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

ORIGINAL

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435129	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

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F 000	INITIAL COMMENTS *Addendums noted with an asterisk per 6/9/16 per telephone with facility administrator. SB/SD DOH/EL Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/25/16 through 4/27/16. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirements: F164, F226, F244, F250, F280, F281, F323, F386, F431, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/25/16 through 4/27/16. Areas surveyed included quality of care/treatment, and physical environment. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirements: F226, F244, F280, and F281.	F 000	F000 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	F164 LPN A and RN B were educated on 5/19/16 by Director of Nursing to ensure the confidentiality of the resident's medication administration records and personal health information. All other staff responsible for maintaining the confidentiality of resident's medication administration records and personal health information was educated on 5/19/16 by Director of Nursing.	6/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	6/9/2016

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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JUN 10 2016
SD DOH L&C

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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, document review, and pamphlet review, the provider failed to ensure the confidentiality of the resident's medication administration records (MAR) had been maintained during three of four medication administrations by two of three staff (licensed practical nurse [LPN] A) and (registered nurse [RN] B). Findings include: 1. Random observations on 4/25/16 from 4:40 p.m. through 4:50 p.m. of LPN A revealed: *She had: -Been administering medications to the residents eating supper in the dining room. -Positioned the medication cart (east wing cart) at the entrance of the dining room. On top of the medication cart had been a computer that contained all the residents' personal and medical history. -Used that computer to retrieve medication information for three unidentified residents during the above time frame. -Left the medication cart at the entrance of the	F 164	DON or designee will audit medication passes once per week for four weeks and monthly for two more months to ensure confidentiality of the resident's medication administration records and other personal health information. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	

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F 164	Continued From page 2 dining room unattended to administer those medications during three separate times. *Each time she was away from the medication cart she had left the computer screen in the up and open position that revealed: -The name of the medication she had administered to those three residents. -Access to their medication history by other residents and visitors would have been possible. *At the above time there had been residents, staff members, and visitors passing by the medication cart. Random observations on 4/25/16 from 5:02 p.m. through 5:30 p.m. of RN B revealed: *She had: -Been administering medications to the residents eating supper in the dining room. -Positioned the medication cart (west wing cart) in the sitting room located by the dining room. On top of the medication cart had been a clipboard containing papers with resident names and personal information regarding them. -Left the medication cart in the sitting room unattended multiple times to administer medications to residents located inside of the dining room. *Each time she was away from the medication cart she had left the clipboard on top of the medication cart. That clipboard had not been covered or flipped over to ensure the residents' health information remained private from other residents, staff members, and visitors passing by the medication cart. Observation on 4/26/16 from 11:30 a.m. through 12:00 noon of RN B revealed: *She had: -Been checking blood sugars and administering	F 164		

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F 164	Continued From page 3 medications to residents located on the east wing. -Positioned the medication cart in the hallway and between resident's rooms during that time frame. On top of the medication cart had been a clipboard containing papers with resident names and personal information regarding them. -Left the medication cart in the hallway unattended four times to check a blood sugar or administer medications to residents located inside of their rooms. *Each time she went into a resident's room she had left the clipboard on top of the medication cart. That clipboard had not been covered or flipped over to ensure the residents' health information remained private from other residents, staff members, and visitors passing by the medication cart in the hallway. Interview on 4/26/16 at 1:55 p.m. with RN B revealed: *The computer screen should have been locked or closed when unattended. *The clipboard should have been turned over to ensure the resident's health information remained private from other residents, staff members, and visitors. Interview on 4/27/16 at 9:30 a.m. with the director of nursing confirmed the above interview with RN B. Review of the provider's undated Notice of Privacy Practices document revealed: *"[Facility name] is required by federal and state law to maintain privacy of your health information." *"We support your right to the privacy of your health information."	F 164		

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F 164	Continued From page 4 *That document had been located in the facility's welcome packet and was given to all the residents and their care givers to review upon admission to the facility. Review of the provider's September 2012 Long Term Care Facilities Resident's Bill of Rights pamphlet revealed: *Privacy and confidentiality: -"You have the right to privacy and confidentiality in a long term care facility." -Had included written communication. The provider had no privacy/confidentiality policy and procedure in place for the staff to review and follow.	F 164		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Surveyor: 32332 Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure two of two resident incidents (9 and 23) were thoroughly investigated and documented. Findings include: Surveyor: 32332	F 226	F226 Investigations on Residents 9 and 23 will be completed immediately following submission of plan of correction. *and event reports will be sent to the SD DOH by 6/15/16. SB/SD DOH/EL Investigations on all other resident incidents will be thoroughly investigated and documented according to facility policy. Education was provided by Administrator on 5/19/16 to All-Staff of Facility Reporting Policy. DON will be responsible for completing incident log and monitoring event reports sent to SD DOH until Facility Social Worker is obtained.	6/15/16

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F 226	Continued From page 5 1. Review of an anonymous report received on 4/7/16 by the South Dakota Department of Health Licensure and Certification complaint department revealed a concern about a gun threat that had occurred on 12/4/15 by the husband of a resident. The concern indicated the administrator had not taken the threat seriously, and had not called authorities. Interview on 4/26/16 at 2:00 p.m. with the administrator regarding an alleged gun threat revealed: *The administration, including department supervisors, had not been aware of a gun threat until police arrived at the facility on 12/4/16. *The police department would not indicate who had called to report the incident. They only reported: -The threat came from resident 23's husband. -He had been upset about noise coming from across the hall. -He had stated he could go home and get a gun. *The resident's husband had already left the facility when the police arrived. *The police went to the resident's home to visit with the husband and recommended he not return to the facility again to visit on 12/4/15. *He had denied making a gun threat. *No employee had brought the information to the attention of their supervisors or administration. *If it had been reported to the administration and there had been a potential for harm, he would have considered reporting the event. Review of resident 23's medical record progress note at that time revealed documentation on 12/4/16 at 6:30 p.m. by the administrator indicating: *He had phoned the resident's son to inform him	F 226	DON or designee will perform audits on incident reports once per week for four weeks and monthly for two more months to ensure thorough investigations have been completed and documented. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	

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F 226	Continued From page 6 about the "incident with his father today." *He gave options to the family for moving the resident to a different room or closing the door. Continued interview with the administrator at that time revealed he agreed: *There was no further documentation in resident 23's medical record regarding follow-up of the event on 12/4/16. *There was no incident report regarding the event. *There was no documentation an investigation had occurred with resident 23's husband or individual staff that had been present at the time of the event to indicate: -The threat had not occurred. -There was no further concern for future violence. Surveyor 26180 2. Review of resident 9's 2/29/16 progress notes revealed: *"Resident was in the bath chair being put up onto the scale. The bath chair hit the lip of the ramp of the scale and tipped. Resident was lowered to the floor by a staff member. No s/s [signs or symptoms] of injury noted. [Physician's name] notified by fax. Will continue to monitor." Interview on 4/26/16 at 8:15 a.m. with the director of nurses regarding the above incident with resident 9 revealed: *The resident had fallen while in the bath chair as stated in the above progress note. *They had concluded the resident was too large for the bath chair they were using at the time of the fall. *She was unable to find an investigation of that incident. *She had told the nurse on duty at the time of the	F 226		

