

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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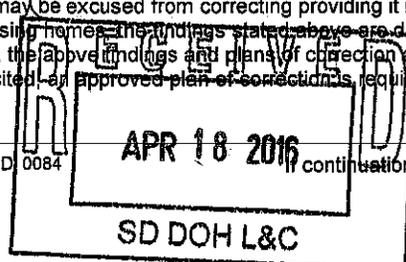
NAME OF PROVIDER OR SUPPLIER SUN DIAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219
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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/21/16 through 3/23/16. Sun Dial Manor was found not in compliance with the following requirements: F226, F274, F280, F281, and F309.	F 000	*Addendums noted with an asterisk per 4/20/16 per telephone with facility administrator. ML/SDDOH/EL	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to: *Thoroughly investigate incidents for three of four sampled residents (1, 2, and 8) to verify no abuse or neglect had occurred. *Report to the South Dakota Department of Health (SD DOH) one of four sampled residents (2) who had a major injury of two new fractures (broken bones) of unknown origin. Findings include: 1. Review of resident 2's medical record revealed: *She was admitted on 12/27/13. *Her diagnoses included dementia (memory loss), Alzheimer's (impaired thinking and decision making) disease, anxiety, depression, dizziness, osteoarthritis (joint pain and stiffness), chronic	F 226	F226- Current written policies & procedures were reviewed & revised to ensure that all areas were covered regarding prohibition of mistreatment, abuse, & neglect of residents and/or their property and/or funds. Policies & procedures for reporting, investigating, & follow-up were also reviewed. An [redacted] in-service education session is to be held on 4/19/16 to re-educate all staff on our policies & procedures & their role in preventing incidents/injuries and/or reporting any suspicious events, incidents, or injuries of unknown origin. *all-staff ML/SDDOH/EL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Gregory Pearson</i>	TITLE <i>Old Administrator</i>	(X6) DATE <i>04-15-16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 1</p> <p>pain, and muscle weakness.</p> <p>*Her 12/11/15 Brief Interview for Mental Status Score (BIMS) was a 2, indicating she had severe impairment in memory and thinking.</p> <p>*She had a history of falls.</p> <p>*From August 2015 through 3/21/16 she had the following 13 falls:</p> <ul style="list-style-type: none"> -August, two falls. -September, one fall. -November, one fall. -December, three falls. --On 12/23/15 she had an x-ray that showed a right rib fracture. -January, two falls. -February, three falls. -March (up to survey date), one fall. --On 3/11/16 she had a diagnosis of new left rib fractures and multiple chronic rib fractures. <p>Review of resident 2's revised 3/10/16 care plan revealed:</p> <p>*She was a high fall risk due to her impaired ability to move around, impaired cognition (memory and thinking), and balance problem.</p> <p>*Falls intervention was: "Encourage resident to use call light. Keep possessions within reach. Ask if she needs anything before leaving her room."</p> <p>-That had been initiated on 1/6/16.</p> <p>*There was no mention of:</p> <ul style="list-style-type: none"> -Her history of falls. -Her rib fractures or interventions related to those fractures. <p>Random observations of resident 2 from 3/21/16 through 3/23/16 revealed certified nursing assistants (CNAs) assisted her to walk with a gait belt and one to two assist in the hallway and her room.</p>	F 226	<p>F226- Due to the lapse of time since the occurrence of Resident 2's incident, it is not possible to retroactively perform a proper investigation of this incident as it should have been done according to our policy & procedures. Education on these procedures will help all staff remember their role in following the procedures relative to reporting and investigating.</p>		

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F 226	<p>Continued From page 2</p> <p>Interview on 3/22/16 at 2:30 p.m. with the director of nursing (DON) and assistant director of nursing (ADON) regarding resident 2 revealed they:</p> <ul style="list-style-type: none"> *Had not done investigations for her rib fractures on 12/23/15 or 3/11/16 to attempt to identify what had caused them. *Thought the fractures were caused by her multiple falls. *Agreed the fractures were not noted immediately following any specific fall, and there was a possibility they had been caused by something else. *Had not reported either of those rib fractures to the SD DOH. *Had not considered the fractures as something that should have been reported, since they were not found right away after a fall. *Agreed the fractures were considered a major injury. *Should have investigated and reported the fractures to the SD DOH since there was a potential for abuse and neglect. <p>2. Review of resident 8's medical record revealed:</p> <ul style="list-style-type: none"> *He was admitted on 6/10/13. *His diagnoses included intellectual disabilities, dementia, depression, and Tourette's disorder (brain condition causing involuntary movements and talking). *His 1/4/16 Minimum Data Set (MDS) Assessment revealed he had severely impaired memory and thinking. *A 2/17/16 nursing progress note at 4:16 p.m. stated: "Resident started yelled, looked over and saw another female resident in her w/c [wheel chair] next to him. He started hollering and hit her 3 times. No injuries." -There were no further progress notes until 	F 226	<p>F226- To ensure future compliance with our policy & procedures regarding investigations, documentation, & follow-through, the DON will review each incident, event, injury, fracture, and/or injury of unknown origin each week. This review will include seeing if a report was completed in timely fashion and was faxed to SDDOH in the initial 24 hours; that there was proper and thorough documentation on the report & in the medical record; that interviews and findings were properly documented; that appropriate steps were taken to prevent another occurrence; that the Care Plan was updated reflecting the interventions and that the provider and POA were notified in timely fashion. The results of these reviews will be monitored and reported at the QA meetings* until there is 2 months of 100% compliance found.</p> <p style="text-align: right;"><i>by the DON</i> MLSDOHJEL</p>		

