizer treatment.</p> <p>Review of the provider's 10/27/15 Medication policy revealed:</p> <ul style="list-style-type: none"> *"Medications will be administered by nursing personnel until the interdisciplinary team has had the opportunity to obtain information necessary to make an assessment of the resident's ability to 	F 176	<p>Resident #5 was assessed on July 18, 2016 for appropriateness to be able to self-administer her nebulizer.) The process for residents self-administering medications was changed to make sure staff stay with residents to ensure resident completed medication process correctly. The self-administration of medications policy to include the changed process was covered at the mandatory all staff meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN coordinators will conduct audits of 2 residents who are self-administering medications on their neighborhood weekly for 2 months for compliance with the self-administration policy. The RN coordinators will report the audit results to the QAPI group that meets every other week and the RN Coordinators will report the results to the PI committee that meets every other month. The PI committee will direct further audits.</p> <p>→*NO other residents self-administer their medications. PE/SDDOHEL</p>	8-26-16

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F 176	Continued From page 2 safely self-administer medications. *Self administration will be evaluated on a quarterly basis and with any status changes. *This will be reflected on the plan of care."	F 176		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure assistive devices that had the potential to be a restraint for two of two sampled residents (6 and 8) had physicians' orders, were appropriately assessed, documented on, and care planned to ensure appropriate use. Findings include: 1. Random observations on 7/5/16 from 4:40 p.m. to 5:30 p.m., on 7/6/16 from 8:55 a.m. to 1:10 p.m., and on 7/7/16 at 10:15 a.m. of resident 8 revealed he had a lap table attached to the left side of his wheelchair (w/c). He had limited range-of-motion with no self-directed movement on the left side of his body. His left hand and arm rested on top of the lap table whenever he was seated in the w/c. Interview on 7/7/16 at 1:10 p.m. with resident 8 revealed: *He could lift the lap table up on its side to ensure any restraining capability had been stopped.	F 221	Resident #6 was assessed on 7/11/16 and Resident #8 was assessed on 7/6/16 for the appropriateness of their restraint. All other residents who are currently on a restraint will [REDACTED] by August 5, 2016. The restraint policy was updated on July 26, 2016 to reflect the need for quarterly evaluations and documentation. The policy was covered at the mandatory all staff meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN Coordinator will audit all residents on a restraint monthly for 3 months to ensure appropriate documentation is in place to support the restraint. The RN coordinators will report the audit results to the QAPI group that meets every other week and the RN Coordinators will report the results to the PI committee that meets every other month. The PI committee will direct further audits. → *have physician order, assessment with documentation and care planned by August 5 th , 2016. PE/SDDOHJEL	8-26-16

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F 221	<p>Continued From page 3</p> <p>*He had required the use of the lap table to ensure proper positioning and support of his left arm.</p> <p>Review of resident 8's medical record revealed: *There had been no physician's order for the use of a lap table. *There had been no assessment completed to support the need and use of a lap table. *His 6/12/15 care plan had not identified the use of a lap table for his left arm. *No documentation to support the medical condition requiring the use of a potential restraint.</p> <p>2. Observation on 7/6/16 at 10:00 a.m. of resident 6 with certified nursing assistants (CNA) S and T revealed: *They had transferred the resident into her w/c. *They secured a seat belt across the upper part of her legs after she had been positioned in the w/c. -The resident did not have the capability of unlatching the seat belt on her own.</p> <p>Interview on 7/6/16 at the time of the above observation with CNA S regarding resident 6 revealed: *The resident had required the use of the seat belt in her w/c to assist her with positioning. *She had always used the seat belt when seated in her w/c.</p> <p>Review of resident 6's medical record revealed: *There had been no physician's order for the use of a seat belt when she was seated in her w/c. *There had been no assessment or documentation to support the use of a seat belt in her w/c. *Her 6/1/15 care plan had not identified the use of</p>	F 221			

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F 221	<p>Continued From page 4</p> <p>a seat belt in her w/c to assist with positioning. *No documentation to support the medical condition requiring the use of the seat belt.</p> <p>3. Interview on 7/6/16 at 4:15 p.m. with registered nurse coordinator A revealed: *He had been aware: -Resident 8 used a lap tray when seated in his w/c to assist him with proper positioning of the left arm. -Resident 6 used a seat belt in her w/c to assist her with positioning. *He had not been aware those devices had been considered a potential restraint. *He had not been aware those devices had required: -An assessment to support their use. -A physician's order. *He agreed those devices should have been documented on the residents' care plans.</p> <p>Interview on 7/7/16 at 2:45 p.m. with the director of nursing revealed: *The nursing staff had recently been educated on the types and use of restraints. *She agreed the above devices used for residents 6 and 8 had been considered restraints. *She would have expected the nursing coordinator to have completed the necessary paperwork to support the use of those devices.</p> <p>Review of the provider's 10/12/12 Restraint policy revealed: **Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."</p>	F 221		

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F 221	Continued From page 5 **Prior to restraint use the facility MUST: Understand and document the medical condition requiring the restraint." **Physician order must be obtained that defines specific time frames of restraint use." **Continued use of restraints requires routine evaluation by the interdisciplinary team and physician." **Ongoing documentation must show the continued need for the restraint."	F 221			
F 223 SS=E	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: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure resident-to-resident incidents of abuse were prevented for: *Six unidentified residents by one of one sampled resident (4). *One identified resident (3) by one of one sampled resident (4). *One sampled resident (4) by one of one unidentified resident. Findings include: 1. Review of resident 4's medical record revealed	F 223			

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F 223	<p>Continued From page 6</p> <p>the following resident-to-resident incidents:</p> <p>a. On 1/7/16 licensed practical nurse (LPN) N had documented: "CNA [certified nursing assistant] [unidentified] reported that this resident attacked another resident around 2000 [8:00 p.m.]. This resident was redirected after she continued to be aggressive." -Nothing more had been documented in the record regarding the event. -No physician notification had been found at the time of the event.</p> <p>b. On 1/29/16 LPN N had documented at 8:00 p.m.: "Resident hit another resident in the nose." -Nothing more had been documented in the record regarding the event. -No physician notification had been found at the time of the event.</p> <p>c. On 1/29/16 LPN N had documented at 9:02 p.m.: "This resident attacked a resident who was sitting at the dining room table sleeping. The other resident hit [resident 4] back. No injuries noted. Both residents redirected." -Nothing more had been documented in the record regarding the event. -No physician notification had been found at the time of the event.</p> <p>d. On 3/29/16 LPN M had documented at 7:40 p.m.: "This resident had gone into another resident's room. The occupant told this resident that she wasn't supposed to be there. A third resident was passing by and attempted to get this resident out of the room. In the process, this resident swung back and hit the helping resident in the nose and right eye. No injuries noted at this time. Both residents were redirected back to their own room."</p>	F 223			

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F 223	<p>Continued From page 7</p> <p>-Nothing more had been documented in the record regarding the event.</p> <p>-No physician notification had been found at the time of the event.</p> <p>e. On 3/31/16 LPN N had documented at 7:30 p.m.: "CNA [unidentified] reported this resident was punching another resident. The other resident did hit back."</p> <p>-Nothing more had been documented in the record regarding the event.</p> <p>-No physician notification had been found at the time of the event.</p> <p>f. On 6/8/16 LPN M documented at 7:30 p.m.: "[Resident 4] was seen hitting another resident in that resident's room. The resident was lying in bed at the time. [Resident 4] entered the room, rolled up to the resident and began hitting her in the face and right thigh. During the altercation, the resident's nasal canula was yanked off. Staff immediately removed [resident 4] from the room and came to inform this writer of the altercation. No physical injuries were noted on either resident at this time."</p> <p>-Nothing more had been documented in the record regarding the event.</p> <p>-No physician notification had been found at the time of the event.</p> <p>g. Interview on 7/7/16 at 7:30 a.m. with the director of nursing (DON) revealed she was unable to locate the incident reports, investigations of the events, or the event reports. The reports should have been sent to the South Dakota Department of Health (SD DOH) to notify them of the above events.</p> <p>2. Interview on 7/5/16 at 2:30 p.m. with resident</p>	F 223	<p>The resident identified has had no further incidents since the identified incident. The care plan was updated on July 7, 2016 to have staff bring resident to an activity of choosing or bring her to the dining room where she can be observed by staff of both neighborhoods. A one to one activity has been implemented daily for resident #4. All other residents who had the potential for abuse have been identified and incidents have been reported. The policy on abuse has been updated on July 26, 2016 to reflect the change of completion of incident reports on all resident to resident abuse. The policy for abuse was covered at the mandatory all staff inservice on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The long term care social worker will conduct audits of resident behavior charting 4 times weekly for two months to identify any instances of potential abuse. The results of those audits will be reported by the long term care social worker to the QAPI group that meets every other week. The long term care social worker will report the results of the audits to the PI committee that meets every other month. The PI committee will direct further audits.</p>	8-26-16

* All PE/SDDOH

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F 223	<p>Continued From page 8</p> <p>3's son revealed: *His mother had been struck in the face by resident 4 several weeks ago. *He pulled his phone out to show this writer a large approximately 3 centimeter (cm) by 4 cm purple bruise on his mother's jawline. *He was concerned for his mother's safety. *The nursing station was located so the staff view was of the dining room and fireplace. There were no mirrors for the staff to view down the resident halls. *He had discussed his concerns with the staff but nothing had changed.</p> <p>Review of resident 4's medical record revealed: *A 5/9/16 Physician's Fax Orders sheet from registered nurse (RN) coordinator K to resident 4's physician indicated: "On 5/8/16 at 1935 [7:35 p.m.] CNA [unidentified] heard a noise from another resident's room. The other resident was sitting in a recliner when this resident entered in her wheelchair, She was confused and telling the other resident that they need to get out of 'her' room. This resident was striking the other resident in the face with her hand. The other resident has an abrasion on (L) cheek and purple bruise on (L) jawline and neck She was removed from the other resident's room. Both families notified This resident's daughters suggested we come up with a plan." *The physician's reply to the fax revealed: "No new meds. Ask coordinator and activities to see if we can help distract her for periods of time." *There was nothing in the resident's nursing progress notes regarding the event.</p> <p>Review of a 5/9/16 initial event report submitted to the SD DOH regarding the above event revealed:</p>	F 223		