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F 226	Continued From page 7 fall to completed an investigation report/. -This had not been done, but should have been. Further record review revealed: *They had no further documentation regarding: -If the provider had determined if the appropriate chair for weighing the resident had been used. -If the scale manufacturer had recommendations for use of a bath chair on the scale incline. -If there were any weight restrictions for the particular bath chair. -If the provider had a policy that addressed the use of a larger bath chair and if so, was it on the resident care plan and staff neglected to follow the plan. -If any other concerns may have contributed to the incident. Review of the provider's 6/4/15 Fall policy revealed "A fall scene investigation Report" should have been completed. 3. Review of the provider's 3/8/12 Resident Incident Policy and Procedure revealed the objective was "To document prompt assessment and evaluation of a resident with incident/accident and provide communication for interested parties e.g. physician, family, and Department of Health." Surveyor: 32332 Procedures in the above policy had included: *When an incident occurred, staff would make sure the resident was safe, and the charge nurse would examine the resident. *The person who had found the incident would have been responsible for completing an incident report. *All incident reports would be given to the director of nursing to assess, and the administrator to	F 226		

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F 226	Continued From page 8 review. *The social worker was to complete a log of all incidents and event reports sent to the Department of Health. *The reports would have been used by the staff and management to prevent future happenings similar in nature. *"When in doubt, complete the incident report." *Event reports would be sent to the Department of Health if it was determined the event had resulted in abuse or neglect.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on resident and family complaint reviews, interview, and Resident Council minutes review, revealed the provider failed to resolve concerns identified by one of one Resident Councils, and one of one confidential resident and family member. Findings include. 1. Review of complaints received 1/9/15, 2/1/16, and 4/7/16, by the South Dakota Department of Health (SD DOH) revealed allegations of: *Staffing shortages. *Call lights not being answered in a timely manner.	F 244	F244 The last 4 months of resident council minutes were reviewed to ensure grievances were resolved. Any unresolved grievances were discussed at the May 2016 Resident Council meeting. Administrator, DON, and interdisciplinary team review and revised as necessary the policies and procedures about receiving, investigating, and resolving resident and family grievances and concerns. Administrator provided education on 5/19/16 to all staff about resident and family grievances. In the event a grievance is not addressed or resolved, continued discussion will be brought to QA Committee for further plan of action.	6/15/16

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F 244	Continued From page 9 *Management not addressing their concerns. 2. Interview on 4/25/16 at 6:00 p.m. with an anonymous family member revealed the residents' call light response times were often slow due the nursing assistants running short on staff. Surveyor: 26180 2. Interview on 4/27/16 at 10:15 a.m. with the Resident Council revealed: *They met monthly and the administrator was present. *They had voiced concerns in previous meetings that call lights were not answered in a timely manner. -It was more common in the evening and occurred frequently. -Staff might come in and answer the call light but would then leave their room. --They were told they would be right back, but then they had not returned for many times up to one-half hour. That was not uncommon. -That sometimes meant they had to wait for medications or to have their blood sugar checked. -Sometimes they had to wait for staff to help them get dressed after they were left to wash up. -They did not like that. -They had not felt the above concerns had been resolved. Review of the Resident Council meeting minutes revealed: *1/12/16; "New Concern: Residents are feeling that sometimes, not all the time, that evening and overnight staffs are not answering call lights in a timely manner. Passes concern on to [name of	F 244	Activity Director or designee will perform audits on resident council grievances to ensure they receive proper response and follow up once per month for six months. Activity Director or designee will present findings from these audits at the monthly QAPI meetings for review.	

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F 244	Continued From page 10 interim director of nurses (DON)], and to MDS [Minimum Data Set] Coordinator. She stated they would educate the floor staff." There would be follow-up at the next meeting. *2/9/16; "New Concern: Residents are feeling that sometimes, not all the time, that evening and overnight staffs are not answering call lights in a timely manner. Passes concern on to [name of interim director of nurses (DON)], and to MDS Coordinator. She stated they would educated the floor staff. [Administrator] also shared that he foresees the QAPI [quality assurance performance improvement] team to investigate this further to bring resolution." -The minutes had not addressed what the residents had been told had been done to resolve their concerns about call lights. *3/8/16; The above concern was listed as Resolved. "Council stated this has gotten much better and did not feel it was a concern any longer." *4/12/16; There was nothing in the minutes regarding any issues related to call lights, or reviewing continued satisfaction with call lights. Interview on 4/27/16 at 11:00 a.m. with the Administrator revealed: *They had been aware of the resident concerns about call lights being answered. *When the residents brought up the concern, they had started auditing responses to call lights and thought it had been going better. *He acknowledged they had staffing challenges, but had tried to have consistent staffing on shifts. *They had followed up with the Resident Council for two months to see if their concern had been resolved. -They thought it was resolved so they had not asked about it in the last meeting.	F 244		

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F 244	Continued From page 11 Further review of the provider's Resident Council minutes revealed: *On 12/8/15 they reviewed Section 10 of Resident Rights which read "You may voice grievances without discrimination or reprisal. Your grievance may be in writing or oral and may related to treatment, behavior or other residents or infringement of your rights." *At the end of every month the minutes read "Residents' Council gives the resident empowerment to express their ideas, concerns, and suggestions. Residents at Dells Nursing and Rehab Center (DNRC) are reminded that this is their home and staff will try to the best of their ability to make living here at DNRC as comfortable as possible." 2. Confidential resident interview on 4/27/16 at 10:30 a.m. revealed: *She had told her physician during a visit: -Sometimes the nursing assistants come in and give her a wash basin to wash up. -They leave her to do that. -They do not always return in a timely manner, and she is left sitting without anything to cover her up. -This was upsetting to her. *The director of nurses (DON) was in the room when she told the physician that concern. *This concern had not been resolved. It still happened all the time. Interview on 4/27/16 at 1:45 p.m. with the DON revealed: *She had been made aware of a different resident having the above concern. *She did not recall this conversation coming up during a physician visit.	F 244		

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F 244	Continued From page 12 *She had told staff that no matter how independent a resident was with washing themselves up, staff were to stay with the resident.	F 244		
F 250 SS=D	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: 26180 Based on observation, interview, and policy review, the provider failed to ensure medically related social services for one of one sampled resident (9) who needed adaptive equipment. Findings include: 1. Random observations of resident 9 on 4/25/16 and 4/26/16 revealed: *He was a tall, large man. *When he was out of bed he sat in a standard size wheelchair. *When his feet were on the pedals his knees appeared higher than his seat, and the wheelchair looked too small including: -His back protruded over the back of the wheelchair causing it to bulge out. -His feet frequently came off the wheelchair pedals. -His body appeared to be very snugly placed in the wheelchair. *He relied on staff to move around the facility in	F 250	F250 Therapy services have been ordered, assessed, and completed for Resident 9. The wheelchair recommendation from Therapy has resulted in the purchase of a new wheelchair. All other residents requiring adaptive equipment have been reviewed to ensure medically related social services. Administrator and governing board reviewed the requirements relevant to a social service designee (SSD) and the availability of a social worker when a SSD is not employed/present. Administrator provided education on 5/19/16 to all staff regarding [redacted] *the expectation of those staff required to fulfill the social worker job responsibilities until an SSD or social worker is hired. A contract with a consultant social worker was established on 5/18/16 and will include quarterly visits. Day-to-day Social Worker job responsibilities will be handled by current facility staff until SSD or Social Worker is hired. SB/SDDOH/EL	6/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435129		04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 250	Continued From page 13 the wheelchair. *He occasionally moved his wheelchair with his feet, but movement was without purpose (not to reach a destination). Observation and interview on 4/26/16 at 8:00 a.m. with certified nursing assistants (CNA) E and F regarding resident 9 revealed: *They always transferred him using a Hoyer (mechanical) lift. *It was very difficult to get him seated properly in his wheelchair. *He was so large and tall, they could not pull him far enough back in the wheelchair so he was sitting correctly. *They did not think he looked comfortable, but he was unable to tell them if he was uncomfortable. *They had told the director of nurses (DON) and the charge nurse about a month ago they thought he could have benefited from a rocker wheelchair. -They had not heard about any follow-up to that request. Interview on 4/26/16 at 9:00 a.m. with registered nurse (RN) B regarding resident 9 revealed: *They had noted he was starting to lean in his wheelchair. *He needed a wider/larger wheelchair. *They had referred him to occupational therapy (OT) about a month ago to evaluate him for a different wheelchair. -She was unsure if that evaluation had occurred. *Review of resident 9's entire medical record revealed there had not been a wheelchair evaluation completed or evidence of a referral. Interview on 4/26/16 at 9:17 a.m. with certified	F 250	DON or designee will perform audits once per week for four weeks and monthly for two more months to ensure adaptive equipment has been arranged for those needing medically related social services. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	