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F 226	<p>Continued From page 3 3/10/16.</p> <p>Random observations of resident 8 from 3/21/16 through 3/23/16 revealed he sat in the television lounge area at times and occasionally yelled out.</p> <p>Review of the provider's Required Healthcare Facility Event Reporting SD DOH report form for resident 8 revealed: *Explanation stated: "Heard resident [name], yelling, looked over into sun room and seen the female resident in her w/c next to him. He then yelled again and hit her 3 times on her R [right] temple area. Her glasses were displaced to R side of her face." *There was no mention of what was done following the incident to prevent another occurrence. *There was no final report.</p> <p>Interview on 3/22/16 at 2:30 p.m. with the DON and ADON regarding resident 8 revealed: *There was no final report conducted since the event was witnessed by staff. *They had no additional documentation to show an investigation of the 2/17/16 incident had occurred. *When asked about what had been done to prevent another incident from happening again they stated: -He was supposed to sit farther away from the other residents when he was in the sun room. -Staff were told in verbal report to move his chair closer to the window to keep him farther away from the other residents. -Staff were supposed to watch him closer. *There was no documentation to confirm the above preventative measures had been done and there should have been.</p>	F 226	<p>F226- Due to the lapse of time since the occurrence of Resident 8's incident, it is not possible to retroactively perform a proper investigation of this incident as it should have been done according to our policy & procedures. Education on these procedures will help all staff remember their role in following the procedures relative to reporting & investigating.</p>	

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F 226	Continued From page 4 3. Review of resident 1's Required Healthcare Facility Event Reporting SD DOH initial report form revealed: *The event date was 2/10/16 with no specific time. *Explanation stated: "[staff name] alerted [registered nurse, RN] that [resident name] had a swollen and bruised left pinky finger. Finger is tender to the touch. Resident cries out and cries when finger is moved or touched. [RN name] alerted by [staff name], the other RN on duty, that it may have happened the previous day (2/9/16) when [resident name] was having a wound looked at on her 4th finger on her left hand. [resident name] fingers are slightly contracted and her pinky was moved by [nurse name] while [nurse name] was trying to assess the wound on the 4th finger. [administrator name, facility name] was also present at that time due to resident trying to hit staff and yelling obscenities at staff. [RN name] ADON and [name] DON made aware. Will continue to monitor and do follow-up report." *For personnel involved there were eight staff names listed. Observation on 3/21/16 at 4:00 p.m. of resident 1 revealed she: *Was laying in her bed on her back. *Had contractures of both hands. *Did not respond when talked to. Review of resident 1's Required Healthcare Facility Event Reporting SD DOH final undated report form revealed: *The event date was 2/9/16, and the initial report was 2/10/16. *Brief background was: "[Resident name] was noted to have a bruised and swollen (L) pinky	F 226	F226- Due to the lapse of time since the occurrence of Resident 1's incident, it is not possible to retroactively perform a proper investigation of this incident as it should have been done according to our policy & procedures. Education on these procedures will help all staff remember their role in following procedures relative to reporting & investigating.		

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F 226	<p>Continued From page 5</p> <p>finger the morning of 2/10/16." *The summary was: "With completion of internal investigation, we were able to determine no abuse or neglect is suspected. Plausible explanation was gained for how the bruise and swelling occurred. Dr. [physician's name] was notified, no interventions ordered." *Action taken by the facility was left blank.</p> <p>Interview on 3/22/16 at 2:30 p.m. with the DON and ADON regarding resident 1 revealed: *They had no additional documentation to show an investigation of the above incident had occurred. *The nurse who had completed the initial report had talked to several staff but had not documented related those converserations. *The resident was unable to participate in the investigation due to her poor cognition. -Residents with poor cognition were at higher risk for abuse or neglect. *There was no documentation showing all the staff listed in the initial report had been interviewed, and there should have been.</p> <p>4. Review of the provider's revised February 2016 Abuse Prevention and Protection of Resident Rights policy revealed: *For reporting: -"2. Any alleged violations involving mistreatment, neglect, or abuse, including injuries of an unknown source and misappropriation of resident property, must be promptly reported to the director of nursing services, and/or social services director, and/or administrator." -"15. The director of nursing, or social services designee, or administrator must notify these individuals in writing (by fax) within 24 hours of any alleged abuse or similar incident:"</p>	F 226	<p>F226- The inservice scheduled on 4/19/16 will be held to review step-by-step the procedures to be followed for reporting any suspicious incidents, events, injuries, or injuries of unknown origin as spelled out in our policy & procedures. The importance of timely, accurate, and appropriate documentation will be stressed including any & all interviews done of other residents, visitors, and/or witnesses.</p>		

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F 226	Continued From page 6 --"Local Ombudsman..." --"State Ombudsman..." --"Complaint Coordinator, SD Dept. [Department] of Health..." --"Other individuals and/or agencies as necessary." *For investigation: -"1. When an incident or suspected incident of resident abuse or neglect is reported, the administrator will appoint a facility representative to investigate the incident." -"2. The representative's investigation shall consist of: --a. A review of the completed Resident Abuse Report form; --b. An interview with the person(s) reporting the incident; --c. Interview with any witnessed [witness] to the incident; --d. Interview with the resident; --e. A review of the resident's medical record; --f. An interview of staff members on all shifts having contact with the resident during the period of the alleged incident; --g. Interview with the resident's roommate, family members, and visitors, and; --h. A review of all circumstances surrounding the incident." -"8. The results of the representative's investigation will be recorded on the Resident Abuse/Neglect Investigation Report Form." Review of the provider's revised November 2005 Accidents and Incidents - Investigating and Recording policy revealed investigative action included: **"Any corrective action taken." **"Follow-up information."	F 226	F226 -	5/12/16	

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F 274 F 274 SS=D	Continued From page 7 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, interview, and Resident Assessment Instrument (RAI) manual review, the provider failed to complete a comprehensive resident assessment within fourteen days after determining or should have determined a significant change occurred in the resident's physical condition for one of ten sampled resident's (4), who was identified as having developed a pressure ulcer and continued weight loss. Findings include: 1. Review of resident 4's medical record revealed: *He had been admitted on 9/16/15. *He had been hospitalized for a stroke on 1/6/16 through 1/8/16. *A 2/19/16 dietitian progress note had indicated: -He had some weight gain at the time of the	F 274 F 274	F274- The Consultant RD was updated on Resident 4's weight loss along with pressure ulcers on 3/22/16 & recommended the addition of 4 oz. Glucerna Supplement twice daily to aid with calories & protein intake & wound healing. On 3/25/16 at the scheduled monthly visit, the RD stated that wt. maintenance would be desired at this point with no further recommendations. At the podiatrist visit on 3/30/16, an order for Betadine soaked dressings to the left heel daily along with daily edema wear to the left leg to drink 1 Ensure daily. Podiatrist stated that this is a pressure ulcer, but he will not stage it until the next appointment with the Wound Specialist on 4/12/16. A Significant Change Comprehensive MDS was completed on 3/30/16 & the (cont'd)	

