

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

**ORIGINAL**

PRINTED: 08/30/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KADOKA NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543</b>
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F 000	<p><i>hg/sddotiel</i></p> <p><i>*Core plans for all residents will be reviewed and revised to include initiation and discontinuation dates.</i></p> <p>Surveyor: 32335</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/15/16 through 8/17/16. Kadoka Nursing Home was found not in compliance with the following requirement(s): F280, F281, F314, F323, F325, F371, F425, and F520.</p>	F 000	<p><i>*Addendums noted with an asterisk per 9/29/16 per telephone with facility DON and ADON. hg/sddotiel</i></p>	
F 280 SS=F	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on record review, observation, interview,</p>	F 280	<p>F280: Care Plans for residents 2, 3, 4, 5, 6, 7, and 8 have been reprinted with initiation dates &amp; reviewed by care plan team. A mandatory in-service was conducted on 9/7/16 and 9/8/16 to include: all staff nurses can change, update, and revise the care plan with initiation and discontinuation dates with stated "initiation" or "discontinuation." Staff nurses will highlight discontinued care plan focus, goal, or intervention with writing "discontinue," the date, and initials when it is no longer in need on the care plan. Care Plan policy was reviewed and revised on 9/6/16.</p> <p>Pressure ulcer prevention, to include tools and measures, will be added to care plan for resident 2, 4, and 6 then on all residents with initiation date and reviewed weekly by DON/Care Plan Team for all residents that are at risk for</p>	<i>10/6/16</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kent Dean</i>	TITLE <i>CEO/ADMINISTRATOR</i>	(X8) DATE <i>9/9/16</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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**SEP 12 2016**

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F 280	<p>Continued From page 1 and policy review, the provider failed to revise and include dates of when new interventions were started for seven of nine sampled residents (2, 3, 4, 5, 6, 7, 8). Findings included:</p> <p>1. Review of the care plan for resident 2 revealed: *Initial dates had been omitted on the entire care plan. *There were handwritten dates under the goal areas but they had not specified if they were initial dates, revision dates or target dates. *"Healed" was handwritten under the skin breakdown intervention, but it did not have a date and had not been initialed. *Aquaphor a cream to prevent skin breakdown had been added to the medication administration record on 7/27/16 but had not been added to the care plan. *The resident had a stage two pressure ulcer added to the careplan on 7/13/16, but since had been resolved and was not indicated on the care plan. *The care plan stated the resident had his own teeth, but the resident had dentures. *The care plan stated the resident had the bed in low position at night, but resident, roommate and random staff stated that was not done. *The care plan stated fasting blood sugars but blood sugars had been done at 4:00 p.m.</p> <p>2. Review of the care plan for resident 5 revealed the initial dates and revision dates had been omitted on the entire care plan.</p> <p>3. Review of the care plan for resident 7 revealed: *The target dates for all goals had been 8/2/16 and had not been updated. *A Code Alert, safety device for wandering residents, was indicated on her care plan, but she</p>	F 280	<p>F280 Continued: skin breakdown. Pressure Ulcer prevention policy will be reviewed and revised by 9/9/16. Wandering risk scale/flowsheet on Point Click Care to be filled out on resident 7 and 8 then on all residents, and upon new admits, 72 hours after admit, and one month later for new residents. Any residents that flag for wandering will have a code alert bracelet on and added to care plan with date of initiation, location of code alert, and expiration date and will be re-assessed at quarterly care plan. Policy for Code Alert Bracelets will be reviewed and revised by 9/9/16. Weights will be done in the am before breakfast for accurate weights. Night nurse will print out report from Point Click Care for comparable weights and provide the daily weight slip with previous weight, staff will reweigh any resident that has a weight gain/loss &gt;3lbs in one day or gain/loss &gt;5lbs in one week, and charge nurse will follow-up on weight, assessment, and will report to physician per policy. Weight schedule to be included on care plan. DM reports weight, % gain/loss, BMI during care plan review. Policy on</p>	
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F 280	Continued From page 2 did not have one on.  Interview on 8/17/16 at 10:45 a.m. with the MDS coordinator revealed: *She realized care plans were incomplete. *She had not had any training on Point Click care plans and it was a new program for her. *She encouraged other staff to read and update care plans but usually that was up to her. Surveyor: 32335 4. Review of resident 3's 5/25/16 care plan revealed they had not addressed an unplanned weight loss. Refer to F325, finding 1.  5. Review of resident 6's 7/13/16 care plan revealed they had not implemented new interventions to prevent two pressure ulcers from developing. Refer to F314, finding 1.  6. Review of resident 8's 6/29/16 care plan revealed there was no mention of her elopement or wearing a code alert device. Refer to F323, finding 3. Surveyor: 35237 7. Review of resident 4's medical record revealed: *She currently had an unstageable pressure ulcer on her coccyx. -Nursing completed a treatment to the ulcer every other day, with baths, and as needed. *Her 11/4/15 and 2/3/16 significant change Minimum Data Set (MDS) assessments indicated she: -Did not have pressure ulcers at that time. -Was at risk for developing pressure ulcers. -Did not have skin treatments such as pressure reducing devices, repositioning, or pressure ulcer care. *Her 5/4/15 significant change MDS assessment	F 280	F280 continued: Weight management will be reviewed and revised by 9/9/16. The Care Plan coordinator/DON will review and monitor changes on the Care Plan weekly to ensure appropriate changes are initiated with initiation date and bring changes to care plan meeting weekly for revision of care plan team. The ADON will monitor 5 random care plans weekly x 1 month, then 1 care plan weekly x one month, then 2 random care plans monthly and report to quarterly QI Meeting on a quarterly basis until 100% compliance achieved.		