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F 250	Continued From page 14 occupational therapy assistant (COTA) G regarding resident 9 revealed: *They had not received a referral for a wheelchair evaluation for the resident. *She agreed his wheelchair was too small for him and he was not sitting correctly in it. -She could see they were not pulling him far enough back in the wheelchair. *If they had received a referral, the OT would have done it. Interview on 4/26/16 at 10:00 a.m. with the DON regarding resident 9 revealed: *She had been asked to review resident 9 a few weeks ago for a rocking wheelchair. *There had been a discussion about his wheelchair but they determined it would restrain this resident because he would not be able to use his feet to move around. -He occasionally scooted in his wheelchair using his feet. *A larger wheelchair would have been a better option, but they did not have an extra one available in the facility. *They did not currently have a social worker (SW) on staff. The DON and the administrator were fulfilling those responsibilities until a SW was hired. Review of the provider's 6/4/15 Use of Wheelchair policy revealed the procedure included: *"Wheelchair should be the proper size. *Lower foot rests and place resident's feet on foot rests if used. Position feet and legs in good body alignment." Review of the provider's January 2011 social service policy revealed "Siderails, chair devices,	F 250		

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F 250	Continued From page 15 and physical restraints will be assessed on an ongoing basis. Administrator, DON, and social worker will oversee the bed and chair devices being used in the facility."	F 250		
F 280 SS=F	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: Surveyor: 18560 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans were reviewed and revised for thirteen of fourteen sampled residents (1, 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 16). Findings include:	F 280	F280 Care plan for Resident 3 has been updated to reflect the accurate code status and interventions. Care plan for Resident 6 has been updated to reflect accurate therapy status, supplements, and weight monitoring. Care plan for Resident 12 has been updated to reflect accurate interventions in regards to visits. Care plan for Resident 5 has been updated with goals and interventions to support documented plan of care. Care plan for Resident 7 has been updated to reflect current plan of care and includes goals and interventions. Care plan for Resident 13 has been updated to reflect current plan of care and includes goals and interventions. Care plan for Resident 16 has been updated to reflect preferred routine when blood sugar levels are low. Care plan for Resident 2 has been updated to reflect current plan of care with goals and interventions. Care plan for Resident 9 has been updated to reflect current plan care with goals, including activity involvement. Care plan for Resident 11 has been updated to reflect current plan of care, as well as therapy status. Care plan for Resident 1 has been updated to reflect current treatment administration. Care plan for Resident 8 has been updated to reflect current nutritional status. Care plan for Resident 10 has been updated to reflect interventions in place to monitor lung concerns. All identified care plans [redacted] updated by MDS Coordinator. *on 6/9/16. SB/SDDOH/EL	6/15/16

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	435129		04/27/2016

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F 280	Continued From page 16 1. Review of resident 3's medical record revealed: *On 3/8/16 her code status had been changed from full code to do not resuscitate. *On 4/16/16 she had a fall resulting in a left hip fracture. *On 4/23/16 an order had been received for a foley catheter. *Her 11/14/13 care plan last had: -Stated her code status as full code. -No interventions related to her left hip fracture. -No interventions related to her foley catheter. 2. Review of resident 6's medical record revealed: *On 12/3/15 occupational therapy (OT) had been discontinued. *On 12/31/15 protein powder supplements had been discontinued. *On 1/19/16 daily weights had been ordered for fluid retention monitoring. *Her 7/10/15 care plan documented: -She currently worked with OT five days a week. -She received protein powder one time a day. -Her weights were to have been done weekly. 3. Review of resident 12's medical record revealed: *A 3/18/16 social service note documented concerns voiced by her guardian related to a male friend. *A 3/23/16 social service note documented procedures should the male friend visit the facility. *Her 12/08/14 care plan had no interventions related to her visits with the male friend. Surveyor: 32355 4. Observation of resident 5 on 4/25/16 from 4:40 p.m. through 4:45 p.m. revealed:	F 280	All other resident care plans will be updated by MDS Coordinator to include but not limited to code status, therapy status, supplements, weight monitoring, outside visits, preferred blood sugar routines, activity involvement, treatment administration, nutritional status. All of these items will include, if applicable, goals and interventions. 6/15/16 SB/SDDOH/EU DON and interdisciplinary team review and revised, as necessary, the policy and procedure about ensuring complete and accurate resident care plans. DON or designee provided education on 5/19/16 to all staff responsible for creation, review, and revision of resident care plans. DON or designee will perform audits on ten resident care plans to ensure they are complete and accurate once per week for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	

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	435129		04/27/2016

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F 280	Continued From page 17 *He had been: -Sitting in a reclining wheelchair (w/c) in the sitting area. -Wearing a protective apron that covered his shirt and fastened behind his neck. *He had made no bodily movements during that entire time frame. Observation of resident 5 on 4/25/16 from 5:00 p.m. through 5:40 p.m. revealed: *He had been sitting in a reclining w/c at the dining room table waiting for his supper meal. *At 5:03 p.m. his meal had been placed on the table in front of him. He had made no attempt to eat that meal on his own. *At 5:12 p.m. an unidentified staff member had sat down beside him and assisted him with his meal. *His meal had been blended and placed inside of a divided plate. Observation of resident 5 on 4/26/16 from 9:25 a.m. through 9:45 a.m. with certified nursing assistants (CNA) D and K revealed: *They had: -Prepared to assist the resident with laying down in his bed and personal care. -Used a gait belt to transfer him from the w/c into his bed. The tips of his toes had been the only part of his feet that touched the floor during the transfer. -Assisted him with personal care and positioning him in his bed. -Not offered to take him to the bathroom prior to laying him down in the bed. *The resident had made no attempt to assist the staff with the transfer, personal care, or positioning in his bed.	F 280		

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	435129		04/27/2016

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F 280	Continued From page 18 Interview on 4/26/16 at 9:45 a.m. with CNA K regarding resident 5 revealed: *He: -Had required total assistance from the staff to meet all of his activities of daily living (ADL). -Could not walk. -Could not make significant body movements on his own without the assistance from the staff. *She could not remember the last time he had been able to use the bathroom. *He had a tendency to hold food in his mouth. The protective apron would have ensured his clothing remained clean when he had allowed that food to run out of his mouth. *She had confirmed he required his food to be blended. *He had not been under hospice (end of life) care for a while. Review of resident 5's care plan dated 8/30/14 revealed: *He had: -Preferred to get out of bed around 9:00 a.m. Observation on 4/26/16 at 7:30 a.m. revealed he had been sitting in his w/c at the dining room table waiting for his breakfast. -The capability to walk with the assistance of one staff member. -Been able to assist the staff with oral care. -Been on hospice care. *He was to have been assisted with using the bathroom. *He was on a regular diet with ground meat. *No documentation to support: -He required the use of a protective apron. -He required his food to be placed inside of a divided plate. -He had been dependent upon the staff to meet his ADLs.	F 280		