*resident myspoc/HLE

*and for the myspoc/HLE
The myspoc/HLE

*was obtained myspoc/HLE

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F 274	<p>Continued From page 8 hospitalization "likely due to fluid." -Gradual weight loss was desired. -She would continue to monitor his weight closely and assist as needed. *His weights were: -On admission 9/17/15: 235 pounds (lb). -10/17/15: 231.5 lb. -11/20/15: 238 lb. -12/19/15: 241 lb. -1/15/16: 227 lb. The electronic medical record (EMR) had indicated a 5.8 percent (%) weight loss since 12/19/15; a 7.9% weight loss since 1/8/16. -2/19/16: 218 lb. The EMR had indicated a 10.1% weight loss since 12/24/15; a 7.8% weight loss since 11/27/15. -3/18/16: 207 lb. The EMR had indicated an 11.1% weight loss since 11/6/15; a 13.9% weight loss since 12/19/15. *A progress note on 2/21/16 by RN B indicated a five centimeter (cm) blister to his left heel, open on one side. *A 3/14/16 physician's progress note had indicated: -The left lateral foot ulceration was noted 2/22/16. -There was a significant area on the heel that extended to "about 7 cm." Review of resident 4's most recent 1/22/16 Braden Scale (for predicting pressure sore risk indicated: *A score of 16 indicating he was at risk for pressure ulcers. *His nutrition was "Probably inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes on 3 servings of meat or dairy products per day."</p>	F 274	<p>F274 continued - pressure ulcer is being monitored/measured weekly by the Wound Nurse who is reporting this information to the Interdisciplinary Team (IDT) each week. On 3/31/16, the nursing staff requested a gradual dose reduction of Ability & Lexapro due to the resident being very sleepy, weight loss, & the pressure ulcers. A request for an order was made to the VA MD with no response as of yet. On 4/8/16, the Consultant RD was informed of continued weight loss since the last assessment. RD made additional recommendations & will monitor the weight closely & assess the Resident's condition at her next monthly site visit. A Weight & Skin Report is now completed weekly by the Bath Aide. This will be reviewed each week by the IDT to review significant changes occurring in the resident's interventions & Care Plan changes made. A new policy was written to assist the IDT to determine when a change noted is truly a Significant Change & to signal that a Significant Change MDS is to be initiated *The CDM will report the results at the QM meetings for for 2 meetings. ML/SDDO/H/EL</p>		

**for all residents ML/SDDO/H/EL*

**NO further residents were identified with this issue. ML/SDDO/H/EL*

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F 274	<p>Continued From page 9</p> <p>No further documentation in his medical record of dietary involvement after 2/19/16 to have addressed continued weight loss or new pressure ulcer concerns.</p> <p>Review of resident 4's following Minimum Data Set (MDS) assessments revealed: *An admission assessment completed on 9/23/15. *A significant change assessment completed on 10/22/15. *A significant change assessment completed on 1/15/16. *No significant change assessment was completed within fourteen days after the pressure ulcer had been discovered. *No further MDSs had been completed quarterly.</p> <p>Interview on 3/23/16 at 12:20 p.m. with the director of nursing, assistant director of nursing, and MDS coordinator revealed: *They used the RAI manual to determine when to perform significant change assessments. *They agreed a significant change in status assessment should have been completed after the discovery of a pressure ulcer and continued weight loss.</p> <p>Review of the RAI manual, Version 3.0, October 2014, page 2-20, revealed the definition of a significant change in resident's status as: *"A decline or improvement of a residents's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease related interventions, is not self-limiting. -Impacts more than one area of the resident's health status. -Requires interdisciplinary review and/or revisions of the care plan."</p>	F 274			
			F274-	5-12-16	

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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure care plans had been revised to reflect the current needs for: *One of three sampled residents (2) with a history of falls and recent fractures. *One of three sampled residents (8) with a history of behaviors. Findings include: 1. Review of resident 2's medical record revealed: *She was admitted on 12/27/13.</p>	F 280	<p>F280- The Care Plan for Resident 2 was updated to include her history of falls, rib fractures, interventions related to fractures, and the Dr. order that the staff should transfer resident without a gait belt.</p>		

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F 280	<p>Continued From page 11</p> <p>*Her diagnoses included dementia (memory loss), Alzheimer's disease (impaired thinking and decision making), anxiety, depression, dizziness, osteoarthritis (joint pain and stiffness), chronic pain, and muscle weakness.</p> <p>*She had a history of falls.</p> <p>*From August 2015 through 3/21/16 she had thirteen falls on the following dates:</p> <p>*On 12/23/15 she had an x-ray that showed a right rib fracture.</p> <p>*On 3/11/16 she had a diagnoses including new left rib fractures and multiple chronic rib fractures.</p> <p>*On 3/11/16 her physician had ordered:</p> <ul style="list-style-type: none"> -To avoid gait belt (belt placed around the waist for staff to use with transfers) use for transfer. -Encourage deep breaths for the next ten days. -Walk with assist. <p>Random observations of resident 2 from 3/21/16 through 3/23/16 revealed certified nursing assistants (CNA) helped her walk with a gait belt, and one or two assisted in the hallway and in her room.</p> <p>Review of resident 2's revised 3/10/16 care plan revealed:</p> <p>*She was a high fall risk due to her impaired ability to move around, impaired cognition (memory and thinking), and balance problem.</p> <p>*Falls intervention was: "Encourage resident to use call light. Keep possessions [personal items] within reach. Ask if she needs anything before leaving her room."</p> <ul style="list-style-type: none"> -That had been initiated on 1/6/16. <p>*There was no mention of:</p> <ul style="list-style-type: none"> -Her history of falls. -Her rib fractures or interventions related to those fractures. -How staff could have transferred her avoiding 	F 280	<p>F280- Nursing staff were provided with a method to keep the Care Plans updated immediately with any changes that affect the resident and how the staff is to provide that care. Notations are being made in a CNA Communications Book so they are aware of changes. They can also access the Care Plans through the kiosks.</p>	