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F 280	<p>Continued From page 3</p> <p>indicated she:</p> <ul style="list-style-type: none"> <li>-Had a stage 1 or greater pressure ulcer.</li> <li>-Was at risk for developing pressure ulcers.</li> <li>-Had a pressure reducing device for her chair only.</li> <li>-Received pressure ulcer care.</li> </ul> <p>Observations of resident 4 on 8/15/16 at 5:30 p.m., and on 8/16/16 at 7:30 a.m., 8:50 a.m., 12:40 p.m., 2:20 p.m. and 3:45 p.m. revealed she:</p> <ul style="list-style-type: none"> <li>*Utilized a wheelchair for mobility.</li> <li>*Had a cushion in the seat of her wheelchair.</li> <li>*Had a personal tempurpedic memory foam mattress on her bed.</li> <li>*Used a stand-lift to transfer with staff assistance.</li> <li>*Had a bordered foam dressing intact to her coccyx pressure ulcer.</li> <li>*Required staff assistance with activities of daily living.</li> <li>*Sat at an assisted table for meals.</li> </ul> <p>Review of resident 4's undated care plan revealed:</p> <ul style="list-style-type: none"> <li>*An undated focus area of "resident has a potential impairment to skin integrity r/t impaired mobility, increase pain and increased confusion."</li> <li>*An undated handwritten entry "resident now has unstageable pressure ulcer to coccyx originally discovered as stage I (5/2/16) and has progressed."</li> <li>*There were undated typed interventions for her skin integrity.</li> <li>-Those interventions had not included: <ul style="list-style-type: none"> <li>--Pressure reducing surfaces in her wheelchair or bed.</li> <li>--How often repositioning should have been completed.</li> <li>--Nutritional interventions to promote healing.</li> </ul> </li> </ul>	F 280		
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F 280	Continued From page 4  Interview on 8/17/16 at 7:40 a.m. with the director of nursing and the assistant director of nursing regarding resident 4 revealed: *They confirmed her coccyx ulcer had started on 5/2/16 as a stage 1 and had currently declined to an unstageable ulcer. *Her care plan did not: -Indicate when interventions and changes had occurred for her skin and pressure ulcer. -Mention pressure reducing devices or repositioning. -Address nutritional interventions to promote healing.  8. Review of the provider's revised 7/30/13 Comprehensive Care Plans policy revealed: **"1. An interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident." **"4. Care plans are revised as changes in the resident's condition dictates. Review are made thirty (30) days after admision, sixty (60) days after admission, ninety (90) days after admission and at least quarterly thereafter. Care Plans are reviewed upon return from the Hospital, within 14 days."  Review of the provider's revised 7/30/13 Care Plan Goals and Objectives policy revealed they should have been reviewed and/or revised: **"a. When there has been a significant change in the resident's condition. *b. When the resident has been readmitted to the facility from a hospital stay. *c. At least quarterly."	F 280			
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 281 SS=E	<p>Continued From page 5 <b>PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on interview and record review, the provider failed to have a process in place for follow-up on weight fluctuations for two of five sampled residents (1 and 4). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She was admitted on 2/27/15. *Her diagnoses included diverticulosis, thyroid disease, gastro-esophageal reflux disease (GERD), macular degeneration, and depression. *Her current undated care plan had a focus area of "potential nutrition problem (weight loss) R/T poor intake and appetitive, impaired cognitive function and need for assistance with eating." *On 11/4/15 and 5/4/16 her significant change Minimum Data Set (MDS) revealed assessments she had unplanned weight losses that were identified.</p> <p>Review of resident 1's weights and vitals summary sheet from 10/27/15 through 8/16/16 revealed her weights were: *100.4 pounds (lb) on 11/22/15 and 96.8 lb on 11/23/15. -That was 3.6 lb down in one day. *99 lb on 11/26/15, up 2.2 lb in three days. *94 lb on 12/25/15 and 101 lbs on 12/30/15. -Up 7 lb in five days. *105.2 lb on 1/4/16, up another 5.2 lb in five days.</p>	F 281	<p>F281: Weight fluctuation measurements, follow-up, and monitoring to be completed by 9/9/16 on resident 1 and 4, then on all residents. Weights will be done in the am before breakfast for accurate weights. Night nurse will print out report from Point Click Care for comparable weights and provide the daily weight slip with previous weight, staff will reweigh any resident that has a weight gain/loss &gt;3lbs in one day or gain/loss &gt;5lbs in one week, and charge nurse will follow-up on weight, assessment, and will report to physician per policy. Intentional weight gain/loss will be applied to the care plan and monitored by nursing staff and followed up by physician. The DON will monitor all daily and weekly weights on a weekly basis x 1 month, then 3 random days per week x 1 month, then 1 x weekly until 100% compliance is achieved. The DON will report Weight QI to the QI meeting on a quarterly basis. Policy on Weight management was reviewed and revised on 9/6/16.</p> <p><i>→* A mandatory inservice covering weight fluctuations and changes was completed on 9/7/16 and 9/8/16 for all nursing staff. HG/SDDOTTEL</i></p>	<p>10/16/16</p>	