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F 280	Continued From page 19 -The care plan had been updated to reflect the above observations and interview. *No goals or interventions in place to support all of the documented areas of concern. Interview on 4/26/16 at 1:55 p.m. with registered nurse (RN) B revealed: *She had confirmed the above care plan for resident 5 had not been current. *The Minimum Data Set (MDS) assessment coordinator and director of nursing (DON) updated the care plans. *The staff referred to the care plans to ensure that proper care had been delivered to the residents. 5. Observation of resident 7 on 4/25/16 from 5:00 p.m. through 5:30 p.m. revealed: *She had been sitting in her w/c at the dining room table eating her supper. *She had a divided plate that had been placed on a non-skid placemat. *She had been leaning to her left side. Review of resident 7's medical record revealed: *An admission date of 5/29/15. *Diagnoses of Parkinson's disease (loss of muscle control), paralysis (unable to move), anxiety, and depression. *She had a history of falls. *In March of 2016 she had fallen and fractured her left wrist and left hip. *She had been working with physical (PT) and occupational (OT) therapies to increase her strength and independence. *She had not been walking since her fall in March of 2016. Review of resident 7's care plan dated 6/9/15	F 280		

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F 280	Continued From page 20 revealed: *No documentation to support: -She had two recent falls that resulted in a fracture to her left wrist and left hip. -Her walking capability had been on hold. -She had been working with PT and OT. -She had required the use of a divided plate at meals -Her plate, silverware, and drinking glasses should have been placed on a non-skid placemat. *No goals or interventions in place to support for all of the documented areas of concern. 6. Random observations of resident 13 from 4/25/16 at 5:10 p.m. through 4/26/16 at 8:15 a.m. revealed: *She had been sitting in a w/c at a table in the dining room eating her meal. That table had been placed at the far end of the dining room and in a corner by a window. *She had been: -Sitting at the table by herself. -Positioned to look out the window with her back to the other residents. Interview on 4/26/16 /at 8:30 a.m. with licensed practical nurse (LPN) C regarding resident 13 revealed: *The resident had preferred: -To be placed in the dining room as observed above. -Not to interact with other residents during her meals. Review of resident 13's care plan dated 8/1/14 revealed: *No documentation to support the above observations of her in the dining room. *No goals or interventions in place for all of the	F 280		

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	435129		04/27/2016

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F 280	Continued From page 21 documented areas of concern. 7. Review of resident 16's medical record revealed: *An admission date of 11/21/12. *Diagnoses of Type II diabetes (uncontrolled sugar levels in the blood), depression, and was legally blind. *Had required the use of insulin (injectable medication) to control her blood sugar levels. Interview on 4/27/16 at 10:00 a.m. with resident 16 revealed: *She had a specific routine in place when her blood sugar levels were 70 or lower. *That routine had been to drink: -One small can of pineapple juice when her blood sugar had been between 70 and 50. -Two small cans of pineapple juice with karo syrup when her blood sugar had been 50 and lower. *She had kept the pineapple juice and karo syrup inside of an end table by her recliner. Review of resident 16's care plan dated 12/17/13 revealed no documentation to support the above routine she had preferred to follow when her blood sugar levels were low. Interview on 4/27/16 at 10:15 a.m. with the MDS assessment coordinator regarding resident 16 confirmed the above routine should have been documented on her care plan. Surveyor: 26180 8. Interview on 4/26/16 at 8:30 a.m. with resident 2 revealed: *He was independent with his ADL's (activities of	F 280		

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F 280	Continued From page 22 daily living to include bathing, dressing, toileting). *He went to restorative therapy every morning independently. *He used his walker for walking, except in the mornings because he had some difficulty with dizziness then. *He had a hip replaced a while back, and he still had pain in that hip. He pointed to his right hip. -He received medication for the pain. Interview on 4/26/16 at 2:00 p.m. with CNA E regarding resident 2 revealed: *She confirmed he was independent with his care. *He occasionally had some dribbling with his urine, but was able to do necessary hygiene himself. Review of resident 2's 9/9/14 care plan revealed: *He required limited to extensive assistance with dressing and personal hygiene. *He occasionally required assistance with toileting due to decreased safety awareness. *He had pain in his right leg. *The care plan: -Did not indicate he was more likely to be dizzy in the morning. -Did not have any measurable goals. -Did not identify who was responsible for interventions on the care plan. -Had not been updated with his changes in his level of independence. -Had no evidence it had been updated since 9/9/14. 9. Interview on 4/25/16 at 8:20 a.m. with CNA E regarding resident 2 revealed: *They no longer took him to the toilet every 2-3 hours because he was not able to go to the	F 280		

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F 280	Continued From page 23 bathroom on demand. -He could "not produce" sitting up like that. *He occasionally said a word but was unable to carry on a conversation. *He did not fit properly in his wheelchair, and needed a larger one. Review of resident 9's 6/24/14 care plan revealed: *"Staff will assist him to the bathroom upon rising, before and after meals, before bed, every 2-3 hours through the night." *The care plan: -Did not address any activities staff provided since he was dependent on them. -Did not acknowledge he needed a larger wheelchair. -Did not have any goals. -Did not indicate who was responsible for what on the care plan. 10. Review of resident 11's 10/28/15 care plan revealed: *"[Name of resident] requires assistance with ADLS due to increased weakness and fatigue, risk for falls and urinary incontinence." *She required extensive assist with toileting needs. -She was working with occupational therapy (OT) to increase independence with toileting. *The care plan did not address any measurable goals, and did not identify who was responsible for the interventions. Interview on 4/27/16 at 10:30 a.m. with resident 11 revealed: *She was independent with most of her ADLs. *Usually the staff provided her with a wash basin and she washed herself up in the morning for the	F 280		

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F 280	Continued From page 24 day. *She was able to go to the bathroom by herself using her walker. *She used a commode at night. *She went to restorative exercises. Interview on 4/27/16 at 11:00 a.m. with CNA F regarding resident 11 revealed: *The resident was quite independent with her ADLs. -She no longer needed extensive assistance with ADLs. *She was no longer receiving OT as was independent with going to the bathroom. Surveyor: 32332 11. Review of resident 1's medical record revealed: *She was admitted on 6/1/12. *She had diagnoses of heart disease and edema (excess fluid in her legs). *Her April 2016 treatment administration record revealed an 8/25/15 treatment to apply Tubigrip (elastic tubular bandage to provide support and reduce swelling) to her left leg every morning, and remove every evening. *Her updated 3/29/16 care plan revealed: -Staff were to have monitored her lower legs for edema. -Nothing regarding the application of the Tubigrip. 12. Review of resident 8's medical record revealed: *He was admitted on 7/27/15. *A diagnosis of dysphagia (difficulty swallowing) following cerebral infarction (stroke). *He had required nutrition and water hydration through a tube due his swallowing difficulties. *His oral intake improved and the tube feedings were discontinued on 4/8/16.	F 280		