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F 223	<p>Continued From page 9</p> <p>*RN coordinator K had summarized the above findings and added resident 3 was given a cold pack for her cheek.</p> <p>*She added when resident 4 was asked what the trouble was she stated "She's in my room."</p> <p>*No staff names were added to the initial report to indicate who had been involved with the residents at the time of the event.</p> <p>*The department of social services had not been contacted nor had the police.</p> <p>*The abuse/neglect claim was confirmed, but it had not been a willful act. There was no documentation as to why it was not a willful act.</p> <p>Review of resident 4's 4/5/16 Minimum Data Set (MDS) assessment had indicated a Brief Interview of Mental Status score of 0, indicating severely impaired cognition (mental ability).</p> <p>Review of the final investigation report sent to SD DOH on 5/13/16 by RN coordinator K revealed:</p> <p>*No documentation the event had been investigated.</p> <p>*No documentation staff, visitors, or family members had been interviewed regarding what had been happening with resident 3 or 4 prior to the event, at the time of the event, or after the event.</p> <p>*The abuse/neglect claim had been confirmed.</p> <p>*The summary statement indicated the physician's notification of the event and his response.</p> <p>*RN coordinator K had suggested "to staff that whenever we see that [resident 4] become agitated, to then have her be a one to one within arms reach."</p> <p>*The activity coordinator's response recommended resident 4 be brought to all scheduled activities. "She is currently on our 1:1</p>	F 223		

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F 223	<p>Continued From page 10</p> <p>list so she is receiving visits from us already. I will encourage staff to come and spend free time with her but I am not sure how often it will be."</p> <p>*Actions taken had included: -Personnel education. -Staff levels reviewed/revised. -Facility procedures reviewed/revised.</p> <p>Interview on 7/5/16 at 5:25 p.m. and on 7/6/16 at 4:30 p.m. with RN coordinator K regarding the above event and resident 4's aggressive behaviors revealed: *She had started working in this facility in April 2016. *She was not aware resident 4 had physically aggressive episodes with other residents in the past. *An initial report and five-day report had been sent to the SD DOH regarding the resident-to-resident event. *She had investigated the event. *She had emails to show the investigation had been done. *She had not documented any interviews, because she did not have all the information regarding the staff members. That information would have included their hire date, license numbers, or social security numbers requested on the event report. *She had contacted the activity department to see if they could do anything more to divert resident 4 during the aggressive periods. The activity department was already doing 1:1 activities with her three times a week. They said they would try to do more but had recommended the resident attend the already scheduled group activities. *Resident 4 did not like to be around a lot of activity and preferred activity in her room. *The resident's care changes had included:</p>	F 223		

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F 223	<p>Continued From page 11</p> <ul style="list-style-type: none"> -1:1 staff during aggressive periods. -A third CNA was placed on the day shift. *There was no special time the aggression was worse. It could be at any time. *The resident was very old. *She received a low dose antidepressant at bedtime. *There was no discussion of adding other medications at other times because she was so old, and "she would be snowed." *She was not sure if other medications had been attempted in the past. *Regarding social services involvement she: <ul style="list-style-type: none"> -Was not sure what involvement social worker (SW) I had with the resident. -Stated SW I spent most of her time in the Boulder Creek unit but would bring resident 4 back to her Arrowhead Trail unit if she had wandered down that hall. -Stated social services completed the cognitive assessment and her part of the MDS assessments for resident 4. *When asked about pain symptoms she reported: <ul style="list-style-type: none"> -Resident 4 did not report pain symptoms unless she had banged into a wall. -She had received Tylenol twice daily and as needed, but it had been decreased several months ago to prevent her from receiving too much. -She now received Tylenol daily at bedtime and as needed. -She had not used the as needed Tylenol and often spit out her scheduled medications. <p>Review of the two emails RN coordinator K had stated were the investigation for the event revealed: *A 5/9/16 email at 4:09 a.m. from RN Q stating: -The above event had occurred and had been</p>	F 223		

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F 223	<p>Continued From page 12</p> <p>witnessed by a CNA whose full name was not identified.</p> <p>-She had attempted to write a quality measure report but did not think that was the proper area to report the event, so she had not documented that.</p> <p>-She had wanted RN coordinator K to notify resident 3's son when he came to visit.</p> <p>*A 5/10/16 email at 8:27 a.m. from the activity coordinator replying on the physician's request for more activity.</p> <p>Review of resident 4's care plan revealed:</p> <p>*The updated 5/22/15 activities care plan revealed her activities included:</p> <p>-Faith.</p> <p>-TV. (Observation of resident 4's room on 7/6/16 at 9:30 a.m. and on 7/7/16 at 8:30 a.m. had revealed there was no television in her room.)</p> <p>-Music.</p> <p>-Walks outside.</p> <p>-"[Resident 4] will receive 3 1:1 visits per week from activity staff."</p> <p>*The updated 6/1/15 Psychological/Mood State/Behaviors/Coping/Depression care plan revealed:</p> <p>-"If resident is yelling, address need, redirect behavior, bring resident outside for fresh air if she wants."</p> <p>-"Redirect behaviors PRN [as needed]."</p> <p>-"If resident is safe/not harming others, leave alone."</p> <p>-"Monthly pharmacy consults, monitor for psychotropic side effects."</p> <p>*The 6/1/15 Pain/Potential for pain care plan revealed:</p> <p>-"Monitor for verbal and nonverbal s/sx [signs and symptoms] of discomfort."</p> <p>-No further interventions.</p>	F 223		

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F 223	<p>Continued From page 13</p> <p>*There were no interventions listed for 1:1 staff during aggressive periods.</p> <p>*The Plan of Care Change flowsheet attached to the care plan had indicated after the 5/8/16 event the care plan had been reviewed on 6/13/16, 6/16/16, 6/30/16, and 7/5/16. On each occasion no changes were made.</p> <p>Observation and interview on 7/6/16 at 9:22 a.m. with unlicensed assistive personnel (UAP) O and P while assisting resident 4 with her personal care revealed:</p> <p>*UAP O stated the staff usually used two to three staff to provide care for resident 4 because of her physical aggression.</p> <p>*Resident 4 displayed physical aggression toward both caregivers throughout the personal care given, including biting, pinching, hitting, and kicking.</p> <p>*When the personal care was completed the caregivers brought the resident to the table in the dining room. The resident remained agitated during the breakfast meal and was grabbing and biting at staff and throwing her food.</p> <p>*UAPs O and P had not known if the resident had pain symptoms.</p> <p>3. On 1/17/16 LPN M had documented an incident had occurred at 4:42 p.m.: "A resident was sitting at a table in the dining room when [resident 4] approached her wheelchair. When this nurse looked over, the resident was striking [resident 4] with her right hand in over head swings. She struck [resident 4] at least three times before staff was able to intervene. [Resident 4] was hit on the left side of her head, arm, and shoulder. [Resident 4] was taken to her room by this nurse and was given an assessment for any injuries. No injuries were noted at this</p>	F 223		
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F 223	<p>Continued From page 14 time."</p> <p>-No further documentation was found in the medical record regarding the event. -No physician notification had been found at the time of the event.</p> <p>Interview on 7/7/16 at 7:30 a.m. with the DON revealed she was unable to locate incident reports, investigations of the events, or the event reports. The event reports should have been sent to the SD DOH to notify them of the above events.</p> <p>4. Interview on 7/7/16 at 8:50 a.m. with SW I regarding resident 4's episodes of physical aggression toward other residents and the aggression by a resident toward resident 4 revealed: *Events of aggression and resident-to-resident abuse were reported and investigated for abuse. *The nursing department usually did the interview and the investigations, because they were present at the time of those events. *She would follow-up on them after they were completed. *She agreed the initial reports and the five-day reports had not been completed or sent to the SD DOH for: -The six unidentified residents who were struck by resident 4. -The unidentified resident who had struck resident 4. *She agreed the SD DOH reports for residents 3 and 4 resident-to-resident aggression had not included a full investigation and interviews with those present at the time of the incidents. *She had knowledge of the events, but she was not present at the time of the events because most events occurred after she went home or</p>	F 223			

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F 223	<p>Continued From page 15</p> <p>were on weekends.</p> <p>*She did not feel comfortable performing interviews or investigations when she had not been present at the time of the event.</p> <p>**"I don't talk to the CNAs, I deal with the families."</p> <p>*When asked who was supposed to be involved with the investigations she stated she and the director of nursing were supposed to perform them.</p> <p>Further interview at that time with SW I regarding resident 4's aggression toward other residents revealed:</p> <p>*She stated the resident had received a medication daily to assist with aggression, but she was not sure if any other medications had been used in the past to assist with the aggression.</p> <p>*The daughter did want something done to prevent her mother from harming other residents.</p> <p>*The resident was very old, so more medications would "snow her."</p> <p>*A hospitalization would not have been appropriate for her.</p> <p>*She was not sure if a psychiatric consultation had been tried to help reduce the behaviors, but she did not think the resident would accept any help.</p> <p>Review of resident 4's physician's progress notes revealed:</p> <p>*A 1/28/16 note indicated she had issues with irritability in the past, and the current antidepressant helped to reduce further aggression.</p> <p>*A 3/17/16 note indicated she was "oftentimes physically aggressive, but she is very frail and likelihood of hurting somebody is low."</p> <p>*A 6/22/16 note indicated she had moments of</p>	F 223			

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F 223	Continued From page 16 aggressiveness with staff but had not been overly aggressive with others. Interview on 7/7/16 at 3:15 p.m. with the DON regarding the above abuse events involving resident 4 revealed she agreed: *The above residents had been subjected to physical abuse from resident 4. *Resident 4 was subjected to abuse by other residents. *The physician should have been notified of each event. *Social services and nursing had not investigated or advocated for the at-risk residents. *Each of the above events should have been reported to the SD DOH . Review of the provider's 10/10/14 Social Services Abuse Prevention and Prohibition policy revealed: *Purpose: "Provide each resident with an environment that is free from abuse and neglect." **"Upon hire and then annually all employees will receive education and training to include the following: -Procedure to report suspected abuse. -Supervisory staff will monitor areas where abuse could occur." ***"Identification of abuse and neglect: Injury on unknown origin [includes bruises, skin tears, that are unusual for that resident]."	F 223			
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.	F 226			