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F 281	<p>Continued From page 6</p> <p>*98 lb on 1/8/16. -Down 7.2 lb in four days.</p> <p>*95 lb on 4/4/16 and 91.8 lb on 4/8/16. -Down 3.2 lb in four days.</p> <p>*94 lb on 4/11/16, up 3.8 lb in three days.</p> <p>*94.4 lb on 5/30/16 and 91 lb on 6/6/16. -That was down 3.4 lb in six days.</p> <p>*93.4 lb on 6/9/16 and 90 lb on 6/13/16. -Down 3.4 lb in four days.</p> <p>*92.4 lb on 7/18/16 and 88.6 lb on 7/23/16. -Down 3.8 lb in five days.</p> <p>*93.2 lb on 7/25/16, up 4.6 lb in two days.</p> <p>*89.4 lb on 7/29/15, down 3.8 lb in two days.</p> <p>*94 lb on 8/2/16, up 4.6 lb in three days.</p> <p>*There were warnings to the right side of thirty-six out of fifty-five recorded weight entries. -Those warnings stated they had been weight changes of 5%, 7.5%, or 10% from comparison weights.</p> <p>Review of resident 1's interdisciplinary progress notes from 10/25/15 through 8/16/16 revealed no: *Mention of the above weight changes. *Follow-up assessments from nursing or dietary to evaluate: -If those weights were accurate. -If the resident had any other signs of weight change such as edema, breathing concerns, or dehydration. *No mention of performing re-weighs to evaluate the accuracy of those weights.</p> <p>2. Review of resident 4's medical record revealed: *She was admitted on 11/11/11. *Her diagnoses included: congestive heart failure, GERD, dementia, constipation, and heart disease. *Her current undated care plan included a focus</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>area of "Resident has a potential nutritional problem (weight loss) R/T history of weight loss, poor intake at times and refusal of nutritional supplements."</p> <p>*On her 5/4/16 significant change MDS assessment she had an unplanned weight loss that was identified.</p> <p>Review of resident 4's weights and vitals summary sheet from 12/15/15 through 8/16/16 revealed her weights were: *103 lb on 1/4/16, and 107.6 lb on her next recorded weight on 1/20/16. -Up 4.6 lb. *109.4 lb on 3/21/16 and 103.8 lb on 3/28/16. -Down 5.6 lb in seven days. *107.6 lb on 4/4/16, up 3.8 lb in seven days. *111.8 lb on 4/11/16, up 4.2 lb in seven days. *There were warnings to the right side of nineteen out of the twenty-six recorded weight entries. -Those warnings stated there had been weight changes of 5%, 7.5%, or 10% from comparison weights.</p> <p>Review of resident 4's interdisciplinary progress notes from 12/15/15 through 8/16/16 revealed no: *Mention of the above weight changes. *Follow-up assessments from nursing or dietary to evaluate: -If those weights were accurate. -If the resident had any other signs of weight change such as edema, breathing concerns, or dehydration. *Mention of performing re-weighs to evaluate the accuracy of those above weights.</p> <p>3. Interview on 8/17/16 at 7:40 a.m. with the director of nursing and the assistant director of nursing regarding the above residents' weights</p>	F 281		

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F 281	<p>Continued From page 8 revealed:</p> <ul style="list-style-type: none"> <li>*The nurses should have used professional judgment to follow-up on abnormal weights for residents.</li> <li>*Night nurses entered the weights in the residents' medical records.</li> <li>-When they were entered the weight they should have reviewed the previous weight.</li> <li>*They would have expected a re-weigh to have been done the next day when a weight was a three or more pound change from a previous one.</li> <li>*They confirmed residents 1 and 4 had weight changes of more than three pounds several times, and there had been no documented:             <ul style="list-style-type: none"> <li>-Follow-up weights the next day.</li> <li>-Nursing assessments of their conditions including edema, breathing, or signs of dehydration.</li> <li>-Evidence that some of those weights might not have been accurate.</li> </ul> </li> <li>*There was no specific policy they followed regarding resident weights.</li> <li>*They did not have specific professional references they would have followed regarding resident weights and weight changes.</li> </ul> <p>Phone interview on 8/17/16 at 8:50 a.m. with the registered dietitian regarding residents' weights revealed:</p> <ul style="list-style-type: none"> <li>*She was aware of weight changes in residents 1 and 4.</li> <li>*Sometimes she asked nursing to re-weigh residents if she felt the weight was not accurate.</li> <li>*She was unsure of their system to follow-up on weight changes.</li> <li>*If a resident had a significant weight change from the previous weight she would have expected a re-weigh and nursing assessment.</li> </ul>	F 281		
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F 281	Continued From page 9 Interview on 8/17/16 at 12:45 p.m. with registered nurse A regarding resident weights revealed: *If their weight was three or more pounds different than the previous weight they should have been re-weighed the next day. *The nurse should have assessed the resident with those weight changes and documented in the medical record.  Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St Louis, MO, p. 496, for weights and assessing the patient's current condition, revealed: **"Height and weight reflect a person's general health status." **"Assessments screen for abnormal weight changes. A patient's weight normally varies daily because of fluid loss or retention. However a downward trend in a frail older adult indicated that there is a serious reduction in nutritional reserves. The nursing history helps to focus on possible causes for a change in weight." **"A weight gain of 5 pounds (2.3 kg) in 1 day indicates fluid-retention problems. A weight loss is considered significant if the patient has lost more than 5% of body weight in a month or 10% in 6 months."	F 281			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314	F314: Pressure ulcer monitoring with dressing changes per orders, staging and sizing weekly, and physician monitoring will be done per policy for resident 4 and 6 and applied to care plan by 9/9/16, then with all other residents that develop pressure ulcers. Weekly skin assessments done on all residents	10/6/16	