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F 280	<p>Continued From page 12 the use of the gait belt.</p> <p>Review of the provider's undated CNA care sheet for resident 2 revealed no mention of avoiding gait belt use or her recent rib fractures.</p> <p>Interview on 3/22/16 at 1:00 p.m. with CNAs H and I regarding resident 2 revealed: *CNA H was a temporary staff and had been working in the facility for one week. *CNA I had been working at the facility for about a year. *They could access residents' care plans from the computer. *They also used their CNA care sheets as a quick reference when taking care of the residents. *Resident 2 needed assistance from one or two staff and a gait belt for transfers. *Both CNAs had been unaware of resident 2's physician's order to avoid using a gait belt. *CNA I stated she had been told by the nurses to just place the gait belt up higher on the resident due to her rib fractures. *They confirmed resident 2's care plan and care sheets had not mentioned to avoid using a gait belt or how they should have transferred her without using a gait belt.</p> <p>Interview on 3/22/16 at 2:30 p.m. with the director of nursing (DON) and assistant director of nursing (ADON) regarding resident 2 revealed they: *Thought the fractures were caused by her multiple falls. *The care sheets for the CNAs had just started this week. They agreed: -The sheet was a reference for the CNA to know how to take care of the resident. -It should have stated to avoid using gait belts for her.</p>	F 280	F280- All nursing staff will be trained on the newly revised procedures for ensuring that all staff members providing care to the resident are included in the planning and provision of care in a concerted manner to ensure continuity & quality of care.		

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F 280	<p>Continued From page 13</p> <p>*Her care plan should have been updated to reflect her fractures and interventions related to them.</p> <p>*The Minimum Data Set (MDS) assessment nurse completed care plans and updates to them.</p> <p>*Charge nurses typically had not updated care plans but could have.</p> <p>Observation on 3/23/16 at 10:20 a.m. of resident 2's transfer and interview with CNA J at that same time revealed:</p> <p>*She had been walking the resident down the hall to her room using a gait belt.</p> <p>*Once in her room the CNA left the gait belt on the resident and assisted her to transfer to and from the toilet with the gait belt in place.</p> <p>*She stated the nurses had told them to place the gait belt up higher due to the resident's rib fractures.</p> <p>*The resident only complained of pain in her sides when they put the gait belt too low.</p> <p>*She had not been aware to avoid using a gait belt for the resident.</p> <p>2. Review of resident 8's medical record revealed:</p> <p>*He was admitted on 6/10/13.</p> <p>*His diagnoses included intellectual disabilities, dementia, depression, and Tourette's disorder (brain condition causing involuntary movements and talking).</p> <p>*A 2/17/16 nursing progress note at 4:16 p.m. stated: "Resident started yelled, looked over and saw another female resident in her w/c [wheel chair] next to him. He started hollering and hit her 3 times. No injuries."</p> <p>*There were no further progress notes until 3/10/16.</p>	F 280	<p>F280- Resident 8's Care Plan was updated to include his history of behaviors and interventions for staff to use to help with his behaviors. (Continued pg.15)</p>		

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F 280	<p>Continued From page 14</p> <p>Review of resident 8's last revised 3/20/16 care plan revealed:</p> <p>*There was no specific focus area for his behaviors.</p> <p>*For communication he had a problem related to dementia (impaired memory), Tourette's disease, autistic disorder (brain disease affecting social interaction, communication, and behaviors), antipsychotic (medication used to treat inappropriate behaviors) use, antidepressant medication use.</p> <p>-Interventions for that focus area had not been revised since 1/18/16.</p> <p>*There was no mention of his history of behaviors toward other residents.</p> <p>*There were no specific interventions for staff to use to help with his behaviors toward other residents.</p> <p>Interview on 3/22/16 at 2:30 p.m. with the DON and ADON regarding resident 8 and what had been done to prevent another incident from happening again they stated:</p> <p>*He was supposed to sit farther away from the other residents when he was in the sun room.</p> <p>*Staff were told in verbal report to move his chair closer to the window to keep him farther away from the other residents.</p> <p>-Staff were supposed to watch him closer.</p> <p>*His care plan had not been updated to reflect preventative measures for his behaviors and it should have been.</p> <p>3. Interview on 3/22/16 at 4:50 p.m. with the MDS nurse revealed:</p> <p>*She had started working for the provider in August 2015.</p> <p>*She had been trying to get the charge nurses more involved with care planning.</p>	F 280	<p>F280 (continued) Notations are being made in the CNA Communication Book so they are aware of changes & the interventions suggested. They can also access the Care Plans through the kiosks to clarify what is to be done. To monitor our accuracy of Care Plans, the MDS Coordinator will audit 4 Care Plans each week for a month, then 2/week during the next month to ensure that they reflect care & services provided to the resident & to ensure that any immediate changes to the resident's care (are updated). Evaluation of care interventions & their success or failure will be done with new interventions proposed if present ones are not working. All Care Plans will be reviewed & revised by the IDT & Charge Nurses as needed & during each assessment. The IDT will ensure that all department staff are aware of pertinent information so that there is a Team effort to correct the issue noted on the Care Plan.</p> <p><i>plans</i></p> <p><i>ML/SDDOHH/EL</i></p> <p><i>5-12-16</i></p> <p><i>*The MDS coordinator will report the results to the QA meetings for 2 meetings.</i></p> <p><i>ML/SDDOHH/EL</i></p>		

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F 280	Continued From page 15 *When she was aware of a change with residents she would have updated their care plans. *It was hard for her to keep up with all the care plan changes, and they sometimes happened when she was not working. *She agreed: -Resident 2's multiple falls, fractures, and physician's order to avoid gait belt use should have been on her care plan and had not been. -Resident 8's behaviors toward others and interventions to prevent them were not addressed on his care plan and should have been. Review of the provider's November 2013 Policy for Comprehensive Care Plan revealed: *"A comprehensive care plan is:" -"2. Prepared by an interdisciplinary team that includes the physician, nursing, other appropriate staff and disciplines as determined by the resident's needs, and, to the extent practicable, the resident, his/her family or legal representative" -"3. Periodically reviewed and revised by a team of qualified persons after each assessment."	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: Based on observation, interview, and record review, the provider failed to ensure: *Physician's orders had been followed for one of three sampled residents (2) with a recent fracture.	F 281	F281- The Care Plan was updated for Resident 2 to ensure that all departments are following the physician orders pertaining to recent fracture. The policy & procedure for following physician orders was updated. Nursing staff were given copies of this policy & procedure & instructed on proper documentation.		