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F 280	Continued From page 25 *His reviewed 11/13/15 care plan revealed: -He was to have NPO (nothing by mouth) due to a sluggish gag reflex. -He was to have received all of his nutritional needs through the feeding tube. 13. Review of resident 10's medical record revealed: *He was admitted on 11/19/15. *He was receiving hospice services. *Diagnoses had included a left lower lung mass, and chronic obstructive lung disease. *Review of his 12/3/15 care plan revealed no interventions were in place to monitor his lung concerns. Surveyor 32355 Interview on 4/27/16 from 9:00 a.m. through 9:30 a.m. with the DON and MDS assessment coordinator revealed: *They confirmed the above care plans had not been consistently reviewed and revised for a long time. *The interdisciplinary care team and nursing staff had been responsible for the reviewing and revising of the care plans. *They agreed all of the above areas of concerns for those residents should have been found on their care plans. *Their care plans had not reflected the current level of care they had required. 26180 14. Review of the provider's 6/3/15 Comprehensive-Care Plan policy revealed: *"An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 26 resident. *Each resident's comprehensive care plan is designed to: -Reflect treatment goals, timetables and objectives in measurable outcomes. -Identify the professional services that are responsible for each element of care."	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 A. Based on observation, record review, interview, and policy review, the provider failed to ensure physicians' orders were followed for the administration of two of two randomly reviewed resident inhalers (17 and 18). Findings include: 1. Observation on 4/27/16 at 1:35 p.m. of resident 17's Advair inhaler (for asthma and chronic obstructive pulmonary disease [COPD]) in the medication cart revealed there was: *An open date of 4/20/16 and it contained sixty inhalations. *Forty-eight doses had been left in the inhaler. Review of resident 17's 4/1/16 through 4/27/16 medication administration records (MAR) revealed: *The Advair inhaler was to have been administered twice a day. Once during the day and once during the evening. *There was documentation he had received the	F 281	F281 Residents 17 and 18 medication administration records were reviewed to ensure physicians' orders were followed for resident inhalers. All other residents with physician orders for inhalers were reviewed to ensure orders were followed. Resident 8's physician order regarding fluid hydration through a feeding tube has been discontinued as feeding tube has since been removed. All other residents with feeding tubes were reviewed to ensure physician orders were followed and clarified. Education was provided by the Director of Nursing on 5/19/16 to all staff responsible for following physician orders regarding inhalers/feeding tubes.	6/15/16

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F 281	Continued From page 27 inhaler from 4/20/16 through the day time on 4/27/16. There was no documentation any doses had been held or refused. *He had not yet received his evening dose on 4/27/16. *There should have been forty-five doses left in the Advair inhaler instead of forty-eight. 2. Observation on 4/27/16 at 1:40 p.m. of resident 18's Serevent inhaler (for COPD) in the medication cart revealed there was: *An open date of 4/15/16 and it contained sixty inhalations. *Fifty-two doses had been left in the inhaler. Review of resident 18's 4/1/16 through 4/27/16 MAR revealed: *The Serevent inhaler was to have been administered twice a day. Once during the day and once during the evening. *There was documentation he had received the inhaler from 4/15/16 through the day time on 4/27/16. There was no documentation any doses had been held or refused. *He had not yet received his evening dose on 4/27/16. *There should have been thirty-five doses left in the Serevent inhaler instead of fifty-two. Interview on 4/27/16 at 1:45 p.m. with the director of nursing (DON) revealed she had confirmed the above observations. She was unsure why the count of those inhalers did not match what had been documented as administered. She had never done a medication audit on the inhalers to ensure the staff had been administering the correct doses per the physicians' orders. Review of the provider's 6/9/15 Administering	F 281	DON or designee will perform 2 audits on resident's inhaler physician orders, specifically inhaler dosages to ensure accurate administration, once per week for four weeks and monthly for two more months to ensure orders are followed appropriately. *given SB/SDDOH/EL Dietary Director or designee will perform an audit on the dietitian notes to ensure dietitian recommendations are followed twice for 1 month month and monthly for 2 more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	

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F 281	Continued From page 28 Medications policy revealed: *"Medications shall be administered in a safe and timely manner, and as prescribed." *"Medications must be administered in accordance with the orders, including any required time frame." Surveyor: 32332 B. Based on record review, and interview, the provider failed to ensure 1 of 1 sampled resident (8) had a physician's order clarified regarding fluid hydration through a feeding tube. Findings include: 1. Review of resident 8's medical record revealed: *He was admitted on 7/27/15. *A diagnosis of dysphagia (difficulty swallowing) following cerebral infarction (stroke). *He had required nutrition and water flushes through a tube due his swallowing difficulties. *A progress note on 3/22/16 from the registered dietitian revealed a swallow study had indicated he was able to take some oral foods and liquids. The physician had approved orders to decrease nutrition through the feeding tube. *A progress note on 4/8/16 from the dietitian had documented a recommendation to "Discontinue the tube feedings as oral intake is adequate." *A 4/8/16 facsimile (fax) request from the dietitian to his physician requesting: -To "Discontinue tube feeds?" The physician had circled 'yes' beside that request. -What the physician wanted to do with the tube and water "Flushes?" The physician had circled 'Pull' beside that question. *A progress note on 4/18/16 from RN L indicated she was unable to provide the 9:00 a.m. water flush because the resident was not available.	F 281		

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F 281	Continued From page 29 Review of the April 2016 medication administration record revealed: *The Osmolite (nourishment used with the tube feeding) had been discontinued on 4/9/16. *The water flushes had been continued at 250 milliliters four times each day except for the missed flush on 4/18/16, and were still being done at the time of the survey. Phone interview on 4/27/16 at 1:50 p.m. with the dietitian revealed: *Resident 8 had not needed to continue the water flushes when the tube feedings had been discontinued. *The nurse noting the order had not notified the dietitian of the order results or to clarify the water flushes. Interview on 4/27/16 at 3:15 p.m. with the director of nursing regarding the 4/8/16 order to discontinue the tube feedings and pull the feeding tube/flushes revealed she had agreed the nurse should have clarified the orders with the resident's physician. Request for a policy for physician clarification of orders revealed the provider did not have a policy. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 305 regarding clarifying physician orders revealed: "The healthcare provider is responsible for directing medical treatment. Nurses follow health care provider's orders unless they believe the orders were in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or harmful,	F 281		

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F 281	Continued From page 30 further clarification from the health care provider is necessary,"	F 281		
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, interview, and manufacturer's recommendations review, the provider failed to ensure safe chemical use for the use of toilet bowl cleaner for all toilets. Findings include: 1. Observation on 4/26/16 at 8:30 a.m. with housekeeping assistant H cleaning a resident room revealed: *He poured Betco Kling toilet bowl cleaner into the toilet and onto the toilet seat. *He stated he used the toilet bowl cleaner on the seats of all the toilets. Interview at that time with the housekeeping supervisor revealed: *Toilet seats should have been disinfected using a bathroom disinfectant. *Toilet bowl cleaner should not have been used on surfaces that came into contact with the residents' skin.	F 323	F323 Housekeeping Assistant H has been educated by Environmental Services Director on 4/26/16 on proper chemical usage on all toilets. All other housekeeping staff was educated by Environmental Services Director on 4/28/16 on proper chemical usage on all toilets. Housekeeping assistant job description has been updated to reflect proper chemical usage as described by labeling. Administrator, DON, infection control nurse, and interdisciplinary team reviewed and revised as necessary the policy and procedure about appropriate use of toilet bowl cleaner by housekeeping. Environmental Services Supervisor will perform audits once per week for four weeks and monthly for two more months to ensure proper chemical usage on all toilets. Environmental Services Supervisor will present findings from these audits at the monthly QAPI meetings for review.	6/15/16

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F 323	Continued From page 31 Review of the manufacturer's guidelines for Kling toilet bowl cleaner revealed: *Causes serious eye damage. *Causes severe burns. *For skin contact, get medical attention immediately. Call a poison center or physician. Wash contaminated skin with soap and water. Continue to rinse for at least ten minutes.	F 323		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS 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. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on record review and interview, the provider failed to ensure: *Physicians' progress notes were documented in residents' medical records for four of fourteen sampled residents (3, 4, 9, and 11). *Physician visits were completed in a timely manner for five of fourteen sampled residents (3, 4, 7, 9, and 11). Findings include: 1. Review of resident 3's medical record revealed:	F 386	F386 Physicians' progress notes for Residents 3, 4, 9, and 11 have been documented in the respective residents' medical records. All other residents were reviewed to ensure physicians' progress notes were documented in the residents' medical records. Physician visits have been completed for Residents 4, 7, 9, and 11. All other residents were reviewed by DON or designee to ensure physician visits were completed in a timely manner. DON or designee will perform audits once per week for four weeks and monthly for two more months to ensure physicians' progress notes and visits were completed and documented in a timely manner. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	6/15/16