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F 314	<p>Continued From page 10 prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to assess and implement interventions for two of four sampled residents (4 and 6) who were identified to have skin issues. Findings include:</p> <p>1. Review of resident 6's skin assessment sheets revealed: *On 4/11/16 it was noted "Skin CDI [clean, dry, and intact] except for little redness et peeling of skin between coccyx." *On 4/18/16 it was noted "Coccyx area still gets small nickel size areas to both inner cheeks of sloughing of skin/peels away [after] bath, but no soreness when asked." *On 4/25/16 it was noted "Wp [whirlpool] bath given. Skin CDI." *On 5/2/16 it was noted "Dry nickel size patches noted to buttocks near coccyx (one on each buttock). Area dry and intact." *On 5/9/16 it was noted "Will continue to monitor for skin breakdown." *On 5/23/16 it was noted "Skin CDI." *On 5/30/16 it was noted "1 x 1 centimeter open wound to R buttock." *On 5/31/16 it was noted "Wound covered with duoderm and measured." *On 6/6/16 it was noted "Stg II continues to R buttock." *On 6/21/16 it was noted "Stg II pressure ulcer remains to R buttock." *On 6/27/16 it was noted "Stg I to L buttock, Stg II to R buttock. Dressing changed."</p>	F 314	<p>F314 Continued: weekly by charge nurse and documented in Point Click Care. Braden Scale assessment done on all new residents on admit, quarterly, significant change, and when an ulcer presents. For a score of 18 or less then initiate pressure ulcer prevention, report to dietary manager and RD, and apply focus, goal, and interventions to the care plan. The DON will stage and size each pressure ulcer on a weekly basis for continuity and report to physician per policy. The ADON will monitor that appropriate staging and sizing is done weekly and the physician addresses at least monthly and with any deterioration per policy on all residents with pressure ulcer until 100% compliance is achieved and reported to QI meeting on a quarterly basis. The wound policy was reviewed and updated on 9/7/16.</p> <p><i>*review weekly skin assessments, HG/SDDOTTEL</i></p> <p><i>*A mandatory inservice covering pressure ulcers and prevention was completed on 9/7/16 and 9/8/16 for all nursing staff. HG/SDDOTTEL</i></p>	
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F 314	<p>Continued From page 11</p> <p>*On 7/4/16 it was noted "Stg II pressure ulcer noted to R buttock et Stg I to left buttock." *On 7/11/16 it was noted "Stg I and II continues to buttock." *On 7/18/16 it was noted "Stg I and II ulcers noted to buttock." *On 7/25/16 it was noted "Stg I and II continues to buttock. Cleaned and dressed per orders. *On 8/1/16 it was noted "Stg I and II continues to buttock. Cleaned and dressed per orders. *There were no skin assessments after 8/1/16.</p> <p>Review of resident 6's medical record revealed: *Her admission date was 1/3/13. *Her diagnoses included: heart disease, osteoarthritis, cardiac pacemaker, incontinence, zoster with other complications, and diverticulitis of large intestine. *She had a history of pressure ulcers to her coccyx. -She had a pressure ulcer to her coccyx from 7/5/13 through 11/5/13 and again starting on 2/24/14. *There had been no documentation the physician had been notified before 5/31/16. *There had been no documentation of a treatment being started prior to 5/31/16.</p> <p>Review of resident 6's 1/13/16 and 7/13/16 Minimum Data Set (MDS) assessments revealed she was at risk for developing pressure ulcers. The interventions had been pressure reducing device in chair, nutrition, and hydration. On the 7/13/16 MDS they had added pressure ulcer care as an intervention. There were no other interventions listed on those MDS assessments. Her brief interview of mental status score was 13 out of 15. A score of 13-15 meant her thinking ability was intact.</p>	F 314		
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F 314	Continued From page 12  Review of resident 6's Braden Scale for Predicting Pressure Sore Risk assessments revealed: *On 10/14/15, 1/13/16, and 4/13/16 she had scores of 23. *A score of 15-18 is at risk, 13-14 is at moderate risk, 10-12 is at high risk, and 9 or below is at very high risk.  Review of resident 6's 7/13/16 care plan revealed: *A focus area that stated "the resident has risk for decline in nutritional status, skin breakdown and UTI's r/t [related to] urinary incontinence (dribbling) and use of incontinence pads and resident has history of skin breakdown and constipation." *Under the goal section there was a handwritten note that stated "Resident currently has stage II pressure ulcer discovered 5/31/16." -It had not indicated the location or mentioned the stage I pressure ulcer mentioned above. *Undated typed interventions included: -"Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. -Educate resident/family/caregivers of causative factors and measures to prevent skin injury. -Encourage intake of 75% or more of foods and fluids offered at mealtimes of a house diet in order to promote healthier skin. -Encourage resident to toilet before and after meals and activities and assist PRN [as needed]. -Monitor and encourage resident to report signs and symptoms of UTI and report to charge nurse/MD [medical doctor]. -Fresh water at bedside. -Liquid fiber supplements PO [orally] TID [three	F 314			

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F 314	<p>Continued From page 13</p> <p>times per day] per dietary recommendations to promote regular bowel movements.</p> <ul style="list-style-type: none"> <li>-Monitor for constipation and encourage resident to report/ask for PRN medications.</li> <li>-Liquid protein supplement 1 oz. daily per dietary recommendations. Started 4/3/13 d/t [due to] skin ulcer.</li> <li>-Monitor dental/oral status. Assist PRN and arrange dental appointments PRN.</li> <li>-Monitor weekly weights and vital signs and report abnormal to charge nurse/MD.</li> <li>-Assist MD in monitoring labs.</li> <li>-Provide incontinence pads and encourage appropriate peri-care and assist PRN if resident allows. Resident prefers privacy.</li> <li>-Whirlpool bath or shower 2 times a week with at least weekly skin assessment by charge nurse. Keep skin clean and dry. Use lotion on dry skin."</li> <li>*Undated handwritten interventions included:             <ul style="list-style-type: none"> <li>- "Wound care per MD orders.</li> <li>- Stage and size weekly."</li> </ul> </li> <li>*There was no mention of:             <ul style="list-style-type: none"> <li>- Pressure reducing surfaces in her wheelchair or bed.</li> <li>- Encouragement of repositioning.</li> <li>- Nutritional interventions since 4/3/13.</li> </ul> </li> </ul> <p>Random observations on 8/16/16 from 8:15 a.m. through 12:10 p.m. and again from 2:15 p.m. through 4:15 p.m. of resident 6 revealed she had been sitting in her recliner in her room. At 9:35 a.m. staff had gone into her room to change the dressing to her pressure ulcer.</p> <p>Surveyor: 36416 Observation of and interview with registered nurse (RN) A on 8/16/16 at 9:35 a.m. during the dressing change of resident 6 confirmed the continued presence of a stage 2 pressure ulcer</p>	F 314		