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F 281	<p>Continued From page 16</p> <p>*One of one sampled resident (8) had been monitored and had documentation following his physical behavior toward another resident. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *On 3/11/16 she had diagnoses including new left rib fractures and multiple chronic rib fractures. *On 3/11/16 her physician had ordered: -To avoid gait belt (belt placed around the resident's waist for staff to assist with transferring) use for transfer. -Encourage deep breaths for the next ten days. -Walk with assistance. Refer to F226, finding 1. Refer to F280, finding 1.</p> <p>Random observations of resident 2 from 3/21/16 through 3/23/16 revealed certified nursing assistants (CNA) helped her walk with a gait belt, and one or two assisted in the hallway and in her room.</p> <p>Interview on 3/22/16 at 2:30 p.m. with the director of nursing (DON) and assistant director of nursing (ADON) regarding resident 2 revealed they: *Confirmed staff continued to transfer the resident using a gait belt following the physician's order to avoid using a gait belt on. *Had not followed the physician's orders related to her rib fractures. *Had not care planned those physician's orders or interventions related to her rib fractures. *Agreed using the gait belt could have injured her further. *Did not have a policy regarding following physician's orders. *Expected physician's orders to be followed as</p>	F 281	<p>F281- The nurses were also provided with a method to keep Care Plans updated immediately to ensure that physician orders are followed through regarding resident care. Our CNA Communication Book is now being used to share any new orders pertaining to resident care given by the CNA's. CNA's can also access the Care Plan through the kiosks. A shift report from our EHR system will be printed out at the end of every shift & placed in a binder at the nurses' station so nursing staff can review any changes & current issues. <i>*NO further residents were identified with this issue. MLYSDOHHTEL</i></p> <p>The ADON will audit the physician orders on 4 resident/week for a month and then 2/week for another month. Findings will be reported at the QA meeting for review & recommendation whether to continue or discontinue this QA study. The audit will be done to ensure that all physician orders are being followed & that changes to orders are immediately updated on the Care Plan and all pertinent departments are aware of the changes to the orders. After 2 months of 100% accuracy, this QA study will be discontinued.</p>	

**by the ADON for 2 meetings. MLYSDOHHTEL*

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F 281	<p>Continued From page 17 written.</p> <p>2. Review of resident 8's medical record revealed a 2/17/16 nursing progress note at 4:16 p.m. stated: "Resident started yelled, looked over and saw another female resident in her w/c [wheel chair] next to him. He started hollering and hit her 3 times. No injuries." There were no further progress notes until 3/10/16. Refer to F226, finding 2. Refer to F280, finding 2.</p> <p>Interview on 3/22/16 at 2:30 p.m. and again on 3/23/16 at 8:30 a.m. with the DON and ADON regarding resident 8 revealed: *They were aware of the above incident on 2/17/16. *There was no documentation following the incident in his progress notes for over three weeks. *Nursing should have been watching his behaviors closer and documenting them. *There was no policy on behaviors. *They had no specific professional standards of practice they followed. *At the nurses station there was a binder with random information for nurses to reference.</p> <p>Review of the Pertinent Information for Nurses binder at the nurse's station revealed no specific information related to following physician's orders, behavior management, or documentation.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, pp. 4 and 305, revealed: *Page 4: "The Standards of Practice describe a competent level of nursing care. The nursing process is the foundation of clinical decision</p>	F 281	<p>F281- The Care Plan for Resident 8 was updated to ensure that staff from all pertinent departments are aware of the recent behaviors and interventions to use when the behaviors are noted. <i>*NO further residents were identified with this issue.</i> <i>ML/SDDOH/EL</i></p> <p>F281-The ADON will monitor shift reports each week. If an inappropriate behavior was documented, the documentation will be reviewed to determine if the procedures of our Behavioral Management for Inappropriate Behaviors was followed depending on the severity of the behavior. (Continued on page 19)</p>		

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F 281	Continued From page 18 making and includes all significant actions taken by nurses in providing care to patients." *Page 305: "The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe the orders are in error or harm patients."	F 281	<i>*The ADON will report monitoring results at the QA meetings for 2 F281- We will continue to monitor these shift reports & the meetings. documentation until 2 quarters of reviews show 100% compliance with our policy & procedures.</i>	5-12-16	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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: Based on observation, record review, interview, and policy review, the provider failed to: *Coordinate services between nursing and dietary departments for the care of one of four sampled residents (4) who had developed a pressure ulcer. *Coordinate services between nursing and dietary departments for three of four sampled residents (2, 4, and 6) with weight loss. Findings include: 1. Observation on 3/22/16 at 2:00 p.m. of resident 4 during a dressing change to his left heel revealed a large dark area on the outer heel. Review of resident 4's medical record revealed: *He had been admitted on 9/16/15.	F 309			

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F 309	<p>Continued From page 19</p> <p>*He had been hospitalized for a stroke from 1/6/16 through 1/8/16.</p> <p>*A 2/19/16 dietitian progress note had indicated: -He had some weight gain at the time of the hospitalization "likely due to fluid." -Gradual weight loss was desired. -She would continue to monitor his weight closely and assist as needed.</p> <p>*His weights were: -On admission 9/17/15: 235 pounds (lb). -10/17/15: 231.5 lb. -11/20/15: 238 lb. -12/19/15: 241 lb. -1/15/16: 227 lb. The electronic medical record (EMR) had indicated a 5.8 percent (%) weight loss since 12/19/15; a 7.9% weight loss since 1/8/16. -2/19/16: 218 lb. The EMR had indicated a 10.1% weight loss since 12/24/15; a 7.8% weight loss since 11/27/15. -3/18/16: 207 lb. The EMR had indicated an 11.1% weight loss since 11/6/15; a 13.9% weight loss since 12/19/15.</p> <p>*A progress note on 2/21/16 by RN B indicated a five centimeter (cm) blister to his left heel, open on one side.</p> <p>*The physician and family had been notified of the skin issue on 2/22/16.</p> <p>*A 3/14/16 physician's progress note had indicated: -The left lateral foot ulceration was noted 2/22/16. -There was a significant area on the heel that extended to "about 7 cm."</p> <p>The most recent 1/22/16 Braden Scale (for predicting pressure sore risk indicated: *A score of 16 indicating he was at risk for pressure ulcers. *His nutrition was "Probably inadequate: Rarely</p>	F 309	F309- Please see F274 which identifies the Interdisciplinary approaches taken to address Resident 4's weight loss & pressure ulcer situation.	