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F 226	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: * Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to have systems in place to investigate, document, and report: *One of one sampled resident (3) with a fracture of unknown cause. *Two of two falls by one of one sampled resident (4). *One elopement by one of one sampled resident (4). *Incidents of resident-to-resident abuse by one of one sampled resident (4) to six unidentified residents. *One reported resident-to-resident abuse by one identified resident (3) by one of one sampled resident (4). *Incident of resident-to-resident abuse by one unidentified resident to one sampled resident (4). *One of one unidentified wound for one of one sampled resident (6). *Six of six randomly reviewed computerized incident reports for three of three sampled residents (4, 7, and 17). Findings include:</p> <p>1. Review of a confidential complaint received by the South Dakota Department of Health (SD DOH) indicated resident 3 was found to have a fractured leg. The complaint had indicated the resident was unable to bear weight and required total assistance with transfers.</p> <p>Review of an initial event report sent to the SD DOH completed by registered nurse (RN) coordinator K had indicated a suspicion/allegation</p>	F 226	<p>The incident identified has been reported to the Department of Health on July 1, 2016. Staff was educated at the mandatory nursing meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16 that a computerized incident report must be completed on all falls, injuries of unknown origin, and resident to resident abuse. All other incidents of abuse have been reported to the Department of Health since this incident. The policy on documenting, investigating and reporting of abuse has been updated on July 26, 2016. The updated policy on abuse was covered at the mandatory all staff inservice on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. A post shift checklist has been implemented to ensure the charge nurses notify the Social Workers, Director of Nursing, and administrator of potential issues that need to be reported during their shift. The long term care social worker will conduct audits of the incident reports 3 times weekly for 2 months to identify any instances of potential abuse. The results of those audits will be reported by the long term care social worker to the QAPI group that meets every other week. The long term care social worker will report the results of the audits to the PI committee that meets every other month. The PI committee will direct further audits.</p>	8-26-16

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F 226	<p>Continued From page 18</p> <p>of physical harm/injury. The report had indicated: *On 6/25/16 unidentified aides had noticed redness on resident 3's right shin. *On 6/26/16 an unidentified nurse had contacted eLTC (a video appointment with a certified nurse practitioner for urgent care), and the resident had been started on an antibiotic for a skin infection. *On 6/27/16 an unidentified aide asked the physical therapist to check the leg. Upon examination the physical therapist found the foot drooped to the side. At that time the provider contacted the eLTC again and were awaiting an X-ray to establish the cause of the injury. *Abuse/neglect had not been determined. *No personnel had been identified as being involved.</p> <p>A 5-day event investigation report was not available for viewing on 7/5/16, eight days after the fracture had been identified.</p> <p>Interview on 7/5/16 at 5:55 p.m. and on 7/6/15 at 4:30 p.m. with RN coordinator K regarding resident 3's injury event reporting revealed: *She had filled out the initial event report on 7/1/16 after it was suspected the resident had a fractured leg. *She had talked to the staff about what might have occurred prior to the discovery of the fracture. She had not documented those interviews. *She had not completed documentation of the interviews in a five day investigation report. Those reports had required information about the staff she did not have access to such as social security numbers, license numbers, and hired dates.</p> <p>Interview on 7/6/16 at 4:20 p.m. with the director</p>	F 226		

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F 226	<p>Continued From page 19 of nursing (DON) regarding resident 3's fracture revealed she agreed no formal investigation had been completed at the time the fracture had been found.</p> <p>Interview on 7/7/16 at 1:40 p.m. with the DON and social worker (SW) I regarding the investigating and reporting process for resident 3 revealed: *The DON stated: -She thought the administrator and RN coordinator K had completed the investigation. -SW 1 had not been involved in the investigation. *SW I stated she only got involved with events if she was present at the time of the event and had witnessed them.</p> <p>2. Review of resident 4's medical record revealed: *An unsigned 5/25/16 Physician's Fax Orders sheet to her physician stated "At 1626 [4:26 p.m.] [resident 4] was in the dining room and had been rolling around the tables when this writer heard another staff call out. The other staff member witnessed [resident 4] flipping over backwards in her wheelchair and did hit her head. " *A 5/25/16 entry in the resident's notes from physical therapist R had indicated a maintenance request was placed to add anti-tip bars to her wheel chair. *A 6/13/16 Physician's Fax Orders sheet to her physician stated "At 1415 [2:15 p.m.], found resident on floor in hallway. She was tipped backwards in her wheelchair." *No documentation in the resident's notes regarding the resident had fallen backward in her wheelchair on 6/13/16.</p> <p>Interview on 7/6/16 at 8:00 a.m. with the DON</p>	F 226		

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F 226	<p>Continued From page 20 regarding fall reporting and event investigation for the above resident's falls revealed:</p> <ul style="list-style-type: none"> *The Patient Falls by Location QM [quality measure] report had not included the 5/25/16 fall, so no incident report had been completed. *No SD DOH event report or five day investigation had been completed. *The Patient Falls by Location QM report had included the 6/13/16 fall, but the report was not complete. *No SD DOH event report or five day investigation had been completed. <p>Interview on 7/7/16 at 3:15 p.m. with the DON revealed SD DOH should have been notified of the above unusual events and investigated.</p> <p>Surveyor: 32355 3. Observation on 7/5/16 at 4:20 p.m. of resident 6 revealed:</p> <ul style="list-style-type: none"> *She had been resting in her bed. *Her right foot had been exposed and revealed an open wound on top of her right foot. The wound had been covered with a dark black/brown scab and measured approximately 1 centimeter (cm) by 0.5 cm. <p>Observation and interview on 7/6/16 at the above time with certified nursing assistant (CNA) S regarding resident 6 revealed:</p> <ul style="list-style-type: none"> *CNA S had been in the process of assisting the resident with her activities of daily living (ADL). *The resident had been dependent upon CNA S to assist her with all ADLs. *The resident had not been able to move the right side of her body without staff support. *She had not been aware the resident had a wound on the top of her right foot. *She had not been informed of the wound during 	F 226		

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F 226	<p>Continued From page 21 shift report that morning. *She had not worked for a few days and would have expected the staff to inform her of the wound.</p> <p>Review of resident 6's medical record revealed: *She had been admitted on 1/17/08. *Diagnoses of traumatic brain injury, aphasia, hemiparesis, and seizures. *She had: -Been dependent upon the staff to assist her with ADLs. -Not been able to move in bed without staff assistance. -Required two staff members and a transfer aide to assist her with all transfers to and from her bed and wheelchair. *No documentation to support: -The staff had been aware of the wound to her right foot. -An incident report and an investigation had been completed to confirm the cause of the wound. -The physician and family had been informed of the wound.</p> <p>Interview on 7/6/16 at 4:20 p.m. with RN coordinator A regarding resident 6 revealed: *He had not been aware of the wound to the top of her right foot. *He would have expected the staff to have informed him of the wound. *He confirmed: -The above medical record review of the resident. -An incident report and investigation should have been completed to ensure physical abuse had not occurred.</p> <p>Interview on 7/7/16 at 2:30 p.m. with the DON revealed:</p>	F 226		

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F 226	<p>Continued From page 22</p> <p>*She had done daily rounds with the staff on each unit every morning and afternoon to gather information on the current condition of the residents.</p> <p>*She had not been aware of a wound to the top of resident 6's right foot.</p> <p>*She confirmed resident 6 had been dependent upon the staff to assist her with all of her ADLs including bed mobility and transfers.</p> <p>*She would have expected:</p> <ul style="list-style-type: none"> -The staff to report an injury of that type to the nursing coordinators. -An incident report and investigation to have been completed. <p>*She agreed an injury of unknown origin should have been reported to the SD DOH.</p> <p>4. Review of resident 17's computerized 9/8/15 incident report revealed:</p> <p>*He was "Ambulating to the bathroom with the assistance of interim caregiver. His gait belt was in place. Resident's legs began to shake so the caregiver used the gait belt to lower him to the bathroom floor. On the way down, however, his lower left back did scrape against the small garbage can resulting in a 3 in long abrasion. Avera staff was then notified. VSS [vital signs] no complaints of pain."</p> <p>*There was no documentation to support if the resident had a change in his medications within the past seven days or not.</p> <p>*No documentation to support what corrective actions or safety devices had been implemented after the fall.</p> <p>*The fall had been referred to the DON and quality measure (QM) department.</p> <p>*There was no documentation to support the DON or QM department had reviewed the incident to ensure no further action were required.</p>	F 226		

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F 226	<p>Continued From page 23</p> <p>5. Review of resident 4's 10/23/15 computerized incident report revealed: *She was "Found laying outside in fenced in patio." *She had been found laying outside at 9:12 p.m. *No documentation to support: -Any witnesses had observed the fall. -When she had last been checked on or observed by the staff. -How long she had been missing. -What safety devices had been put in place since the fall. -If she had a change in her medications within the past seven days or not. -If the door alarms had been in place or activated at the time of the elopement. -The staff working during that time had been interviewed. -The SD DOH had been notified of the elopement. -An investigation had been initiated and completed following the elopement with a fall. *She had obtained an abrasion and bruise from the fall. -No documentation to support the location, severity, and size of the bruise and abrasion. *The physician had been notified with direction for the staff to complete serial temperatures. -No documentation to support the stability of her vital signs or why the serial temperatures had been recommended. *The family had not been notified. *The fall and elopement had been referred to the DON and QA department for further review. *There was no documentation to support the DON or QA department had reviewed the incident to ensure no further action from the staff were required.</p>	F 226		

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F 226	Continued From page 24 Review of resident 4's 4/26/16, 5/11/16, and 6/13/16 computerized incident reports revealed: *She was "Found on floor." *No documentation to support: -The exact location of the fall and the position the resident had been laying on the floor. -If any witnesses had observed the fall. -The last time the staff had assisted the resident or checked on her. -What safety devices had been put in place since her fall. -If she had a change in medications within the past seven days or not. -If an injury had occurred. *The fall had been referred to the DON and QA department for further review. *There was no documentation to support the DON or QA department had reviewed the incident to ensure no further action from the facility and staff were required. 6. Interview on 7/7/16 at 2:15 p.m. with the DON and SW I revealed: *They were not aware the computerized incident reports had not been fully completed. *They had no documentation to support any of the above incidents had been reviewed to ensure no further action by the staff were needed. *They would have expected the staff to have completed the incident reports as directed. *They would have expected the staff to have reported the wound to resident 6's right foot. -Any wound or injury of unknown origin should have been investigated and reported to the SD DOH. Review of the provider's 10/10/14 Social Services Abuse Prevention and Prohibition policy revealed:	F 226			

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F 226	Continued From page 25 *Purpose: "Provide each resident with an environment that is free from abuse and neglect." **Upon hire and then annually all employees will receive education and training to include the following: -Procedure to report suspected abuse. -Supervisory staff will monitor areas where abuse could occur." *"Identification of abuse and neglect: Injury on unknown origin [includes bruises, skin tears, that are unusual for that resident]."	F 226			
F 250 SS=E	Refer to F223 and F250. 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on record review, interview, and policy review, the provider failed to ensure social services were provided: *For one of four sampled residents (9) with depression. *To assist in maintaining a safe environment for all residents. Findings include: 1. Review of resident 9's Minimum Data Set (MDS) assessments for mood revealed: *On 3/25/16 admission MDS resident mood	F 250			