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F 386	Continued From page 32 *She had last been seen by her physician on 2/12/16. *No progress note had been received from her physician as of 4/27/16. Interview on 4/27/16 at 10:30 a.m. with the director of nursing (DON) regarding resident 3 confirmed: *The physician's progress note from 2/12/16 was not in her medical record. *She had not been seen by her physician since 2/12/16. Surveyor: 26180 2. Review of resident 9's medical record revealed: *The physician saw him on 10/2/15. -They did not receive a copy of the physician's progress note until 11/1/15. *The physician saw him on 12/8/15. -They did not receive a copy of the physician's progress note until 4/1/16. *He was hospitalized 1/20/16 - 1/22/16. -The physician saw him for the required 30 day visit on 2/12/16. -They did not receive a signed copy of the physician's progress notes until 4/20/16. *The resident had never had a 60 day post hospital physician visit. 3. Review of resident 11's medical record revealed: *The resident was seen by her physician on 7/21/15. -They did not receive a copy of the physician's progress notes until 10/12/15. *The resident was also seen by her physician on 2/12/16 and 3/30/16, but there were no progress notes in her record for those visits.	F 386		

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F 386	Continued From page 33 Interview on 4/27/16 at 8:00 a.m. with the DON revealed: *They had a lot of problems getting resident's 9 and 11 physicians to do their required visits in a timely manner. *They also did not receive the progress notes in a timely manner. *She confirmed some progress notes were received periods of time after a resident saw their physician. *They sent the physician a list of required visits and when they were due, but it continued to be a problem. *They had brought this to the medical director's attention. Surveyor: 32355 4. Review of resident 4's medical record revealed: *The resident was seen by her physician on 12/8/15. They had not received a signed physician's progress note from that visit until 4/21/16. *The resident was also seen by her physician on 2/12/16. There was no progress notes in her record from that visit. 5. Review of resident 7's medical record revealed: *The resident had been seen by her physician on 1/9/16, 3/11/16, and 4/15/16. *No documentation to support she had been seen by her physician from August 2015 through December 2015. The provider had no policy or procedure in place for the staff to follow for physician visits or progress note documentation from those visits.	F 386		

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 32355	F 431	F431 LPN A was educated by DON on 5/19/16 on proper security of medications in medication cart. All other staff responsible for maintaining security of medications to ensure proper integrity and security of medications were educated by DON on 5/19/16. All medication blister packs with tampered or broken seals were removed by DON on 4/28/16 to ensure all medications are properly secured. Administrator, DON, and pharmacy consultant reviewed and revised as necessary the policies and procedures about maintaining the integrity of the medications in blister packs and the security of medications during medication administration pass. DON or designee will perform audits once per week for four weeks and monthly for two more months to ensure proper medication security and integrity of medication blister packs. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	6/15/16

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F 431	Continued From page 35 Based on observation, interview, and policy review, the provider failed to ensure: *Medications remained secure in the medication cart during medication administration by one of three nurses (A). *Medications had been properly secured in 3 of 42 observed medication blister packs. Findings include: 1. Random observations on 4/25/16 from 4:00 p.m. through 4:30 p.m. of licensed practical nurse (LPN) A revealed: *She had been administering medications on the east wing. *She had left the medication cart unlocked three times while administering medications to residents inside of their rooms. *The medication cart had been out of her sight during those three times. *Several unidentified residents, visitors, and staff had been observed passing by that medication cart. Random observations on 4/26/16 from 4:50 p.m. through 5:10 p.m. of LPN A revealed: *She had been: -Administering medications in the dining room. -Administering medications from the east and north wing medication carts. *She had left the: -North wing medication cart unlocked during the above time frame. -East wing medication cart unlocked three times while administering medications. *She had been several feet away from the medication carts and had turned her back to them multiple times. *Several unidentified residents and visitors had been observed passing by those medication	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 36 carts. Interview on 4/26/16 at 2:00 p.m. with registered nurse (RN) B confirmed the medication carts should have been locked when unattended. Interview on 4/27/16 at 9:15 a.m. with the director of nursing (DON) confirmed the interview with RN B. Review of the provider's 6/9/15 Administering Medications policy revealed "During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide." 2. Observation and interview on 4/27/16 at 2:00 p.m. with the DON regarding the west and east wing medication carts revealed: *Both medication carts had a secured drawer that required a key to open it. *Inside of those drawers had been multiple medication blister packs containing narcotic controlled medications such as: -Ativan (anti-anxiety medication). -Hypnotics (medication for sleep). -Hydrocodone (pain medication). *Three of those controlled medications had: -One hydrocodone blister pack containing a total of nine pills. Three of those pills had slits through the packaging and had been re-taped on the back of the blister pack. -One Ativan blister pack containing a total of thirty-one pills. One of those pills had a slit through the packaging and had been re-taped on the back of the blister pack. -One Zolpidem (medication for sleep) blister pack containing a total of fifteen pills. Three of those pills had slits through the packaging and had	F 431		

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F 431	Continued From page 37 been re-taped on the back of the blister pack. *The DON: -Had not been aware the staff were re-taping the blister packs to secure the medications inside of the packages if they had been slit open. -Could not guarantee the medications in those blister packs with the re-taping had been diverted (stolen) and replaced with other pills. -Agreed that had not been a good practice and those pills should have been destroyed. The provider had no policy or procedure for the staff to follow to ensure proper security of controlled medications inside of a blister pack.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, 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.	F 441	F441 A MDS Coordinator has been hired and will be responsible for maintaining the infection control program. Training by DON began on 5/2/16 that will include review of the facility policies and procedures, surveillances strategies, and outbreak management. Restorative Aide I was educated by DON on 5/19/16 on proper cleaning of common use exercise equipment. All other Restorative staff were educated by DON on 5/19/16 on proper cleaning of common use exercise equipment. CNA J was educated by DON on 5/19/16 on proper cleaning of the shower stall and shower chair.	6/15/16

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	435129		04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Maintain an effective infection control program. *Follow manufacturer's instructions for disinfecting common-use exercise equipment for one of one restorative room. *Clean and disinfect one of two (Rising Sun) shower area and shower chair. *Deliver insulin injections in a sanitary manner for one of three (16) residents observed receiving insulin injections. *Maintain sanitary conditions during personal care for three of three observed residents (4, 5, and 9). *Ensure clean technique was used for resident self-care for two observations of one resident (7) with a history of urinary tract infections. *Ensure clean technique was used for obtaining a	F 441	All other staff responsible for baths/showers were educated by DON on 5/19/16 on proper cleaning of the shower stall and shower chair. LPN A was educated by DON on 5/19/16 on proper infection control standards in regards to blood sugar checks. All other staff responsible for blood sugar checks were educated by DON on 5/19/16 on proper policy and procedures. CNA D, CNA K, CNA E, and CNA F were educated by DON on 5/19/16 on proper glove use in regard to personal cares. All other staff responsible for assisting with personal cares were educated by DON on 5/19/16 on proper glove use. CNA K was educated by DON on 5/19/16 on proper urine sample collection procedures. All other staff responsible for urine sample collection were educated by DON on 5/19/16 on proper policy and procedures. RN B was educated by DON on 5/19/16 on proper removal and cleaning techniques of nebulizer apparatus. All other staff responsible for removing and cleaning nebulizer apparatus were educated by DON on 5/19/16 to proper policy and procedures.	