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F 309	<p>Continued From page 20</p> <p>eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes on 3 servings of meat or dairy products per day."</p> <p>No further documentation in the medical record of dietary involvement after 2/19/16 to have addressed continued weight loss or new pressure ulcer concerns.</p> <p>Review of resident 4's care plan revealed: *A 1/13/16 nutrition care plan indicated: -"Gradual weight loss would be beneficial to overall health." -"Scheduled HS [bedtime] snack=cookie." *The 2/27/16 pressure ulcer care plan: -Had listed one intervention for a foam off-loading boot to his left foot at all times. -Had no dietary interventions listed.</p> <p>Interview on 3/22/16 at 4:45 p.m. with the dietary manager regarding resident 4's weight loss and pressure ulcer revealed: *The care plan team had just started meeting weekly for skin issues on 3/16/16. *She attended the meeting but had not been told resident 4 had a pressure ulcer. "They only told me it was a foot problem." *The dietitian had seen resident 4 on 2/19/16 (two days before the pressure ulcer had been found) and had been aware of the weight declines, but had planned to just monitor for further weight loss. *The dietitian had not been notified of further weight loss or of the pressure ulcer. *The dietitian was going to be in the facility on 3/25/16 and would have been notified at that time. *She usually notified the dietitian of changes when she visited.</p>	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2016
NAME OF PROVIDER OR SUPPLIER SUN DIAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219		
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F 309	Continued From page 21 Interview on 3/23/16 at 12:00 noon with the dietitian revealed: *She had been notified of resident 4's pressure ulcer and continued weight loss on 3/22/16. *She had not been aware of those issues before 3/22/16. *The dietary manager could have called her or emailed her any time after her last visit with any changes in a resident's status. *The dietary manager had called her with changes "two or three times" in the last year since she had become their dietitian. *She would have expected the dietary manager to call her for significant weight changes, pressure ulcers, or skin changes to address protein needs. Interview on 3/23/16 at 12:20 p.m. with the director of nursing (DON), assistant director of nursing (ADON), and Minimum Data Set (MDS) coordinator revealed they agreed the dietitian should have been contacted at the time the pressure ulcer was identified. Review of the provider's 5/10/12 Prevention of Pressure Ulcers policy revealed: *"Identify residents at risk for developing pressure ulcers using the Braden Scale, MDS Raps [RAPs] and Triggers, monitoring I & O's [intake and output, and weight loss and mobility." *"Insure that the resident drinks plenty of liquids and eats a well-balanced diet." *If there was a concern about a decline in weight the bath aide reported it to the charge nurse and the dietary manager. *"The director of nursing will review the skin conditions and concerns and assess/intervene as needed."	F 309			

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F 309	Continued From page 22 2. Review of resident 6's medical record revealed: *She had been admitted on 7/26/12. *She had multiple medical diagnoses including heart failure, constipation, edema (swelling), dementia (impaired memory and thinking), and kidney disease. *Her weights on the following dates were: -11/5/15, 152.5 pounds (lb.) -12/3/15, 150.5 lb. -1/7/16, 142.5 lb. -2/4/16, 141.5 lb. -3/3/16, 133 lb. -3/17/16, 130.5 lb. *She had lost 22 lb in four months. That was a 14.4 percent (%) weight loss. *On 2/19/16 there was a registered dietitian (RD) progress note that stated: -She had a steady weight loss, and her current weight was 135 lb. -Further weight loss was not desired. -She was on a special diet, so she recommended the physician approve a snack of cheese or cottage cheese once a week to help with protein and calorie intake. -"Will continue to monitor and assist as needed." *Progress notes by the dietary manager on the following dates included: -2/19/16, she did not like taking her physician ordered supplement between meals, so they would attempt to offer them at breakfast and supper. -2/22/16, they were still awaiting a response from the physician for the RD recommendation for snacks, the resident was moved to a visually supervised table in the dining room for encouragement to continue eating meals. -2/23/16, received the fax orders for "ok to	F 309	F309 - Resident 6 was assessed by the Consultant RD on 3/25/16 and due to continued weight loss, the RD recommended increasing Ensure/Boost juice supplement to 8 oz. TID with meals & documented "No further weight loss desired...maintenance or slight gain would be best." On 4/18/16, CDM reported to RD that Resident had lost 2 more pounds since 3/25/16. RD made recommendation to increase the snack of cottage cheese or cheese and crackers to daily rather than only 2 times/week (due to low phosphorous diet). CDM & RD will watch weight closely & assess again at the next monthly site visit.		

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F 309	<p>Continued From page 23</p> <p>liberalize diet to add in snacks for patient [resident]", so they scheduled a PM (afternoon) snack of cottage cheese on Monday and a PM snack of cheese and crackers on Thursday weekly.</p> <p>*There were no further notes regarding resident 6's continued weight loss, what her meal/supplement/snack intakes had been, or any further interventions implemented related to her weight loss.</p> <p>Observations on 3/21/16 at supper and on 3/22/16 at breakfast and lunch of resident 6 revealed:</p> <p>*She ate independently at the dining room table.</p> <p>*Nursing staff were not sitting at her table but in the dining room within viewing distance.</p> <p>3. Review of resident 2's medical record revealed:</p> <p>*She had been admitted on 6/10/13.</p> <p>*Her diagnoses included Alzheimer's disease (affecting memory and thinking), anxiety (nervousness), depression, pain, muscle weakness, and history of falls.</p> <p>*Her weights on the following dates were:</p> <p>-10/20/15, 135 lb.</p> <p>-11/26/15, 137 lb.</p> <p>-12/28/15, 133 lb.</p> <p>-1/25/16, 128.5 lb.</p> <p>-2/29/16 123.5 lb.</p> <p>-3/21/16 120.5 lb.</p> <p>*She had lost 12.5 lb in three months. That was a 9.4% weight loss.</p> <p>*The RD progress note on 1/8/16 stated:</p> <p>-Resident received a regular diet with foods cut up/prepared for her.</p> <p>-Weight had gone down 8 lb or 5% in the last month which was a significant weight loss.</p>	F 309	<p>F309- Resident 2's condition was assessed by the Consultant RD on 3/25/16 & due to continued weight loss, RD recommended adding high calorie cereal at breakfast, high calorie potatoes at dinner, and a Magic Cup for snack BID. RD states that the goal is for weight maintenance. Resident 2 has received her new denture plate. An order was signed by the MD on 3/28/16 for a speech consultation per dietary recommendation. Resident was seen by Aegis Professional Speech Therapy & has started on services 3 times per week to determine most appropriate texture consistency & see if she can upgrade food texture to increase meal intake. She currently receives pureed texture foods. Weight is up 1.5 pounds since implementing the high calorie interventions.</p>		