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F 250	<p>Continued From page 26</p> <p>interview noted: -"Thoughts that you would be better off dead, or of hurting yourself in some way" she had responded yes, and the frequency had been two to six days. *On 6/17/16 the quarterly MDS resident mood interview noted: -"Thoughts that you would be better off dead, or of hurting yourself in some way" she had responded yes, and the frequency had been seven to eleven days.</p> <p>Review of resident 9's depression screening assessments completed by the social workers (SW) and documentation of her "better off dead comments" revealed: *On 3/25/16: "SW asked [resident] if she has had thought of hurting herself. [Resident] asked if SW was talking about suicide. SW informed [resident] that she was talking about suicide or self harm. [Resident] explained to SW that she wouldn't be able to do anything while here at Rehab but she has been saving pills at home. SW asked what kind of pills she has been saving but she did not say. [Resident] said that she would take a handful of them if she was 'pushed to the edge.' SW asked what would drive her to being pushed to the edge? [Resident] replied, 'when she just couldn't take it anymore.' [Resident] did say that she would never do it but was saving pills if it ever came to it. [Resident] also informed SW that all of her family is aware that she has depression and are supportive of her. SW said that it was good that she had such a good support system and [resident] agreed and was thankful for her family. SW informed nursing of what [resident] had said to her and a fax was sent off to her primary care physician informing him of the conversation." *On 5/13/16: "[Resident] stated that she does</p>	F 250	<p>Resident #9 was referred and was seen by counselor on July 13, 2016. Resident #9's care plan has been updated to address potential for mood changes on July 8, 2016. All other residents who have the potential for suicidal thoughts based on their MDS will be referred to physician or counselor when identified during screening process. The policy for Comprehensive Assessment/Care plan policy was updated on July 26, 2016 to include the potential for residents who may have suicidal thoughts. The Comprehensive Assessment/Care Plan policy was covered at the mandatory all staff inservice on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The long term care social worker will audit 2 resident charts weekly for 2 months to identify potential resident referrals to the counselor or physician. The results of those audits will be reported by the long term care social worker to the QAPI group that meets every other week. The long term care social worker will report the results of the audits to the PI committee that meets every other month. The PI committee will direct further audits.</p>	8-26-16

and the LTC-SW involvement with those residents. PE/STOOHEL

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F 250	<p>Continued From page 27</p> <p>have thoughts of harming herself. She has had these reoccurring thoughts for many years. When asked if she had a plan to harm herself, [resident] stated 'I could make a plan if there was someone to help me. I am in here (POP) and can not form a plan for what I want to do.' [Resident] was very guarded with her answers. SW encouraged [resident] to talk about her feelings with staff at POP. SW relayed that the goal is to keep [resident] safe and to provide assistance with any reoccurring thoughts she may be troubled with." *On 6/17/16: "No."</p> <p>Further review of resident 9's medical record revealed no other social services documentation related to her depression.</p> <p>Interview on 7/6/16 at 4:30 p.m. with SW H regarding resident 9 revealed: *She had talked to registered nurse coordinator J about the resident's comments. *She had sent a note to the resident's physician. *She was unable to locate documentation of the note. *She had been seen by the chaplain. *There was no documentation of the chaplain's visits with her. *About "two weeks" ago she had sent a referral to the provider's psychologist, but she was on vacation. *There should have been something more in place for the resident related to her depression and "better off dead" comments.</p> <p>Interview on 7/7/16 at 3:40 p.m. with the director of nursing confirmed something more should have been in place for resident 9 related to her depression and "better off dead" comments.</p>	F 250			

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F 250	<p>Continued From page 28</p> <p>Surveyor: 32332</p> <p>Review of the provider's October 2011 Social Worker Job Description revealed some of the essential functions included:</p> <ul style="list-style-type: none"> *The summary indicated the social worker job was: <ul style="list-style-type: none"> -To assist the residents and their families to resolve psychosocial problems related to care needs. -To assist the interdisciplinary team in the overall care delivery system to maintain a safe, respectful and homelike environment for all residents. *She was to have been an advocate for the patient (resident) rights including dignity and safe care within and outside of the facility. *She was to have developed policies and procedures for social services. *She was to take an active role in providing education to staff on resident rights, abuse and neglect reporting, and follow-up. *The role required problem-solving skills, critical thinking skills, and the ability to multi-task. *She was to work effectively in a team environment, coordinating work flow with other team members, and ensuring a productive and efficient environment. <p>Review of the provider's 11/15/13 Social Services Policy revealed:</p> <ul style="list-style-type: none"> *Social services was responsible to ensure each resident was provided "The necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being through care planning and appropriate referral process." *The resident care plan would provide direction for staff to provide a safe and inviting environment. 	F 250		

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F 250	Continued From page 29 *Social services would monitor for changes in anxiety, depression, and behaviors. -Changes would have been noted in the medical record. -Appropriate interventions would have been addressed on the individual plan of care. *Referrals regarding changes in anxiety, depression, and behaviors would be made as needed.	F 250		
F 280 SS=E	Refer to F 223, F 226, and F 323. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

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F 280	<p>Continued From page 30 Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to update care plans to reflect the current status and needs for 6 of 13 sampled residents (2, 3, 4, 6, 8, and 9). Findings include:</p> <p>1. Random observations on 7/5/16 from 2:00 p.m. through 5:30 p.m. of resident 3 revealed: *She was laying in bed with oxygen running. *She had not gotten out of bed. *Family were at her bedside. *She had a mechanical lift system above her bed used to transfer her from her bed to her chair.</p> <p>Interview on 7/5/16 at 4:30 p.m. with registered nurse (RN) coordinator K regarding resident 3 revealed: *She had a leg fracture. *She had received hospice services since 7/1/16 due to declines in her health. *She had not taken any food or fluids other than oral care. *She had not moved herself in bed. *She had not gotten out of bed.</p> <p>Review of resident 3's medical record revealed: *She had been admitted on 4/1/13. *She had a fractured leg. *Hospice services had started on 7/1/16. *A 4/26/16 Minimum Data Set assessment indicated she required total assistance with: -Bed mobility and positioning. -Transferring. -Personal care. -Toileting.</p> <p>Review of resident 3's care plan revealed: *A 5/28/15 ADL (activities of daily living) care plan</p>	F 280	<p>Resident #3 no longer resides in the facility. Resident #4's care plan has been updated on July 7, 2016 to include a 1:1 staff member assigned to resident when her behaviors escalate. Resident #9's care plan has been updated on July 22, 2016 to address her depression, dehydration, fluid maintenance and constipation. Resident #2's care plan has been updated on July 22, 2016 to remove the clinical intervention for adverse drug reaction. Resident #6's care plan was updated on July 25, 2016 to reflect the current plan of cares related to ADL's, transfers, therapy needs, suctioning, nebulizer use and feeding tube use. Resident #8's care plan was updated on July 25, 2016 to address the lap tray on his wheelchair, oxygen use and the use of a brace on his left arm and hand. The Comprehensive Assessment/Care Plan policy was updated on July 26, 2016 and was covered at the mandatory all staff meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN Coordinators will audit 5 care plans weekly for 2 months to make sure the most current information is on the care plan. The results of those audits will be reported by the RN Coordinators to the QAPI committee that meets every other week. The Director of Nursing will report the results to the PI committee that meets every other month. The PI committee will direct further audits.</p>	8-26-16

**all other care plans reviewed and updated. PLS/DW/HKL*

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F 280	<p>Continued From page 31 indicated:</p> <ul style="list-style-type: none"> -She was fed with extensive assistance and set-up assistance after cueing by staff. -She received a pureed diet and a supplement three times daily with her meals. -She was toileted with extensive assistance of one person. -She was positioned with extensive assistance of one person. -She transferred with assistance of one person using a pivot transfer with a gait belt. <p>2. Review of resident 4's medical record revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 7/26/12. *She had multiple episodes of physical aggressiveness and agitation. *A 6/2/16 care conference indicated she was to be assigned a 1:1 staff person when behaviors had escalated or she was agitated. *She had multiple falls. <p>Review of resident 4's care plan revealed:</p> <ul style="list-style-type: none"> *Her 5/22/15 activity care plan indicated she was to receive three 1:1 activities weekly from the activity program. *Her 6/1/15 Psychological/Mood State/Behaviors/Coping/Depression care plan indicated staff were to: <ul style="list-style-type: none"> - "Redirect behaviors PRN [as needed]." - "If resident is safe/not harming others leave alone." *Her 6/1/15 Falls/Potential for Falls care plan revealed: <ul style="list-style-type: none"> - "Redirect back to neighborhood when wandering. 8/24/15." - "Remind resident to call for help." <p>Resident 4's care plan had not included she was</p>	F 280			

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F 280	<p>Continued From page 32</p> <p>to have an assigned 1:1 staff member with her when behaviors had escalated or when she was agitated.</p> <p>Surveyor: 18560</p> <p>3. Review of resident 9's medical record revealed she:</p> <ul style="list-style-type: none"> *Had been admitted on 3/18/16. *Had a diagnosis of major depressive disorder. *Had problems with dehydration, fluid maintenance, and constipation. <p>Review of resident 9's current care plan revealed no interventions to address her depression, dehydration, fluid maintenance, or constipation.</p> <p>Interview on 7/7/16 at 10:30 a.m. with RN coordinator J confirmed the above concerns should have been addressed on resident 9's care plan.</p> <p>Surveyor: 16385</p> <p>4. Review of resident 2's 9/1/15 care plan revealed a clinical intervention for adverse drug reaction and the use of psychoactive medication for depression.</p> <p>Review of resident 2's October 2015 medication administration record revealed the medication citalopram had been discontinued on 10/15/15.</p> <p>Review of the physician's 10/15/15 progress note revealed resident 2 was "on citalopram at a low dose" and "I am going to stop it."</p> <p>Interview on 7/7/16 at 9:45 a.m. with RN coordinator A revealed any RN or nurse coordinator could have made changes to the care plan.</p>	F 280		

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F 280	<p>Continued From page 33</p> <p>Surveyor: 32355 5. Observation on 7/5/16 at 4:20 p.m. of resident 6 revealed: *She had: -Been laying in her bed with two repositioning wedges located on each side of her body. -A tracheostomy. -A Foley catheter. *There had been: -A tube feeding pump, oxygen system, and nebulizer equipment located by her bed. -A floor mat located next to the left side of her bed. *Her mattress had raised edges.</p> <p>Observation on 7/6/16 from 9:57 a.m. through 10:10 a.m. of resident 6 with certified nursing assistants (CNA) S and T revealed: *The CNAs assisted the resident with personal care and transferred her out of bed and into a wheelchair (w/c). The w/c had a seatbelt attached to it. *After the resident had been transferred into her w/c the CNAs secured the seat belt across the upper part of her legs.</p> <p>Interview on 7/6/16 at the time of the above observation with CNA S revealed resident 6 had always used the seatbelt when she was sitting in her w/c. The seat belt had been used to help position her better in the w/c.</p> <p>Review of resident 6's medical record revealed: *She had been admitted on 1/17/08. *Diagnoses of traumatic brain injury, aphasia, hemiparesis, and seizures. *She had:</p>	F 280			