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F 441	Continued From page 39 urine specimen for one of one sampled resident (7). *Clean the nebulizer apparatus for two of two residents (21 and 22) after nebulizer use. Findings include: 1. Interview and review of the provider's infection control program on 4/27/16 at 10:45 a.m. with the infection control nurse revealed: *She had recently started as the infection control nurse. *She had no formal training. *Before she started as the infection control nurse, the director of nursing (DON) was attempting to handle the roles of Minimum Data Set (MDS) coordinator and infection control nurse. *There was no infection control data reviewed for October, November, and December 2015, and no data for February and March 2016. *She had just completed the infection control data for January 2016 on April 26. *When the infection control program became updated, she planned to dedicate two hours each week on infection control. *She was not aware of audits for handwashing having been done. *There previously was an infection control committee and meetings, but she could not locate information those meetings had been done. *There was not an infection control committee currently. Review of the provider's undated infection control policy revealed: *The objective was to accurately track infections in the facility. *There would be weekly review of the infections. *Antibiotics would be accurately ordered based on a culture report.	F 441	Administrator, DON, infection control nurse, and interdisciplinary team reviewed and revised as necessary the policies and procedures about ensuring a nurse designated as the infection control nurse receives training and resources for the assigned task, following manufacturer's recommendations or instructions for cleaning and disinfecting common-use exercise equipment, appropriate cleaning and disinfection of shower areas and shower chairs, appropriate cleaning and maintenance of nebulizer apparatus', appropriate clean technique utilized for obtaining a urine specimen, and appropriate handwashing, hand hygiene, and glove use. DON or designee will perform audits once per week for four weeks and monthly for two more months to ensure infection control program is complete, proper cleaning techniques are followed for common use exercise equipment, appropriate cleaning and disinfection of shower areas and shower chair, appropriate cleaning and maintenance of nebulizer apparatus', appropriate clean technique is utilized for obtaining a urine specimen, and appropriate handwashing, hand hygiene, and glove use. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	

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F 441	Continued From page 40 *Infections would be separated by wing to track possible outbreaks. *Information would have been reviewed monthly by the quality assurance and performace improvement (QAPI) committee, and submitted to the medical director for review. 2. Observation and interview on 4/26/16 at 8:00 a.m. with restorative aide I regarding cleaning common use exercise equipment revealed: *She used AF79 disinfectant to clean the exercise machines and multi-use equipment after each resident use. *When asked about the process of disinfecting she stated she could either: -Spray the equipment with disinfectant and wipe the equipment off or: -Spray the equipment with disinfectant and allow it to sit on the equipment ten minutes before wiping it off. -Both ways were their acceptable practices. Upon request, the provider stated there was no policy for disinfecting multi-use exercise equipment. Review of the manufacturer's undated instructions for Betco AF79 revealed surfaces should have been wiped with a cloth and allowed to air dry. 3. Observation and interview on 4/26/16 at 9:20 a.m. with certified nursing assistant J cleaning the shower stall and shower chair in the Rising Sun wing revealed: *She applied gloves and sprayed the shower stall and shower chair with AF79 disinfectant. *Stated the disinfectant would sit on the shower stall and chair for ten minutes.	F 441		

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F 441	Continued From page 41 *After the ten minute wait, she rinsed the stall and chair, and used a squeegee to remove excess water from the floor. *When asked about scrubbing the stall and chair after spraying disinfectant she stated no, she did not use a brush to scrub the areas down before rinsing. Review of the provider's undated Bath Tubs and Showers Cleaning Policy revealed "Scrub tub, safety chair and belt. Follow manufacturer's guidelines using recommended solutions." Review of the manufacturer's undated instructions for Betco AF79 revealed surfaces should have been wiped with a cloth and allowed to air dry. Surveyor: 32355 4. Observation on 4/25/16 at 5:05 p.m. with licensed practical nurse (LPN) A with resident 16 revealed: *She had: -Prepared to administer the resident's insulin (injectable medication to control blood sugar levels) injection. -Taken the resident into a bathroom used by other residents, visitors, and staff. -Taken two gloves with her into the bathroom. -Dropped one of those gloves onto the floor. -Picked that glove up off the floor and put it on one of her hands. -Administered the insulin injection to the resident using that soiled glove. Interview on 4/25/16 at 5:35 p.m. with LPN A revealed: *She had confirmed: -The bathroom had been used by multiple people.	F 441		

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F 441	Continued From page 42 -The glove was considered dirty after it had dropped onto the floor. *She: -Should have thrown that glove in the garbage and retrieved a clean one. -Agreed the above process had created the potential for cross-contamination of bacteria to that resident. 5. Observation on 4/26/16 at 7:55 a.m. through 8:30 a.m. of CNA D with resident 4 revealed: *She had been assisting the resident with personal care in the bathroom. *With gloved hands she had washed the resident's bottom. *With those soiled gloves CNA D: -Assisted the resident with pulling up her incontinent brief and pajama bottoms. -Assisted the resident to sit down in the wheelchair (w/c). -Touched the w/c handles and pushed the resident out of the bathroom and to her night stand. -Pushed the divider curtain open. -Removed her gloves after touching all of those surfaces and then washed her hands. Continued observation on 4/26/17 of CNA D with resident 4 during the above time frame revealed: *CNA D had allowed the resident to wash her perineal area (area between the thighs) two times. *Each time the resident cleansed herself she had wiped the perineal area from the back (bottom area) to the front. Interview on 4/26/16 at 8:30 a.m. with CNA D revealed: *That had been her usual process for assisting	F 441		

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F 441	Continued From page 43 the residents with personal care. *She agreed: -The gloves had been soiled after cleansing the resident's bottom. -The gloves should have been removed and her hands should have been washed prior to touching all of those surfaces. -The above process had created the potential for cross-contamination of bacteria to that resident or her roommate. *She confirmed the resident had: -A history of urinary tract infections (UTI) and currently had one. -Always assisted the staff with cleansing herself. *She had not been aware: -The process the resident used to cleanse herself was incorrect. -That process could have created the potential for a UTI. *She could not remember having been educated on the correct process for providing perineal care. Review of resident 4's medical record from 1/1/16 through 4/27/16 revealed she had been treated for a UTI every month during that time frame. Interview on 4/26/16 at 1:55 p.m. with registered nurse (RN) B revealed: *She agreed: -The above processes had not been completed in a sanitary manner. -Resident 4 had cleansed her perineal incorrectly and should have been educated on the correct process. 6. Observation on 4/26/16 from 9:25 a.m. through 9:40 a.m. with CNA K with resident 5 revealed: *She had: -Prepared to transfer him into his bed and provide	F 441		

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F 441	Continued From page 44 personal care. -Missed two opportunities to remove her gloves, wash her hands, and put on clean gloves. -Not changed her gloves or washed her hands until all of her tasks had been completed. Interview at that time with the CNA K revealed she should have changed her gloves and washed her hands a minimum of two times during the above process. Surveyor 26180 7. Observation on 4/26/16 at 8:00 a.m. with CNAs E and F with resident 9 revealed: *They were assisting him in washing up prior to getting him for breakfast. *With gloved hands they washed his face, hands, legs and arms. *They stated he had a bowel movement so they were going to wash his bottom. *After washing him they changed their gloves. -They did not wash their hands before putting the new gloves on. *They continued to finish getting him dressed, used a hoyer lift, and transferred him into his wheelchair. *When they were completely finished, they removed their gloves and then washed their hands. Interview on 4/26/16 at 8:15 a.m. with CNA E revealed they should have washed their hands after they cleaned him up from his bowel movement. They had not done that. Surveyor 32355 8. Observation on 4/26/16 at 11:25 a.m. with CNA K with resident 7 revealed: *CNA K had prepared to assist the resident to the	F 441		