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F 314	<p>Continued From page 14 on her coccyx.</p> <p>Surveyor: 32335 Review of resident 6's interdisciplinary progress notes from October 2015 through 8/16/16 revealed: *They included: -Certified dietary manager (CDM) notes on 10/15/15, 1/14/16, 4/14/16, 6/8/16, and 7/14/16. -A Registered dietitian (RD) note on 1/20/16 and 6/16/16. -There were no further RD notes or assessments. *There was no mention of what interventions had been implemented besides the 1 oz. of liquid protein started in 2013 to prevent the pressure ulcer from developing or worsening.</p> <p>Review of resident 6's social services notes revealed on 7/20/16 staff had discussed with the resident about staff providing peri-care.</p> <p>Interview on 8/17/16 at 7:40 a.m. with the director of nursing and the assistant director of nursing regarding resident 6 revealed: *They agreed the 4/11/16 documentation revealed the beginning of a pressure ulcer. *Weekly assessments should have been started at that time. *They expected weekly assessments to have been completed by the nurse on duty that day. *The physician should have been notified and treatment started. *Her care plan had not: -Indicated when interventions and changes had occurred for her skin and pressure ulcer. -Mentioned pressure reducing devices or repositioning. -Addressed nutritional interventions to promote healing.</p>	F 314			

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F 314	<p>Continued From page 15</p> <p>*The RD visited monthly.</p> <p>-Her notes or assessments should have been documented on any resident she had reviewed.</p> <p>-Residents with pressure ulcers should have been assessed monthly by the RD.</p> <p>*They had not followed their pressure ulcer policy.</p> <p>Phone interview on 8/17/16 at 8:50 a.m. with the RD regarding resident 6 revealed she:</p> <p>*Was aware she had a pressure ulcer.</p> <p>*Had charted on her in June.</p> <p>*Responded "I don't know I guess. The CDM may be giving her additional protein. I don't have it written down." when asked what interventions were in place.</p> <p>Surveyor: 35237</p> <p>2. Review of resident 4's medical record revealed:</p> <p>*She was admitted on 11/11/11.</p> <p>*Her diagnoses included: heart disease, congestive heart failure, anemia, hypertension, osteoporosis, and dementia.</p> <p>*Her BIMS score was 3, which indicated severe cognitive impairment.</p> <p>*She currently had an unstageable pressure ulcer on her coccyx.</p> <p>-Nursing completed a treatment to the ulcer every other day, with baths, and as needed.</p> <p>*She had Braden scale assessments done on 11/4/15, 2/3/16, and 5/4/16.</p> <p>-Her scores were 19, 19, and 17.</p> <p>-A score of 19 was considered not at risk of skin breakdown.</p> <p>-A score of 15 to 18 indicated she was at risk for skin breakdown.</p> <p>*Her 11/4/15 quarterly and 2/3/16 significant change Minimum Data Set (MDS) assessments indicated she:</p>	F 314		

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F 314	<p>Continued From page 16</p> <ul style="list-style-type: none"> <li>-Did not have pressure ulcers at that time.</li> <li>-Was at risk for developing pressure ulcers.</li> <li>-Did not have skin treatments such as pressure reducing devices, repositioning, or pressure ulcer care.</li> <li>*Her 5/4/16 significant change MDS assessment indicated she: <ul style="list-style-type: none"> <li>-Had a stage 1 or greater pressure ulcer.</li> <li>-Was at risk for developing pressure ulcers.</li> <li>-Had a pressure reducing device for her chair only.</li> <li>-Received pressure ulcer care.</li> </ul> </li> </ul> <p>Observations of resident 4 on 8/15/16 at 5:30 p.m., and on 8/16/16 at 7:30 a.m., 8:50 a.m., 12:40 p.m., 2:20 p.m. and 3:45 p.m. revealed she:</p> <ul style="list-style-type: none"> <li>*Utilized a wheelchair for mobility.</li> <li>*Had a cushion in the seat of her wheelchair.</li> <li>*Had a personal tempurpedic memory foam mattress on her bed.</li> <li>*Used a stand-lift to transfer with staff assistance.</li> <li>*Had a 8/16/16 dated bordered foam dressing intact to her coccyx pressure ulcer.</li> <li>-Surveyor was unable to observe coccyx pressure ulcer due to the scheduling of dressing changes.</li> <li>*Required staff assistance with activities of daily living.</li> <li>*Sat at a table for those requiring assistance with meals.</li> </ul> <p>Observation and interview on 8/16/16 at 8:50 a.m. with CNA H during resident 4's personal care revealed:</p> <ul style="list-style-type: none"> <li>*The nurses took care of the dressing on the resident's coccyx pressure ulcer.</li> <li>*If the dressing was loose or had come off they told the nurse.</li> <li>*The resident had a pressure reducing cushion</li> </ul>	F 314			

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F 314	<p>Continued From page 17</p> <p>on her wheelchair and her own mattress on her bed.</p> <p>*She used a stand-lift to transfer her to the bathroom and back to her wheelchair.</p> <p>*The resident required assistance with the transfers, toileting, and personal hygiene.</p> <p>Review of resident 4's wound care measurement and assessment forms for her coccyx pressure ulcer revealed:</p> <p>*On 5/2/16 it had started as a stage 1.</p> <p>*On 6/15/16 it was a stage 2.</p> <p>*On 6/27/16 it was a stage 3.</p> <p>*On 7/13/16 it was unstageable.</p> <p>*Weekly assessments had not been completed for the first month after the pressure ulcer had developed on 5/2/16.</p> <p>Review of resident 4's undated care plan revealed:</p> <p>*A undated focus area of "resident has a potential impairment to skin integrity r/t impaired mobility, increase pain and increased confusion."</p> <p>*An undated handwritten entry "resident now has unstageable pressure ulcer to coccyx originally discovered as stage I (5/2/16) and has progressed."</p> <p>*Goals were:</p> <p>- "The resident will maintain clean and intact skin through 8/16."</p> <p>- "Pressure ulcer will begin to heal and be free of infection through 8/16."</p> <p>*Undated typed interventions included:</p> <p>- "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short.</p> <p>- Educate resident/family/caregivers of causative factors and measures to prevent skin injury.</p> <p>- Encourage good nutrition and hydration in order</p>	F 314			