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F 280	<p>Continued From page 34</p> <ul style="list-style-type: none"> -Been dependent upon the staff to assist her with ADLs. -Not been able to move in bed without staff assistance. -Required two staff members and a transfer aide to assist her with all transfers to and from her bed and w/c. -Currently been working with physical therapy to help with better positioning in her w/c. -Frequently required suctioning from her tracheostomy to help remove any secretions. -Required the use of nebulizer treatments twice a day to help keep her airways open. -Required the use of a feeding tube to meet all of her nutritional needs. <p>Review of resident 6's 6/1/15 care plan revealed no intervention, focus areas, and goals, to address the above observations on 7/5/16 and 7/6/16. Her care plan had not been revised since 6/1/15 to ensure the level of care she required remained current.</p> <p>6. Observation on 7/6/16 at 4:45 p.m. of resident 8 revealed: *He had been sitting in his room in a w/c. *His left arm had been resting on top of a lap tray attached to the w/c. *He had been: -Wearing a brace on his left arm and hand. -Receiving oxygen.</p> <p>Review of resident 8's medical record revealed: *He had been admitted on 12/24/13. *Diagnoses of chronic obstructive pulmonary disease, history of pneumonia, history of a stroke with left sided paralysis, and urinary retention.</p> <p>Review of resident 8's 6/12/15 care plan revealed</p>	F 280		

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F 280	Continued From page 35 no interventions and focus areas to address the above observations on 7/6/16. His care plan had not been revised since 6/12/15 to ensure the level of care he required remained current. 7. Interview on 7/6/16 at 4:40 p.m. with RN coordinator A revealed the above concerns should have been addressed on both residents 4 and 8's care plans. He confirmed the care plans had not been reviewed and revised to ensure they reflected the residents' current levels of care. Interview on 7/7/16 at 2:45 p.m. with the director of nursing revealed she had expected the nursing staff to review and revise the care plans. They should have been doing that with their assessments and as needed to ensure appropriate care needs were being met. Review of the provider's January 2015 Comprehensive Assessment/Care Plan policy revealed: **"It is the responsibility of all staff to keep care plans current on a daily basis." **"Care plans will be updated on an ongoing basis." **"Care plans will be the guide for care that is provided."	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: 18560	F 281			

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F 281	<p>Continued From page 36</p> <p>Based on record review, interview, and policy review, the provider failed to ensure professional nursing standards were followed for one of one sampled resident (9) with constipation concerns. Findings include:</p> <p>1. Review of resident 9's 3/25/16 admission Minimum Data Set assessment revealed her bowel patterns indicated constipation had been present.</p> <p>Review of resident 9's 3/31/16 Care Area Assessment related to dehydration and fluid maintenance revealed: *A concern with dehydration and fluid maintenance due to her recent constipation. *Her bowel movements would be monitored daily.</p> <p>Review of resident 9's bowel record revealed: *For April 2016: eleven of thirty days had no documentation of her bowel movements. *For May 2016: nine of thirty-one days had no documentation of her bowel movements. *For June 2016: nineteen of thirty days had no documentation of her bowel movements. *From 7/1/16 through 7/5/16: two of six days had no documentation of her bowel movements.</p> <p>Interview on 7/6/16 at 11:10 a.m. with registered nurse coordinator J confirmed resident 9's bowel movements should have been charted daily by the certified nursing assistants. Daily bowel movement charting would have been their standard protocol.</p> <p>Interview on 7/7/16 at 3:40 p.m. with the director of nursing (DON) confirmed bowel movement patterns should have been documented per their standard protocol.</p>	F 281	<p>A stool softening medication was ordered for resident #9 on July 26, 2016. An updated constipation management program policy was created on July 26, 2016 to address each resident's individual need for intervention. The updated policy was covered at the mandatory nurse meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN coordinators will audit the BM report weekly for 2 months to ensure the constipation management policy has been initiated. The RN Coordinators will report the results to the QAPI committee that meets every other week. The RN coordinators will report the results to the PI committee that meets every other month. The PI committee will direct further audits.</p> <p><i>*on all residents PE/SDDO/H/EL</i></p>	8-26-16
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F 281	Continued From page 37	F 281			
	Review of the provider's 1/2/02 Bowel/Bladder policy revealed "Each resident/patient will be fully informed and encouraged to take an active role in the bowel/bladder program."				
	Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO, 2013, p. 350, revealed "High-quality documentation and reporting are necessary to enhance efficient, individualized patient care. Quality documentation and reporting have five important characteristics: they are factual, accurate, complete, current, and organized."				
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			
	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.				
	This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on record review and interview, the provider failed to have an individualized and comprehensive combined care plan for three of three sampled residents (3, 11, and 13) on hospice care. Findings include:				
	1. Review of resident 11's medical record revealed: *She had been admitted to hospice care on				

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F 309	<p>Continued From page 38 5/13/16.</p> <p>*The only mention of hospice on her current undated provider care plan was: -"No code." -"No hospitalization." -"Treatment in long term care (LTC) for infection."</p> <p>Interview on 7/7/16 at 9:45 a.m. with registered nurse (RN) coordinator A revealed: *The hospice care plan was separate. *All provider services had been included in the provider care plan. *Hospice services had been additional to the provider services. *The care plans had not been integrated.</p> <p>Surveyor: 18560 2. Review of resident 13's medical record revealed: *She had been admitted to hospice care on 4/16/16. *Her current provider care plan had no documentation related to hospice care.</p> <p>Interview on 7/7/16 at 3:45 p.m. with RN coordinator K revealed: *There was no information on resident 13's care plan related to her receiving hospice care. *Resident 13's hospice care plan was a separate care plan. *The two care plans had not been integrated. *Hospice care staff visited with her regarding resident 13 and any concerns. *The hospice visit reports had been kept in a separate file cabinet at the nurses' station.</p> <p>Surveyor: 32332 3. Review of resident 3's medical record revealed:</p>	F 309	<p>Resident #13's care plan has been updated on July 7, 2016 to integrate with the Hospice care plan. Residents #3 and #11 no longer reside in our facility. All other care plans for residents currently on hospice have been updated on July 28, 2016 to integrate with the Hospice care plan. The Hospice staff have been informed of the need to have integrated care plans for residents. The Comprehensive Assessment/Care plan policy was updated on July 26, 2016 to include the need to have Hospice care plans integrate with the regular care plan. The need to have integrated care plans was covered at the mandatory all staff meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN Coordinators will audit the Hospice care plans weekly for 2 months to ensure they are integrated. The RN coordinators will report the results of the audits to the QAPI committee that meets every other week and report the results to the PI Committee that meets every other month. The PI committee will direct further audits.</p>	8-26-16	

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F 309	<p>Continued From page 39</p> <ul style="list-style-type: none"> *She had received hospice services from 10/29/15 to 5/9/16. *The hospice services had been discontinued on 5/9/16, as she no longer met the requirements. *Hospice services had been restarted on 7/1/16. *Physician's orders dated 7/1/16 for medications and hospice services. *No hospice documentation had been located in the medical record other than the physician's orders. *No current care plan from hospice for the current admission. *No record of what services the hospice staff provided. *Resident 3's 11/2/15 End of Life Planning section of the provider's care plan included: <ul style="list-style-type: none"> - "Hospice care start 10/30/15." - The hospice RN was to have seen her weekly and as needed. - The hospice aide was to have provided personal care as needed. - "Collaboration b/t [between] staff and hospice staff re: resident care." *No updated information that hospice had been discontinued in May or restarted in July. <p>Interview on 7/6/16 with RN coordinator K regarding hospice collaboration of care revealed:</p> <ul style="list-style-type: none"> *The hospice staff had their documentation in a separate electronic medical record (EMR). *She was not allowed access to that EMR system. *The provider had not yet received documentation of the care plan or charting from hospice. <p>4. Interview and review of the above information on 7/7/16 at 3:15 p.m. with the director of nursing revealed:</p>	F 309			

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F 309	Continued From page 40 *She was not aware the provider's staff could not access the hospice EMR. *She would have expected the hospice provider's staff and her staff to collaborate what care would have been provided by each of them. *There was no policy available for the collaboration of hospice and provider care.	F 309			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure resident's safety had been maintained for one of one sampled resident (4) who eloped from an opened door and had fallen on the ground outside in potentially hazardous weather conditions. Findings include: 1. Review of resident 4's medical record revealed on 10/23/15 at 11:09 p.m. licensed practical nurse (LPN) M had documented: **At 2112 [9:12 p.m.] resident was found laying outside in the grass. She was brought inside, given a warm shower by staff, dried off completely, dressed in long pajamas, and put into bed with heated blankets. Vital signs WNL [within	F 323	The vendor fixed the door that the resident was able to get out of on 11/18/15. Maintenance will continue to test the wander monitoring system daily as part of their rounding checklist. Nursing staff will continue to check wander bracelets daily as part of their daily routine. All staff were educated on the responsibility of everyone to respond to door alarms and the reporting procedure for elopement at the all staff meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The long term care social worker will conduct audits of the bracelet checks weekly for 2 months. The long term care social worker will report the audits to the QAPI committee that meets every other week. The long term care social worker will report the results of the audits to the PI committee that meets every other month. The committee will conduct further audits.	8-26-16	