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F 441	Continued From page 45 bathroom and collect a urine sample. *The staff had suspected the resident had a UTI and had been instructed to collect some urine for testing. *CNA K had: -Placed a clean specimen collection container underneath the toilet seat. -Assisted the resident to pull down her pants and sit down on the toilet. -Not cleansed the resident's perineal area prior to assisting her onto the toilet to collect a urine sample. Interview on 4/26/16 at 1:57 p.m. with RN B revealed: *She agreed: -The above process had not been completed in a clean or sanitary manner. -Resident 7 should have had her perineal area cleansed prior to collecting a urine sample. -There was potential for that urine sample to have been contaminated resulting in inaccurate test results. 9. Observation on 4/26/16 from 11:35 a.m. through 11:45 a.m. of RN B with resident 21 revealed: *She had prepared and assisted the resident with a nebulizer treatment (medication administered in the form of a mist). *After the resident had completed his nebulizer treatment she had removed the apparatus without the use of gloves. *With her ungloved hands she had: -Turned on the water faucet without the use of a barrier. -Rinsed out the medication chamber with water and placed it on the counter of the sink. -Cleansed the nebulizer mask with soap and	F 441		

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F 441	Continued From page 46 water. -Turned the water faucet off without the use of a barrier. -Placed the apparatus on a barrier on top of the resident's night stand. *She had washed her hands and turned the water faucet off with a clean paper towel. Observation on 4/26/16 from 11:50 a.m. through 11:58 a.m. of RN B with resident 22 revealed: *She had prepared and assisted the resident with a nebulizer treatment. *After the resident had completed his nebulizer treatment she had cleansed the apparatus using the same process as observed above. Interview on 4/26/16 at 2:00 p.m. with RN B regarding the nebulizer treatments revealed: *That had been her usual process to cleanse the apparatus after the residents had completed their nebulizer treatment. *She had not recognized the water faucet handles and the counters of the sinks as unclean surfaces. *She agreed that: -Had not been a best practice to cleanse the nebulizer apparatuses using that process. -Process had created the potential for cross-contamination of bacteria to the residents. Interview on 4/27/16 at 9:20 a.m. with the director of nursing (DON) and minimum data set (MDS) assessment coordinator revealed: *They agreed: -The above observations and processes had not been performed in a sanitary manner. -Those processes had created the potential for cross-contamination of bacteria from one resident to another.	F 441		

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F 441	Continued From page 47 *They had not: -Been aware resident 4 was assisting the staff with her perineal care. -Educated resident 4 on the proper process for cleansing her perineal area. *They confirmed resident 4 had a history of UTIs and struggled to have them completely resolved. *They had no documentation to support the staff had been observed during: -Medication administration. -Residents' personal care. -Collecting a urine specimen. Review of the provider's 6/9/15 Administering Medications policy revealed "Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable." Review of the provider's 6/4/15 Perineal Care of the Female Resident policy and procedure revealed: *"Wash from front to back (top to bottom)." *"Continue to clean entire perineal area working from the center toward the outside and from front to back changing wipe as needed." Review of the provider's 6/4/15 Specimen Collection policy and procedure revealed the staff were directed to cleanse the perineal area prior to collecting a urine specimen. Review of the provider's undated Face Masks, T-Piece, or Mouth Piece, for Nebulizer Treatments policy revealed no indication for when the staff should have used gloves during the cleansing process of the apparatus.	F 441		

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F 441	Continued From page 48 Review of the provider's undated Gloves policy revealed: *"Gloves are used to prevent contamination of healthcare personnel hands when: -Anticipating direct contact with blood of bloody fluids, mucous membranes, on intact skin and other potentially infectious material. -Handling or touching visibly or potentially contaminated patient care equipment and environmental surfaces." *"During patient care, transmission of infectious organizsms can be reduced by adhering to the principles of working from clean to dirty and confining or limiting contamination to surfaces that are directly needed for patient care." *"It may be necessary to change gloves during the care of a single patient to prevent cross contamination of body sites." Review of the provider's undated Handwashing procedure revealed no direction for when the staff should have washed or sanitized their hands.	F 441		

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

ORIGINAL

PRINTED: 05/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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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 4/27/16. Dells Nursing and Rehab Inc. was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 4/27/16 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000	K000 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain at least two conforming exits from each floor level of the building. The basement had only one conforming exit. Findings include:	K 032	K032	F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: May 19, 2016

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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MAY 23 2016
SD DOH L&C

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DELLS NURSING AND REHAB CENTER INC	**1400 THRESHER DR** **DELL RAPIDS, SD 57022**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 032	Continued From page 1 1. Observation at 11:00 a.m. on 4/27/16 revealed the basement had only one conforming exit directly to the exterior of the building. The second egress routes were through hazardous areas (the boiler and laundry rooms) to an area well equipped with a fixed ladder. Review of previous survey data confirmed that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. This deficiency would not affect any of the residents and minimal staff within the facility.	K 032		

ORIGINAL

FORM APPROVED

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	10613		04/27/2016

NAME OF PROVIDER OR SUPPLIER: DELLS NURSING AND REHAB CENTER INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 1400 THRESHER DR, DELL RAPIDS, SD 57022

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S 000	Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 4/25/16 through 4/27/16. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirement(s): S122 and S355.	S 000	S000 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
S 122	44:73:02:02 Pets No pet kept in or visiting a facility may negatively affect the well-being of a resident. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to maintain documentation of vaccinations for two of two pets who frequently visited the facility. Findings include: 1. Observation on 4/26/16 at 8:30 a.m. in the resident lounge revealed a small dog standing by the medication cart with licensed practical nurse (LPN) C. Interview with LPN C at that time revealed: *The dog belonged to her. *She frequently brought it to work with her, because the residents enjoyed having it around. 2. Observation on 4/26/16 at 11:00 a.m. at the nurses station revealed a small black dog being carried in to visit a resident. Interview at that time with the administrator revealed: *That dog belonged to resident 24. *The resident's daughter brought it to visit her several times per week.	S 122	S122 Vaccination records for two observed pets have been obtained and put on file at the facility. Facility will obtain vaccination records for all other pets who make frequent visits to the facility. Education was given by the Administrator to the Activity Director on 5/17/16 of the facility Pet Policy. Activity Director or designee will perform audits once per week for four weeks and monthly for two more months to ensure vaccinations records are on record for any pets making frequent visits to the facility. Activity Director or designee will present findings from these audits at the monthly QAPI meetings for review.	6/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: ADMINISTRATOR (X6) DATE: 6/9/2016

STATE FORM 6899 R6FT11 If continuation sheet 1 of 3

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S 122	Continued From page 1 *The provider normally kept files of vaccination records for frequent pet visitors. *He was unable to locate vaccination records for either identified pet. Review of the provider's July 2015 Pet Policy revealed all visiting dogs would have proof of vaccinations.	S 122		
S 355	44:73:10:04 Provision of Social Services A facility shall provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee shall be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility shall have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26180 Based on interview, and policy review, the provider failed to have a social worker (SW) or a written agreement with a qualified SW to provide quarterly consultation. Findings include: 1. Interview on 4/26/16 at 3:00 p.m. with the administrator revealed: *They currently did not have a social worker employed. -That position had been unfilled for about one month. *The administrator and the director of nurses were responsible for social services until that position was filled.	S 355	S355 Facility has formed a contract with a consultant social worker to provide quarterly consultation until a facility-hired representative has been obtained. Education was given by Administrator to All Staff on 5/19/16 regarding current status of Facility Social Worker. Administrator or designee will perform audits once per week for four weeks and monthly for two more months, or until SSD or Social Worker is hired, to ensure proper social work job responsibilities, such Social History Questionnaires, BIMS, and MDS's are complete. Administrator or designee will present findings from these audits at the monthly QAPI meetings for review.	6/15/16

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S 355	Continued From page 2 *They did not have an agreement with a licensed SW to do quarterly consultation. Review of the provider's January 2011 social service policy revealed it did not address how social services werehandled when they did not have a qualified SW on staff.	S 355		