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F 314	<p>Continued From page 18 to promote healthier skin.</p> <ul style="list-style-type: none"> <li>-Identify/document potential causative factors and eliminate/resolve where possible.</li> <li>-Use a draw sheet or soaker pad to move resident.</li> <li>-Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.</li> <li>-Whirlpool bath once weekly with skin assessment by charge nurse at least weekly. Keep skin clean and dry. Use lotion on dry skin."</li> <li>*Undated handwritten interventions included:             <ul style="list-style-type: none"> <li>-"Wound care per orders.</li> <li>-Stage and size weekly.</li> <li>-Stage 1 to coccyx. Wound care per protocol/orders 5/4/16."</li> </ul> </li> <li>*An undated focus area of "Resident has a potential nutritional problem (weight loss) R/T history of weight loss, poor intake at times and refusal of nutritional supplements."</li> <li>-There was no mention of interventions specific to her pressure ulcer.</li> <li>*There was no mention of:             <ul style="list-style-type: none"> <li>-Pressure reducing surfaces in her wheelchair or bed.</li> <li>-How often repositioning should have been completed.</li> <li>-Nutritional interventions to promote healing.</li> </ul> </li> </ul> <p>Review of resident 4's interdisciplinary progress notes from October 2015 through 8/16/16 revealed:</p> <ul style="list-style-type: none"> <li>*They included:             <ul style="list-style-type: none"> <li>-Certified dietary manager (CDM) notes on 11/5/15, 2/4/16, 5/5/16, and 8/4/16.</li> <li>-A registered dietitian (RD) note on 10/28/15.</li> <li>-There were no further RD notes or assessments.</li> </ul> </li> <li>*There was no mention of:             <ul style="list-style-type: none"> <li>-The stage 1 pressure ulcer starting on 5/2/16.</li> </ul> </li> </ul>	F 314		
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F 314	<p>Continued From page 19</p> <ul style="list-style-type: none"> <li>-The pressure ulcer by the CDM on 5/5/16 or 8/4/16.</li> <li>-The coccyx pressure ulcer until 6/24/16.</li> <li>-What interventions had been implemented to prevent the pressure ulcer from developing or worsening from a stage 1 to an unstageable ulcer.</li> </ul> <p>Interview on 8/16/16 at 3:00 p.m. with the CDM regarding the nutritional assessments by the RD revealed:</p> <ul style="list-style-type: none"> <li>*She usually called the RD any time a resident had a new pressure ulcer or weight loss to get recommendations from her.</li> <li>*They talked about the residents with skin issues during the RD's monthly visits.</li> <li>*She thought the RD documented her assessments in the interdisciplinary progress notes for each resident she reviewed.</li> <li>*She confirmed assessments should have been completed more frequently on residents with pressure ulcers.</li> </ul> <p>Interview on 8/17/16 at 7:40 a.m. with the director of nursing and the assistant director of nursing regarding pressure ulcers and resident 4 revealed:</p> <ul style="list-style-type: none"> <li>*They confirmed her coccyx ulcer had started on 5/2/16 as a stage 1 and had currently deteriorated to an unstageable ulcer.</li> <li>*There were no weekly assessments completed from 5/2/16 until 6/3/16 for that ulcer.</li> <li>*They expected weekly assessments to have been completed by the nurse on duty that day.</li> <li>*Her care plan had not:               <ul style="list-style-type: none"> <li>-Indicated when interventions and changes had occurred for her skin and pressure ulcer.</li> <li>-Mentioned pressure reducing devices or repositioning.</li> </ul> </li> </ul>	F 314		
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F 314	<p>Continued From page 20</p> <ul style="list-style-type: none"> <li>-Addressed nutritional interventions to promote healing.</li> <li>*The RD visited monthly.</li> <li>-Her notes or assessments should have been documented on any resident she had reviewed.</li> <li>-Residents with pressure ulcers should have been assessed monthly by the RD.</li> <li>-They confirmed resident 4 had not been assessed by the RD since she had developed the pressure ulcer in May 2016.</li> <li>*They confirmed there were interventions they had utilized that were not documented and should have been. Those included:               <ul style="list-style-type: none"> <li>-The pressure reducing mattress on her bed and cushion in her wheelchair.</li> <li>-Repositioning every two hours.</li> <li>-Her sitting at an assisted table in the dining room.</li> </ul> </li> <li>*They had not followed their pressure ulcer policy.</li> </ul> <p>Phone interview on 8/17/16 at 8:50 a.m. with the RD regarding resident 4 revealed she:</p> <ul style="list-style-type: none"> <li>*Was not aware she had a pressure ulcer.</li> <li>*Had not assessed the resident since 4/27/16.</li> <li>*Tried to complete assessments quarterly on some residents.</li> <li>*Was usually called by the CDM with any new pressure ulcers.</li> <li>*Discussed weight changes and pressure ulcers during her monthly visits.</li> <li>*Confirmed she had not completed assessments monthly on resident 4.</li> <li>*Agreed residents with pressure ulcers should have been assessed and had nutritional interventions implemented to promote healing.</li> </ul> <p>Interview on 8/17/16 at 12:45 p.m. with registered nurse A regarding resident 4 revealed:</p> <ul style="list-style-type: none"> <li>*She was unsure why the weekly wound</li> </ul>	F 314			