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F 323	<p>Continued From page 41</p> <p>normal limits] except temp. eLTC [urgent care telehealth encounter] [long-term care telephone communication with licensed medical professionals for urgent care] was contacted and informed this nurse to continue to monitoring the temp. Resident did respond appropriately to this nurse's questions. Family will be contacted in the morning. No new bruises or lacerations noted at this time. Will perform another skin assessment in the morning."</p> <p>*"Running temperatures post fall: -2115 [9:15 p.m.], 87.3 [degrees]. -2125 [9:25 p.m.], 90.7. -2135 [9:35 p.m.], 91.7. -2145 [9:45 p.m.], 92.9. -2157 [9:57 p.m.], 94.2. -2225 [10:25 p.m.], 95.1. -2255 [10:55 p.m.], 95.8. -2330 [11:30 p.m.], 96.4."</p> <p>*On 10/23/15 at 9:45 p.m.: "Provider notified: eLTC notified of fall for consult. Reason for notification: Consult post fall for low temp."</p> <p>Further review of resident 4's medical record revealed: *No further documentation in the nurses progress notes regarding the event or the resident's status. *A 10/26/15 note in her Plan of Care change flow sheet by registered nurse (RN) coordinator G stated "Care plan reviewed d/t [due to] fall 10/23/15." There was a 0 with a line through it and a triangle indicating "[No change] at this time." *A 1/15/16 note in her Plan of Care change flow sheet by social worker (SW) I stated, "Resident unable to leave neighborhood unaccompanied." *Her 6/1/15 Cognitive Loss/Dementia care plan indicated: -She had a diagnosis of dementia.</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>-She was not to leave the neighborhood without staff or family.</p> <p>*An 8/24/15 Falls/Potential for Falls care plan indicated staff were to "redirect back to neighborhood when wandering."</p> <p>*Her 5/5/15 Minimum Data Set (MDS) comprehensive assessment done to measure each resident's cognitive, emotional, and physical status documentation for her Brief Interview of Mental Status (BIMS) was left blank.</p> <p>*Her BIMS scores on the 1/2/16 and on 4/5/16 MDS had been marked as 0 indicating severe brain impairment.</p> <p>*Multiple falls in the past nine months.</p> <p>Interview on 7/6/16 at 5:30 p.m. with RN coordinator K regarding resident 4's elopement and fall outdoors on 10/23/15 revealed she had not known about the event. She had not been working at the facility at the time.</p> <p>A copy of all of resident 4's falls noted in the medical record and all reportable event reports that were to have been provided to the South Dakota Department of Health (SD DOH) were requested on 7/6/16. On 7/7/16 at 8:00 a.m. the director of nursing (DON) provided a Patient Falls by Location report stating the computer generated report had listed all falls, events, and reportable events that had been documented. The list included the 10/23/15 event that consisted of: "Resident found laying outside in fenced in patio."</p> <p>Interview at that time with the DON regarding the above Patient Falls by Location report revealed:</p> <p>*She was unable to locate any incident report or further documentation.</p> <p>*A report of the fall/elopement had not been filled</p>	F 323		

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F 323	<p>Continued From page 43 out or sent to the SD DOH. *She could not locate any investigation of the event.</p> <p>Interview on 7/7/16 at 8:50 a.m. with SW I revealed: *She recalled resident 4 had been found outdoors on 10/23/15. *The two courtyard doors: -Had been left unlocked after the provider moved into the new building in June 2015. -They remained unlocked so residents could freely go outdoors, because it was the summer months. *A coding system had been installed on the doors after resident 4 had been found outdoors to prevent residents who wandered from going outdoors unassisted. *Nurses were to have locked the doors after a certain hour, but she did not know what time that was. *She was not sure if there was a policy for locking the doors.</p> <p>Further interview with SW I at the above time regarding her participation in events and investigations revealed she stated: *Normally the nurse would fill out the investigations, but she followed-up on the investigations and reporting. *Resident 4's elopement/fall on 10/23/15 should have been investigated, but she was not present at the facility at the time of the event. *She was not comfortable doing the investigation interviews with the staff, because she was not there at the time of the event. Most events occurred on the weekend. **"I don't talk to the CNAs [certified nursing assistants]. I deal with the families."</p>	F 323		

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F 323	Continued From page 44 Interview on 7/7/16 at 3:15 p.m. with the DON and the management facility services director revealed: *There was no policy regarding the courtyard doors. *The door alarms were added on 11/18/15 after resident 4 had been found outdoors. *They agreed the doors should have been locked to prevent cognitively impaired residents from wandering outdoors. *The DON agreed an event report should have been completed, and the event should have been investigated. *The DON stated: -The Patient Falls by Location report was the same as a QI/QM report. -The QI/QM reports were the same as an incident report. -She would not have a policy for those reports. Review of the provider's 10/10/14 Social Services Abuse Prevention and Prohibition policy revealed: *Purpose: "Provide each resident with an environment that is free from abuse and neglect." **"Upon hire and then annually all employees will receive education and training to include the following: -Procedure to report suspected abuse. -Supervisory staff will monitor areas where abuse could occur." **"Identification of abuse and neglect: Injury of unknown origin [includes bruises, skin tears, that are unusual for that resident]."	F 323			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329			

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F 329	<p>Continued From page 45</p> <p>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review and interview, the provider failed to ensure psychotropic medication use for two of four sampled residents (7 and 8) had been monitored for effectiveness. Findings include:</p> <p>1. Review of resident 7's medical record revealed: *He had been admitted on 9/13/14. *He had current diagnoses of: -Dementia. -Major depressive disorder.</p>	F 329	<p>Daily charting on resident behavior was started on July 22, 2016 for resident #8 and on July 25, 2016 for resident #7. All other residents who are on [REDACTED] medications will begin daily charting on August 8, 2016. Resident #7 saw his physician on July 20, 2016. Physician chose to continue Zyprexa as ordered. The consultant pharmacist will review all residents on [REDACTED] medications monthly to determine if a decrease or discontinuation is appropriate. The medication policy has been updated on July 26, 2016 to reflect the changes in anti-psychotics and to include the need for daily behavioral charting. The medication policy was covered at the mandatory nurse meeting on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN coordinators will audit daily charting for behavior on 3 residents on [REDACTED] medications weekly for 2 months. The RN coordinators will report the results of the audits to the QAPI committee that meets every other week. The RN coordinators will report the results of the audits to the PI committee that meets every other month. The PI committee will direct further audits.</p>	8-26-16

*anti-
psychotics
PE/SDDOT/EL

*anti-psychotics
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F 329	<p>Continued From page 46</p> <ul style="list-style-type: none"> -Heart disease. -High blood pressure. -Constipation. <p>*The 4/26/16 quarterly Minimum Data Set assessment was unable to rate his Brief Interview for Mental Status score, since he refused to respond to questions.</p> <p>Review of resident 7's physician's orders revealed:</p> <ul style="list-style-type: none"> *On 2/8/16 he had been prescribed Zoloft (an antidepressant) 25 milligrams (mg) daily and Ativan (to reduce anxiety) 0.5 mg twice a day. *On 4/21/16 he was prescribed Zyprexa (an antipsychotic) 5 mg at bedtime for hallucinations. *On 5/16/16 he was noted to have increased behaviors. -Zyprexa 5 mg at bedtime was discontinued. -Ativan 0.5 mg twice daily was discontinued. -He was prescribed Zyprexa 2.5 mg twice a day. *On 5/26/16 he was noted to have increased behaviors. -His Remeron (antidepressant/sleep aid) was increased to 30 mg at bedtime. <p>Review of the provider's interdisciplinary progress notes for resident 7 revealed there was documentation of his behavior:</p> <ul style="list-style-type: none"> *Once in January by nursing staff. *Once in February by the registered nurse (RN) coordinator. *No entries by staff in March. *Two entries in April by nursing staff. *One entry in May by the RN coordinator. *Two entries in June by the RN coordinator and the social worker. <p>Interview on 7/7/16 at 1:15 p.m. with the director of nursing (DON) regarding resident 7 revealed:</p>	F 329		

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F 329	<p>Continued From page 47</p> <p>*She acknowledged it was difficult to assess his response to medications and reduction of symptoms without charting his behaviors on a regular basis.</p> <p>*It was her expectation there would be charting every day regarding the resident's behavior.</p> <p>Surveyor: 32355</p> <p>2. Review of resident 8's medical record revealed:</p> <p>*He had been admitted on 12/24/13.</p> <p>*Diagnoses of chronic obstructive pulmonary disease, history of pneumonia, history of a stroke with left sided paralysis with sexual behaviors, and urinary retention.</p> <p>*He was alert and oriented with good memory recall.</p> <p>*He had required the use of a suprapubic catheter to assist his bladder with emptying urine.</p> <p>*A physician's order for Zyprexa 2.5 mg everyday at bedtime dated 7/31/14 for inappropriate sexual behaviors.</p> <p>*On 7/21/15 the pharmacy had recommended the physician try a dose reduction of the Zyprexa.</p> <p>Review of resident 8's physician's orders revealed:</p> <p>*On 7/23/15 the physician had ordered the Zyprexa to be discontinued.</p> <p>*On 9/18/15 the staff had sent a request to the physician for the Zyprexa to be restarted due to inappropriate sexual behaviors.</p> <p>*The physician had restarted the Zyprexa on 9/18/15 after receiving the above staff request.</p> <p>Review of resident 8's progress notes from 7/23/15 through 9/18/15 revealed no documentation to support the resident had an increase in sexual behaviors during that time</p>	F 329			

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F 329	Continued From page 48 frame. Interview on 7/6/16 at 4:30 p.m. with registered nurse coordinator A confirmed there had been no behaviors documented in resident 8's medical record to support the restarting of the Zyprexa. Interview on 7/7/16 at 2:40 p.m. with the DON regarding resident 8 revealed it was her expectation the staff had been charting every day regarding his behaviors. The staffs' charting should have supported the use of the antipsychotic medication. The provider had no policy or procedure in place for the staff to follow for behavioral documentation of an antipsychotic or mood altering medication.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, and policy review, the provider failed to ensure a less than five percent medication error rate had occurred for 1 of 29 resident (18) during two medication administrations for that resident. Findings include: 1. Observation on 7/6/16 at 8:00 a.m. of licensed practical nurse C with resident 18 revealed she: *Administered Refresh Optive eye drops with one	F 332		

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F 332	Continued From page 49 drop into each eye. *Immediately followed the above with the administration of dorzolamide eye drops with one drop in each eye. *Verified that was her usual practice with eye drops. Interview on 7/7/16 at 1:15 p.m. with the director of nursing regarding resident 18's eye drops revealed it was her expectation staff wait at least several minutes between administering two different eye drops. Review of the provider's 10/27/15 Medication policy revealed it had not addressed the administration of eye drops. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO, 2013, p. 617, revealed "If patient [resident] receives more than one eye medication to the same eye at the same time, wait at least five minutes before administering the next medication."	F 332	Resident #18 is currently receiving the medication by the correct process. Staff were educated at the mandatory all staff inservice on 7/27/16, 7/28/16, 8/1/16 and 8/2/16 on the correct process for delivering identified medication. The medication policy was covered at the mandatory nurses meetings on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN coordinators will audit medication delivery process to include proper eye drop administration 4 times weekly for 2 months. The results of those audits will be reported by the RN Coordinator to the QAPI committee that meets every other week. The results will be reported by the RN coordinator to the PI committee that meets every other month. The PI committee will direct further audits.	8-26-16	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	*All other residents receiving eye drops were reviewed to ensure they were receiving eye medications correctly. PE/SDDOTT/EL		