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F 309	<p>Continued From page 24</p> <ul style="list-style-type: none"> -Recommend adding 4 ounces of nutritional supplement at all meals. -Further weight loss was not desired. -"Will monitor resident monthly until weight is stable." *The RD progress note on 2/19/16 stated: -Resident had become weaker in past few weeks resulting in more falls. -Was currently on a regular diet with her food cut-up and prepared for her. -She sats at a supervised dining table. -Meal intakes had declined in the past two weeks. -Her weight on 2/15/15 was 126.5 lb which was down from 11/16/15 but had been stable in last month. -Recommend increasing 4 ounce nutritional supplement to 8 ounces to increase calorie and protein intake to help with weight maintenance or slight gain. -"Will continue to monitor and assist as needed." *On 2/19/15 there was a dietary manager progress note addressing: -The RD recommendation to increase supplements to 8 ounces. -Nursing had requested a texture change to pureed until the resident got her new bottom denture plate, which was expected by 3/2/16. -The resident currently had no bottom teeth/dentures which made chewing food difficult. *On 2/23/16 a dietary manager progress note stated: -She continued on a regular diet with pureed textures until she would receive her lower denture plate. -She was seated at a supervised table in the dining room for staff to assist her with eating. *There were no further progress notes addressing her weight loss, intake, or continuing on the pureed diet related to her dentures. 	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2016	
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F 309	<p>Continued From page 25</p> <p>Observations on 3/21/16 at supper and on 3/22/16 at breakfast and lunch of resident 2 revealed: *She sat at an assistance table in the dining room. *Nursing staff were sitting next to her and providing her food and fluids. -She did not attempt to feed herself.</p> <p>4. Interview on 3/21/16 at 6:20 p.m. with the dietary manager revealed: *She had not mentioned resident 4 as being a concern for weight loss or pressure areas. *Residents 2 and 6 were being monitored monthly for weight loss by the RD. *The RD was expected to be at the facility at the end of the week for her monthly visit.</p> <p>Interview on 3/22/16 at 3:00 p.m. with the DON and ADON revealed: *They were aware of resident 2's weight loss. -She had not been eating well. *They thought the dietary manager had been increasing her supplements, and the RD had been reviewing her monthly. *Resident 6 had multiple medical problems and had been losing weight. -Her appetite had been decreasing. *The RD usually reviewed all residents monthly, gave recommendations as needed, and gave them to the dietary manager or nursing to follow-up on.</p> <p>Interview on 3/23/16 at 7:45 a.m. with the dietary manager revealed: *Regarding resident 2: -She had been experiencing a general decline. -She remained on a pureed diet.</p>	F 309	<p>F309- The issues of pressure ulcers & weight loss will be monitored as noted: Wound monitoring will be done by the Wound Nurse who will report any changes in resident skin conditions to the IDT weekly. At the end of each quarter, the ADON will report to the QA team the skin concerns requiring action during the 3 month period noting healed wounds and/or progress of current wound healing under current treatments. QA reviews will continue on this indefinitely (continued on page 27) mlyspdoth/el → *for at least 2 QA meetings.</p>	

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F 309	<p>Continued From page 26</p> <p>-She was unsure of the status of the resident's dentures.</p> <p>-She had been getting supplements at all meals and staff assisted her to eat.</p> <p>*Regarding resident 6:</p> <p>-The RD followed her closely related to her multiple medical problems and special diet.</p> <p>-It was difficult to figure out additional snack/food options due her diet limitations.</p> <p>-She had continued losing weight since the addition of the twice a week snack order.</p> <p>-She had been moved to a supervised table to be watched closer for eating.</p> <p>*She confirmed there was a lack of progress notes for residents 2 and 6 who had continued losing weight.</p> <p>*She typically had not called or updated the RD in between her monthly visits but could have.</p> <p>Phone interview on 3/23/16 at 12:00 noon with the dietitian revealed:</p> <p>*She was aware of residents 2 and 6's significant weight losses.</p> <p>-She had not reviewed them since last month and was unaware of their continued weight losses following her last recommendations.</p> <p>*The dietary manager could have called her or emailed her any time after her last visit with any changes in a resident's status.</p> <p>*The dietary manager had called her with changes only two or three times in the last year since she had become their dietitian.</p> <p>*She would have expected the dietary manager to call her for residents' significant weight changes.</p> <p>Review of the provider's revised June 2015 Unintended Weight Loss policy revealed "The facility has a weight-tracking program in place to identify any individuals with unintended weight</p>	F 309	<p>F309 (continued) Weights will be monitored each week & changes reported to the IDT. At the end of the quarter, the CDM will report findings to the RD & the QA team. Residents with significant weight loss or gain will be identified & interventions noted. QA reviews will continue indefinitely. <i>*for at least 2 QA meetings. NO further residents were identified with this issue.</i></p> <p>To prevent concerns of weight loss problems in the future for other residents, the CDM is doing a weekly report for any significant weight loss or gain. Information is reported to the IDT at each week's meeting. The Consultant RD will be informed weekly of any new significant changes for the residents at risk with the RD's recommendations being implemented right away.</p> <p>In addition, the Bath Aide will document on a Report Sheet the weights, any changes in weights, and if any new skin issues are reported to the nurse. The nurse & CDM will each receive a copy of this report & any abnormal weights will be redone to verify (cont'd)</p>		