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F 314	<p>Continued From page 21</p> <p>assessments had not been completed from 5/2/16 to 6/3/16 by the nurses.</p> <p>*All pressure ulcers should have been assessed, staged, and sized weekly by the nurse on duty that day.</p> <p>*The assessments were scheduled weekly on the resident's medication administration record.</p> <p>*Interventions had been implemented for the resident and included:</p> <ul style="list-style-type: none"> <li>-Pressure reducing mattress and cushion in her wheelchair.</li> <li>-Repositioning every two hours.</li> <li>-Physician order changes for the pressure ulcer treatment.</li> </ul> <p>3. Review of the provider's 9/27/06 Prevention of Pressure Ulcer policy revealed "A record of any reddened area, rash, or breaks in the skin should be:</p> <ul style="list-style-type: none"> <li>*a. reported to the Charge Nurse.</li> <li>*b. initiate care of the area.</li> <li>*c. DOCUMENT size, depth, drainage, etc, and care given in Inderdisciplinary Care Notes (Nurse Notes).</li> <li>*d. UPDATE CARE PLAN of resident to reflect current treatment." <p>Review of the provider's revised 6/23/16 Pressure Ulcer Protocol policy revealed:</p> <p>*The objective was "To monitor and treat pressure ulcers. To provide aggressive intervention. To provide prevention of pressure ulcers."</p> <p>**3. Treatment plan as followed:</p> <ul style="list-style-type: none"> <li>-a. Initiate repositioning every 1-2 hours depending on the sight of the ulcer. Reposition residents with pressure ulcers every 15 minutes when in wheelchair or geri-chair."</li> <li>-b. Place a pressure relieving air/foam layered</li> </ul> </li></ul>	F 314			

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F 314	<p>Continued From page 22 mattress to the resident's bed (or a mattress of equal use). -c. Protecting the ulcer: --i. Buttock/coccyx ulcers: place a pressure relieving pad to wheelchair or geri-chair if immobile. Use pillows or wedges to keep ulcer free of pressure when in bed to increase blood circulation and promote healing." **4. Consult with MD/PAC for special treatment plan." **5. Report pressure ulcer to DM/RD for initiation of nutritional supplement and calculation of calorie, protein, Vitamin C and fluid requirements." **7. Monitor the healing process at least 1 time per month. An RN is to assess, stage, and size ulcer weekly. If the ulcer healing process is noted to deteriorate at any time, refer back to step 3 and follow the steps again. If progression of healing is noted after 1 month, continue treatment plan and consult the MD/PAC monthly for status updates."</p> <p>Review of the provider's undated Skin Assessment policy revealed interventions and prevention of skin breakdown included: **"Turn immobile resident at least every 2 hours." **"Reposition seated residents every 2 hours unless they can perform pressure-relief exercises/movements themselves at least every 15 minutes." **"Clean and dry skin after each incontinent episode." **"Wheelchairs are equipped with the appropriate cushion."</p> <p>Review of the provider's 9/20/06 Nutritional Assessments policy revealed "Monthly charting is done on those residents who show a 5% or</p>	F 314			

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F 314	Continued From page 23 greater monthly weight loss, >7% quarterly weight loss or >10% semi-annual weight loss. Those residents who have pressure ulcers or on any residents that the FSS [food service supervisor] requests."  Review of the provider's undated Identifying Residents at Risk for Nutritional Problems policy revealed: *Residents at risk included pressure ulcers. **4. The Dietary Manager will contact the RD consultant by phone when a resident presents with a pressure ulcer, dehydration, or significant weight loss diagnosis. The RD will evaluate the information and provide nutrition advice to the Dietary Manager for the resident(s) in question." ***5. On the next visit the RD consultant will document the nutritional needs and plan of care to meet those needs for the resident in question plus any other residents she has determined to be at nutritional risk."	F 314		
F 323 SS=D	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: 36413 Based on observation, interview, care plan review, and record review, the provider failed to	F 323	F323 Wandering risk assessments will be done on Point Click Care for residents 7 and 8 by 9/9/16 then on all residents in the facility; assessment on any new admits, 72 hours after admit, 1 month after admit, then on a quarterly basis, significant change, and annually for any residents that score >9 on the assessment tool. At any time a score is >9, code alert bracelet will be cleaned, tested, applied with documentation of name, location of bracelet, initiation date, expiration date to flowsheet in	10/6/16