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F 371	<p>Continued From page 50</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Based on observation and interview, the provider failed to ensure sanitary conditions were maintained during two of three meal services by three of three food and nutrition workers (E, F, and U). Findings include:</p> <p>1. Observation on 7/5/16 at 5:00 p.m. of the evening meal service in the Rehab kitchenette revealed food and nutrition worker U: *Pushed the thermometer through the aluminum foil to take the temperatures of all food served from the steam table. *With gloved hands she: -Handled drawer handles, cupboard handles, food cart handle, entered key code on door, opened door going back and forth between nutrition service area and kitchenette four times, handled ice cream container, used pencil off and on to scratch off names of residents who had been served, handled wrap over hamburger buns, handled knife to cut RTE hamburger buns, and filled hamburger buns throughout the serving time. *Had not been observed changing her gloves or washing her hands during the entire meal service to prevent cross-contamination when handling RTE food.</p> <p>2. Observation on 7/5/16 from 5:00 p.m. through 5:30 p.m. of food and nutrition worker E in the second floor kitchenette revealed: *He had been in the process of serving the supper meal. *He had gloves on and with those gloved hands he: -Handled drawer and cupboard handles, food cart</p>	F 371	<p><i>*Including staff members E, F and U.</i> <i>DE/SDDO/H/EL</i></p> <p>Kitchen staff was educated on the correct process for taking temperatures of prepared food and proper glove use on July 25 and July 26, 2016. Kitchen staff is currently using the correct process for taking temperatures for prepared food. The policy for taking temperatures was updated on July 25, 2016 to reflect the proper process for taking the temperature of food covered in foil. The updated temperature policy and the hand hygiene policy were covered at the all staff meeting on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The support services manager will conduct audits of food temperatures 3 times per week for 2 months. The support services manager will also conduct audits of glove use 3 times per week for 2 months. The support services manager will report the results of the audits to the PI committee that meets every other month. The committee will conduct further audits.</p>	8-26-16
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F 371	<p>Continued From page 51</p> <p>handle, removed tin foil from two serving wells, opened the refrigerator door to retrieve a container of cottage cheese, removed the plastic covering a salad, handled paper with resident meal information, and used a pencil to document on residents who had been served.</p> <p>-Opened and filled hamburger buns throughout the meal service.</p> <p>-Touched lettuce twice while preparing a salad for two unidentified residents.</p> <p>*He had not been observed changing his gloves and washing/sanitizing his hands during the entire meal service.</p> <p>-That had created the potential for cross-contamination of bacteria when handling RTE foods.</p> <p>Surveyor: 16385</p> <p>3. Observation on 7/6/16 at 11:45 a.m. of the noon meal service in the second floor kitchenette revealed food and nutrition worker F had pushed the thermometer through the aluminum foil to take the food temperatures. He continued the process with all the food served from the steam table.</p> <p>Surveyor: 18560</p> <p>4. Interview on 7/7/16 at 9:10 a.m. with the certified dietary manager revealed:</p> <p>*Gloves should have been used for one task and changed when task completed.</p> <p>*Gloves should have been used when handling RTE foods.</p> <p>*The food and nutrition workers should have only touched the RTE food with gloved hands.</p> <p>*Food temperatures should not have been taken through the aluminum foil.</p> <p>*They did not have a policy or procedure for glove</p>	F 371		

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F 371	Continued From page 52	F 371		
F 386 SS=D	<p>use or for the food temperature process.</p> <p>483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS</p> <p>The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review and interview, the provider failed to ensure the physicians reviewed 2 of 13 sampled residents' (6 and 8) entire plans of care with each visit. Findings include:</p> <p>1. Review of resident 6's medical record revealed: *She had been seen by the physician for a sixty day review on 5/12/16 and 6/30/16. *The physician had reviewed all of her medications during those visits. -Those medications had been signed and dated by the physician. *No documentation to support the physician had taken an active role in reviewing her treatments the staff had assisted her with on a daily and as needed (PRN) basis. -Those treatments had not been attached to the current medication list for the physician to review on those visits.</p>	F 386	<p>The physician order sheet to include treatments was updated on July 26, 2016 and signed by the physician for residents #6 and resident #8. On 8/2/16, we will begin using the electronic MAR. The electronic MAR will include the treatments as well as the medications for the physician to review sign on all 60 day visits. The updated policy was covered at the mandatory nurses meeting on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN coordinators will audit 2 physician order sheets weekly for 2 months to ensure an updated physician signature has been obtained. The RN coordinators will report the audits to the PI committee that meets every other month. The PI committee will conduct further audits.</p>	8-26-16

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F 386	Continued From page 53 2. Review of resident 8's medical record revealed: *He had been seen by the physician for a sixty day review on 6/20/16. *The physician had reviewed all of his medications during that visit. -Those medications had been signed and dated by the physician. *No documentation to support the physician had taken an active role in reviewing his treatments the staff had assisted him with on a daily and PRN basis. -Those treatments had not been attached to the current medication list for the physician to review on that visit. 3. Interview on 7/6/16 at 4:20 p.m. with registered nurse coordinator A confirmed the above medical record reviews. He had not been aware the physicians had not been reviewing the resident's entire plan of care. He agreed the above physicians should have been reviewing the resident's treatment plans to ensure they remained current and appropriate for the resident. Interview on 7/7/16 at 2:45 p.m. with the director of nursing revealed: *She would have expected the physicians to have been reviewing the residents' entire plans of care, including treatment plans and orders. *The provider had no policy or procedure in place for the staff and physicians to follow to ensure the resident's plan of care had been completely reviewed.	F 386			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 54 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (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.	F 441	Resident #6's feeding supplement was removed and the nebulizer mask has been dated and initialed on July 27, 2016. The oxygen tubing, suction tubing and feeding tube for resident number #12 was dated and initialed on July 27, 2016. The nursing staff completed an inservice on 7/27/16, 7/28/16, 8/1/16 and 8/2/16 on the proper catheter bag care, proper hand hygiene, and proper perineal area cleaning procedure. The policy for cleaning the whirlpool tubs was posted in the whirlpool rooms on July 27, 2016. The whirlpool tub cleaning policy was covered at the mandatory nurses meeting on 7/27/16, 7/28/16, 8/1/16 and 8/2/16. The RN coordinator will conduct audits of oxygen, suctioning or feeding tubing on 3 residents weekly for 2 months. The RN Coordinator will conduct audits of the cleaning of the whirlpool tub 2 times weekly for two months. The RN Coordinator will conduct audits of proper glove use and hand hygiene 3 times weekly for two months. The RN Coordinator will audit proper perineal area cleaning procedure 3 times weekly for two months. The results of those audits will be reported by the RN Coordinator to the QAPI committee that meets every other week. The results will be reported by the RN coordinator to the PI committee that meets every other month. The PI committee will direct further audits.	8-26-16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/07/2016
NAME OF PROVIDER OR SUPPLIER AVERA PRINCE OF PEACE		STREET ADDRESS, CITY, STATE, ZIP CODE 4513 SOUTH PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103		
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F 441	<p>Continued From page 55</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 32355</p> <p>A. Based on observation, interview, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *Proper placement of two of two urinary catheter bags for two of two sampled residents (6 and 8) who had a catheter. *Proper handwashing and glove use observed during medication administration and personal care for one of one sampled resident (6) by one of one licensed practical nurse (LPN) C. *A clean technique had been used during personal care for one of two sampled residents (6) who had a Foley catheter. *Medical equipment had been dated and initialed by the staff when changed for three of three sampled residents (6, 8, and 12). *Two of two tube feeding bottles had been dated, timed, and initialed by staff upon opening for two of two sampled residents (6 and 12) who had a feeding tube. *Proper placement of suctioning equipment after use for one of two sampled residents (12). <p>Findings include:</p> <p>1a. Observation on 7/6/16 at 7:30 a.m. of registered nurse (RN) B with resident 6 revealed:</p> <ul style="list-style-type: none"> *The resident had been laying in her bed. Attached to the side of her bed was a Foley catheter bag. *RN B assisted the resident with multiple areas of personal care. *After RN B had completed the personal care she lowered the resident's bed down closer to the floor. *The opening to the resident's Foley catheter bag had been touching the floor after RN B lowered her bed. 	F 441		

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F 441	<p>Continued From page 56</p> <p>b. Observation on 7/6/16 at 8:55 a.m. of certified nursing assistant (CNA) D with resident 8 revealed: *The resident had been laying in his bed. Attached to the side of his bed had been a Foley catheter bag. *He had: -Prepared to transfer the resident from his bed to a wheelchair (w/c). -Removed the Foley catheter bag from the side of the bed and laid it down on the floor during the transfer. -Not placed a barrier between the Foley catheter bag and the floor to ensure cross-contamination of bacteria had not occurred.</p> <p>Interview on 7/6/16 at the time of the observation with CNA D revealed: *That had been his usual process for transferring the resident from his bed to the w/c. *He agreed: -The floor had not been considered a clean surface. -He should not have laid the Foley catheter bag directly on the floor. -The process had created the potential for cross-contamination of bacteria.</p> <p>c. Interview on 7/6/16 at 9:30 a.m. with LPN C confirmed the catheter bags should not have been placed on the floor. She agreed the process had created the potential for cross-contamination.</p> <p>2. Observation on 7/6/16 at 9:10 a.m. of LPN C with resident 6 revealed: *She had prepared to assist the resident with multiple tasks. The tasks had been to: -Administer medications through her feeding</p>	F 441			

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F 441	<p>Continued From page 57 tube.</p> <ul style="list-style-type: none"> -Wash her face and apply a special cream. -Lotion her arms and legs. -Administer a nebulizer treatment. <p>*She had changed her gloves multiple times during each of the above tasks. *She had not been observed washing or sanitizing her hands until she had completed all of the tasks above.</p> <p>Interview on 7/6/16 at the time of the above observations with LPN C revealed: *That had been her usual process for completing the above tasks for the resident. *She agreed: -She should have washed or sanitized her hands after each glove change. -The process had not been completed in a sanitary manner and had created the potential for cross-contamination of bacteria.</p> <p>3. Observation on 7/6/16 at 9:10 a.m. of CNA C with resident 6 revealed: *She had prepared to assist the resident with perineal care. *With gloved hands she had washed the resident's bottom first. The resident had been incontinent with a large bowel movement. *With those soiled gloves CNA C washed the perineal area of the resident. She had washed the area from the back to the front.</p> <p>Interview on 7/6/16 at the time of the above observation with CNA C revealed: *That had been her usual process for assisting the residents with perineal care. *She had not been aware she washed the resident's perineal area from back to front. *She agreed:</p>	F 441			