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NAME OF PROVIDER OR SUPPLIER SUN DIAL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219		
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F 309	Continued From page 27 loss, so that assessment of the problem and appropriate interventions can be implemented." Review of the 10/1/14 Nutrition Consulting Services Agreement with the dietitian revealed: **A. Complete resident nutritional assessments, care planning, accurate and timely documentation in medical records. *B. Provide recommendations regarding nutritional support/interventions for residents at nutrition risk. *C. Work closely with the facility to provide quality dining experiences, assist in monitoring compliance with standards and regulations, sanitation and safety, and assist with QA process and audits."	F 309	F309 (cont'd) the accuracy. Any significant information will be reported to the RD and/or MD for further evaluation and recommendations/orders. A weekly IDT meeting will be held with items to be covered to include: skin issues, significant weight loss/gain, falls, infections, and behaviors. A Communication Book at the nursing station was started for nursing and dietary department staff members to share pertinent information on residents' condition. The policy and procedures for Prevention of Pressure Sores & Unintended Weight Loss was updated to include the above changes. All issues will be addressed at the staff meeting on 4/19/16.	5-12-16	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/23/16. Sun Dial Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Peggy Pearson* TITLE *Administrator* (X6) DATE *04-15-16*

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.

APR 18 2016

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South Dakota Department of Health

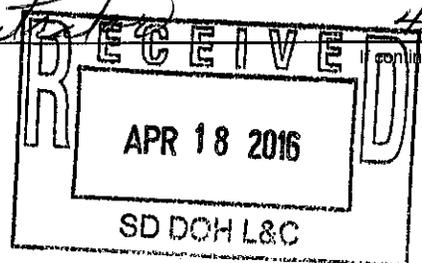
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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NAME OF PROVIDER OR SUPPLIER SUN DIAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 410 2ND STREET POST OFFICE BOX 337 BRISTOL, SD 57219
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 35121 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/21/16 through 3/23/16. Sun Dial Manor was found not in compliance with the following requirement: S206 44:73:04:05 Personnel Training</p> <p><i>*Addendums noted with facility administrator</i></p> <p>The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects:</p> <ol style="list-style-type: none"> (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. <p>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.</p>	S 000	<p>S206- A policy was initiated to ensure that newly hired employees & current personnel will be educated on the required mandatory inservices. To ensure education has been provided on incidents & diseases and the reporting mechanisms during the Orientation process, we have added that topic to the Orientation Checklist & will mark this off after the education has been provided. All newly hired employees will sign & date the Orientation form to verify the information and education has been received. Each employee will receive an Orientation packet which will include the following topics: fire prevention & response, emergency procedures & preparedness, infection control & prevention, accident prevention & safety procedures, proper use of restraints, resident rights, confidentiality of resident information (HIPAA), incidents & diseases subject to mandatory reporting & the facility's reporting mechanisms, care of residents with unique needs, dining assistance, nutritional risks & hydration needs of residents, oxygen safety, and abuse, neglect, mistreatment and misappropriation of resident property & funds. The employee will view the Mandatory Extravaganza DVD which includes all required (continued on page 2)</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Peggy Pearson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-15-16</i>
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUN DIAL MANOR

**410 2ND STREET POST OFFICE BOX 337
BRISTOL, SD 57219**

(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 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to ensure: *Four of five sampled employees (C, D, F, and G) had received an orientation program on incidents and diseases subject to mandatory reporting and the reporting mechanisms. Findings include:</p> <p>1. Review of sampled employees C, D, F, and G's personnel records revealed: *The employees had been hired on the following dates: -Certified nursing assistant (CNA) G on 1/21/16. -CNA F on 1/19/16. -Licensed practical nurse (LPN) D on 2/11/16. -Social services designee C on 2/17/16. *There had been no documented orientation training on incidents and diseases subject to mandatory reporting and the reporting mechanisms.</p> <p>Interviews on 3/22/16 at 4:00 p.m. with the assistant director of nursing (ADON) and again on 3/23/16 at 8:30 a.m. with the ADON and DON regarding personnel training revealed: *There was no documentation to support the above employees had received the training for incidents and diseases subject to mandatory reporting, and the reporting mechanisms. *The provider did not have a policy on employee training. *Their expectation was all employees should have received all the mandated training according to the regulation.</p>	S 206	<p>S206- education topics. Upon receipt of the Orientation packet & training, the employee will sign acknowledgement that they received this information.</p> <p>Current employees will attend mandatory staff meetings to cover all the required education annually. Each employee will have documentation in their employee file to indicate that they have received this training each year.</p> <p>S206- Employees C,D,F,& G did have verification in their Employee File that they had received their packet of information which included the information on incidents and diseases subject to mandatory reporting & the facility's mechanism for reporting. This was checked off on their Orientation Checklist & signed by each employee verifying receipt of the "required Educational Information for New Hires". Employee C signed on 2/17/16, Employee D on 2/9/16, Employee F on 1/9/16, & Employee G on 1/21/16. <i>*G ML/SDDCH/EL</i> Education on reporting incidents and diseases, investigations, reporting of incidents, events, injuries of unknown origin, fractures, and any injuries will be provided for all staff on 4/19/16.</p>	

(continued on page 3)

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10598	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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NAME OF PROVIDER OR SUPPLIER SUN DIAL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 410 2ND STREET POST OFFICE BOX 337 BRISTOL, SD 57219
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 35121 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 3/21/16 through 3/23/16. Sun Dial Manor was found in compliance.</p>	S 000	<p>S206 (continued) The DON will review files of all newly hired employees monthly to verify that they have received the required information including the incidents & diseases it is mandated to report and the facility's reporting mechanism. The results will be reported at the QA meeting in July. The Medical Records Clerk will monitor the Employee files for completeness of all on-going required education monthly and report this to the DON who will monitor this for 2 consecutive months & when 100 % compliance has been achieved for 2 [redacted] this QA study will be discontinued.</p> <p><i>*and report the results to QA for 2 consecutive QA meetings.</i></p>	<p><i>*by the DON, mlyjddothiel</i></p> <p><i>*QA meetings mlyjddothiel 5-12-16</i></p>
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