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F 441	<p>Continued From page 58</p> <ul style="list-style-type: none"> -Her gloves had been soiled after washing the resident's bottom. -She should have removed her gloves and washed her hands prior to washing the resident's perineal area. -She should have washed the resident's perineal area first. -The above process had created the potential for cross-contamination of bacteria. <p>4a. Observation on 7/5/16 at 4:10 p.m. of resident 6's room revealed:</p> <ul style="list-style-type: none"> *An open bottle of tube feeding supplement attached to plastic tubing and a pump. The bottle had been a fourth full. *The pump had been turned off, and the feeding tube supplement was not connected to the resident's feeding tube. *The tube feeding bottle had no date, time, or initials on the label to indicate: <ul style="list-style-type: none"> -The date it had been opened. -The time of day it had been opened. -Who had opened the bottle. *A nebulizer machine with the mask and chamber attached to it on her bedside table. The equipment had not been dated or initialed to support: <ul style="list-style-type: none"> -When it had been changed. -Who had changed it. <p>b. Observation on 7/5/16 at 4:30 p.m. of resident 8 and his room revealed:</p> <ul style="list-style-type: none"> *He had been: <ul style="list-style-type: none"> -Sitting in his wheelchair in his room. -Receiving oxygen through a plastic tubing placed inside of his nose. *The oxygen tubing had no date or initials on it to indicate the last time it had been changed and by whom. 	F 441		

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F 441	<p>Continued From page 59</p> <p>*A nebulizer machine with the mask and chamber attached to it on his bedside table. The equipment had not been dated or initialed to indicate: -The date it had been changed. -Who had changed it.</p> <p>c. Observation on 7/6/16 at 3:50 p.m. of resident 12 and her room revealed: *She had been laying in bed with oxygen attached to her tracheostomy. The oxygen tubing had no date or initials on it to support the last time it had been changed. *There had been a feeding tube bottle attached to plastic tubing and a pump. The resident had been receiving the supplement through her feeding tube. *The tube feeding bottle had no date, time, or initials on the label to support: -The date it had been opened. -The time of day it had been opened. -Who had opened it. *Further observation revealed: -A Yankauer suction tip had been laying directly on top of the resident's bedside table. The suction tip had no barrier between it and the top of the bedside table. -Suction tubing attached to the suction unit on the wall. The tubing had no date, time, or initials to support the last time it had been changed. -The end of the suction tubing had not been covered, and the tubing had been full of thick yellow colored phlegm. -The phlegm had been dropping out of the end of the open tubing onto the resident's bedside table.</p> <p>d. Interview on 7/6/16 at 4:30 p.m. with RN coordinator A and RN B revealed: *They confirmed:</p>	F 441		

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F 441	<p>Continued From page 60</p> <ul style="list-style-type: none"> -The catheter bags and their openings should not have been placed on the floor. -LPN C should have washed or sanitized her hands in-between each glove use. -Personal care for resident 6 had not been performed in a sanitary manner. The CNA should have washed the perineal area first and from the front to the back. -All medical equipment and tube feeding bottles should have been dated, timed, and initialed by the staff to support timeliness of changing. -All of the suction equipment should have been placed in a plastic bag or some type of barrier to ensure no cross-contamination of bacteria transferred to the resident. <p>*They agreed the above processes had not been completed in a sanitary manner, and there had been potential of cross-contamination of bacteria to the resident.</p> <p>Interview on 7/7/16 at 2:50 p.m. with the director of nursing further confirmed the above interview with RN coordinator A and RN B. She would have expected them to have been monitoring the above processes to ensure sanitary conditions were maintained.</p> <p>Review of the provider's August 2015 Infection Prevention and Control Standard Precautions policy revealed: *Purpose: -"Provide for protection of patients [resident] and visitors from the spread of infectious illness and disease. -To reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection." *"All patients are potential sources of infectious illness and disease. Standard precautions are to</p>	F 441			

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F 441	<p>Continued From page 61</p> <p>be used for the care of all patients." *"Administration, department heads/managers, and supervisors share responsibility for monitoring compliance with standard precautions." *"Hand Hygiene is the single most important method to prevent the spread of infection and will be performed: -Before and after glove removal. -Between different tasks and procedures on the same patient to prevent cross-contamination of body sites." *"Patient supplies and equipment: -"Will be stored in a manner to prevent cross-contamination and protected from the environment." -Revealed no process or procedure to ensure all medical equipment and tube feeding supplies/bottles were dated, timed, and initialed by the staff.</p> <p>Review of the provider's 1/13/13 Cleaning/Care of Catheter Bags policy revealed no process or procedure in place for the staff to follow to ensure proper placement did not occur on the floor or on contaminated surfaces.</p> <p>Surveyor: 32332 B. Based on observation, interview, and policy review, the provider failed to follow their policy for cleaning and disinfecting two of two observed whirlpool tub cleanings. Findings include:</p> <p>1a. Observation and interview on 7/6/16 at 9:00 a.m. with CNA L instructing how she cleaned a whirlpool tub in the Boulder Creek spa room revealed between every resident-use she would have: *Placed the tub chair in the tub and closed the</p>	F 441		

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F 441	<p>Continued From page 62</p> <p>door.</p> <ul style="list-style-type: none"> *Closed the drain and turned the disinfectant/cleansing knob to disinfectant. *Turned on the water and jets. *Filled the tub "about half-way full" (She pointed to an area approximately two feet off the tub floor.) *Used a scrub brush to scrub the entire chair and all of the walls and the floor of the tub. *Left the disinfectant in the tub "about ten to fifteen minutes." *Turned the jets off and drained the tub. *Rinsed the disinfectant from the tub. <p>Further interview with CNA L regarding:</p> <ul style="list-style-type: none"> *The 'cleaner' knob for pre-cleaning the tub revealed she: <ul style="list-style-type: none"> -Had not known the knob turned to the cleaner. -Had not used the pre-cleaner. *The tub cleaning directions revealed she stated there were no directions available in the spa room for the cleaning of the tub. <p>b. Observation and interview on 7/6/16 at 10:15 a.m. with CNA D on how he cleaned the whirlpool tub in the Bluegrass Way/Platinum Ridge spa room revealed between every resident-use he would have:</p> <ul style="list-style-type: none"> *Placed the tub chair in the tub and closed the door. *Rinsed the tub and tub chair with water, but he would not close the drain or fill the tub with water. *Obtained a container of Cid-A-L II quaternary disinfectant from the spa closet and "sprinkled the cleaner onto tub and chair and then scrubbed." *Allowed the disinfectant to sit "a few minutes" before rinsing. *Rinsed the disinfectant off the tub and chair with water. 	F 441		

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F 441	<p>Continued From page 63</p> <p>Further interview with CNA D at the above time regarding how much disinfectant he used to clean the tub revealed he: *Stated he knew how much he used. *Displayed how he would shake the cleaner from the container two or three times without measuring. *Stated there were no directions available for cleaning the whirlpool tub.</p> <p>Further observation during the above cleaning observation by CNA D revealed he had also not: *Used the disinfectant/cleaner knobs on the whirlpool tub. *Turned on the whirlpool jets.</p> <p>c. Review of the provider's March 2008 Cleaning and Disinfecting of Apollo Bathing Systems policy revealed cleaning of the whirlpool tub was to have been completed between each resident's use. The CNA was to have: *Placed the chair in the tub and closed the door. *Closed the drain. *Turned the rinse knob to cleanser. *Turned the clean knob to the on position. *Turned the jets on. *Filled the tub with five inches of the water cleaner mixture. *Turned the jets off. *Scrubbed the inside of the tub and the chair with a brush and allowed the cleaner to sit for ten minutes. *Rinsed the tub and opened the drain. *Opened the tub door.</p> <p>Disinfection of the whirlpool tub was to have been completed at the end of the day. The CNA was to have:</p>	F 441		

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F 441	<p>Continued From page 64</p> <ul style="list-style-type: none"> *Placed the chair in the tub and closed the door. *Closed the drain. *Turned the rinse knob to disinfectant. *Turned the clean knob to the on position. *Turned the jets on. *Scrubbed the inside of the tub and the chair with a brush and allowed the cleaner to sit for ten minutes. *Rinsed the tub. *Rinsed the tub and opened the drain. *Opened the tub door. <p>The disinfection procedure had not included:</p> <ul style="list-style-type: none"> *Filling the tub with water or disinfectant solution. *Turning the jets off. <p>Interview on 7/7/16 at 1:15 p.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> *She agreed the staff had not followed their policy for the whirlpool cleaning and disinfection. *She had requested manufacturer's directions and the new tub policy from the provider several times after the facility had opened in June 2015. However she had not received a copy. *She would have expected the staff to follow the manufacturer's directions for cleaning the whirlpool tub. 	F 441		

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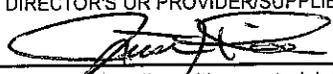
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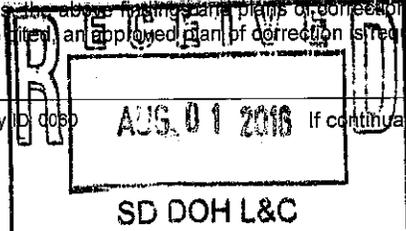
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 7/6/16. Avera Prince of Peace (building 02 replacement facility) was found in 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 New 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 	TITLE <i>Administrator</i>	(X8) DATE <i>7-29-16</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 a requisite to continued program participation.



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

ORIGINAL

PRINTED: 07/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 3 B. WING _____	(X3) DATE SURVEY COMPLETED 07/06/2016
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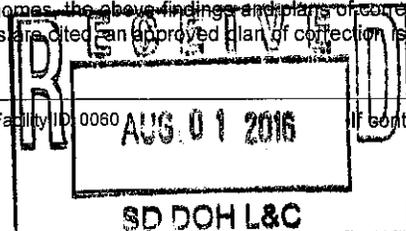
NAME OF PROVIDER OR SUPPLIER avera prince of peace	STREET ADDRESS, CITY, STATE, ZIP CODE 4513 SOUTH PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new business occupancy) was conducted on 7/6/16. Avera Prince of Peace (building 03 business occupancy) 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 New Business 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 	TITLE <i>Administrative</i>	(X6) DATE <i>7-29-16</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.



ORIGINAL

PRINTED: 07/18/2016
FORM APPROVED

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/07/2016
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NAME OF PROVIDER OR SUPPLIER avera prince of peace	STREET ADDRESS, CITY, STATE, ZIP CODE 4513 PRINCE OF PEACE PLACE SIOUX FALLS, SD 57103
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/5/16 through 7/7/16. Avera Prince of Peace was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 18560 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 7/5/16 through 7/7/16. Avera Prince of Peace was found in compliance.	S 000		

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

TITLE

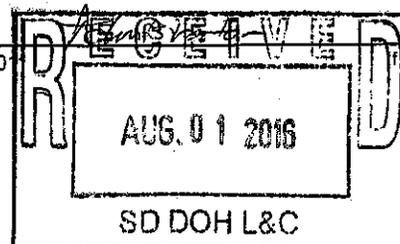
(X6) DATE

7-29-16

STATE FORM

6899

LIMO



Continuation sheet 1 of 1