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F 323	<p>Continued From page 24</p> <p>monitor and document use of the code alert system safety device for residents identified at risk of wandering or elopement for two of three sampled residents (7 and 8). Findings include:</p> <p>1. Observation on 8/17/16 at 1:10 p.m. revealed: *An alarm was going off at the nurses station. *Therapy staff C turned off the alarm without looking at the monitor. *Activity staff B was standing at the nurses station talking to a resident.</p> <p>Interview on 8/17/16 at 1:15 p.m. with therapy activities staff C revealed when asked why the alarm was sounding he stated: *It was probably an employee who had gone out the back door. *Whoever it was would be "long gone by the time I got there."</p> <p>Interview on 8/17/16 at 1:20 p.m. with activities staff B revealed: *She was not allowed to shut off the alarm. *It was not her job to find out who went out the door. *It was the certified nursing assistants job to find out who went out the doors and they were usually too busy to check.</p> <p>2. Review of resident 7's July 2016 care plan revealed: *Handwritten entry stated "Code alert to alert staff of resident going OOF (out of facility)."</p> <p>Observation and interview on 8/17/16 at 11:10 a.m. with registered nurse (RN) A revealed: *The resident did not have a code alert on. *RN A stated she was supposed to have one on, and it probably had been taken off when she was</p>	F 323	<p>Continue F323</p> <p>the code alert box, and applied to care plan. Maintenance will check the code alert monitoring system on each door weekly per policy and nurses will check alarm bracelets <del>policy to</del> <sup>*daily</sup> ensure all bracelets are working properly and within expiration date. <i>WG/SDDOHEL</i></p> <p>The DON/ADON will monitor the weekly testing of bracelets and the location of each resident's code alert bracelet to ensure the same location that is documented and on the care plan weekly x 1 month then monthly until 100% compliance is achieved and report to QI meeting on a quarterly basis. The policies on Code Alerts and elopement were reviewed and updated on 9/7/16.</p> <p>→ *A mandatory In service covering the code alert system was completed on 9/7/16 for all nursing staff. On 9/22/16 the training was provided to all staff. <i>WG/SDDOHEL</i></p>	
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F 323	<p>Continued From page 25 hospitalized in June. *RNA put a code alert device on the resident.</p> <p>Review of resident 7's medical record revealed there was no mention of a code alert in the nurse's notes or physician orders.</p> <p>Interview on 8/17/16 at 2:30 p.m. with RNA revealed she could not find any mention of a code alert device in resident 7's chart.</p> <p>Surveyor: 32335 3. Review of resident 8's social services notes from 6/16/16 through 8/10/16 revealed: *On 8/4/16 the licensed social worker had written: -"She used to volunteer at this facility so is used to coming and going. -As a result, she has attempted to leave so now wears a code alert device."</p> <p>Review of resident 8's 6/29/16 care plan revealed there was no mention of her elopement or wearing a code alert device.</p> <p>Review of resident 8's medical record revealed there had been no documentation of her elopement or of her wearing a code alert device.</p> <p>Interview on 8/17/16 at 1:25 p.m. with the director of nursing revealed staff should have documented in the nursing notes regarding her exiting the facility. Staff should have documented on the care plan the initiation of the code alert device. They did not have a process in place to test the devices.</p> <p>4. Interview on 8/17/16 at 3:30 p.m. with the assistant director of nursing revealed they did not</p>	F 323		
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F 323	Continued From page 26 have a list of who had code alert devices. She created one after the survey team had requested it.	F 323			
F 325 SS=E	A policy had been requested but the provider did not have a policy on the code alert system according to the assistant director of nursing. <b>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b>  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to address and implement interventions for three of five sampled residents (1, 3, and 4) with significant weight changes. Findings include:  1. Review of resident 3's 5/25/16 Minimum Data Set (MDS) assessment revealed she had an unplanned weight loss since her prior MDS assessment on 2/24/16. Her weight was 174 pounds (lb) on that date.	F 325	F325: Assessment for residents 1, 3, and 4 have been assessed for unplanned weight loss, diagnosis, and interventions have been added to each care plan with initiation dates. Assessments have been discussed at team care on Wed 9/7/16 with communication with DM and nursing. Resident 1 receives 2 – 4oz nutritional supplements per day at meal time and 2 – 4oz nutritional supplements at afternoon and night snack, is assisted by staff during meal times for food/fluid intake, and will be weighed on a weekly basis. Resident 3 is using a plate guard and built up silverware to assist in eating independently. Staff encourage food/fluid intake during meal time with current intake of 80-90%. Resident 1 will be weighed on a weekly basis. Resident 4 receives 4oz nutritional supplement 3 times daily during meal times and 1oz protein supplement daily, staff encourage/assist resident during	10/6/16	

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F 325	<p>Continued From page 27</p> <p>Observations on 8/15/16 from 5:10 p.m. through 5:45 p.m. and again on 8/16/16 from 11:50 a.m. through 12:40 p.m. of resident 3 revealed she had difficulty lifting the spoon to her mouth. She had spilled several times onto the clothing protector. She had not received assistance from staff.</p> <p>Review of resident 3's 5/25/16 care plan revealed they had not addressed the unplanned weight loss. The care plan had a focus area for a weight gain. There were no dates when that focus area had been initiated.</p> <p>Review of resident 3's 6/8/16 quarterly care plan evaluation note revealed "she is still able to feed herself, but needs encouragement."</p> <p>Review of resident 3's interdisciplinary notes revealed a registered dietician (RD) note on 5/18/16 stated she was down 9 lb or 5% for the quarter. She had not made any recommendations at that time. There was no other documentation from the RD. The certified dietary manager (CDM) had written a note on 5/27/16 and stated she needed more encouragement to eat and drink.</p> <p>Review of resident 3's nutritional assessments revealed they had been completed by the CDM.</p> <p>Surveyor: 35237</p> <p>2. Review of resident 1's medical record revealed: *She was admitted on 2/27/15. *Her diagnoses included diverticulosis, thyroid disease, gastro-esophageal reflux disease</p>	F 325	<p>meal times for food/fluid intake, and weekly weights for monitoring. All residents will be assessed for Weight fluctuation, follow-up, and monitoring for unplanned weight loss/gain. Weights will be done in the am before breakfast for accurate weights. Night nurse will print out report from Point Click Care for comparable weights and provide the daily weight slip with previous weight, staff will reweigh any resident that has a weight gain/loss &gt;3lbs in one day or gain/loss &gt;5lbs in one week, and charge nurse will follow-up on weight, assessment, and will report to physician per policy. Intentional weight gain/loss will be applied to the care plan and monitored by nursing staff and followed up by physician. The DON will monitor all residents for unplanned weight loss weekly x 1 month, then 2 times per month x 3 months, then monthly until 100% compliance is achieved. The DON will report unplanned weight loss QI to the QI meeting on a quarterly basis. Policy on Weight management was reviewed and revised on 9/6/16.</p>		

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F 325	<p>Continued From page 28</p> <p>(GERD), macular degeneration, and depression. *Her weights from November 2015 through August 2016 ranged from 88 pounds to 105 pounds. *On her 11/4/15 and 5/4/16 significant change Minimum Data Set (MDS) assessments she had unplanned weight losses that were identified. *Her nutritional assessment form had been completed by the CDM on 11/5/15, 2/4/16, 5/5/16, and 8/4/16. *Her interdisciplinary progress notes included: -CDM notes on 11/5/15, 2/4/16, 5/5/16, and 8/4/16. -RD notes on 11/24/15 and 4/27/16. *Those RD notes or assessments had not been completed monthly or following her 5/4/16 MDS.</p> <p>Refer to F281, finding 1.</p> <p>Review of resident 1's interdisciplinary progress notes from 10/25/15 through 8/16/16 revealed no: *Mention of her weight fluctuations other than the CDM and RD notes above. *Follow-up assessments from nursing or dietary to evaluate: -If the weights were accurate. -If the resident had any other signs of weight change such as edema, breathing concerns, or dehydration. *Mention of: -Performing re-weighs to evaluate the accuracy of her weights. -Adding or changing nutritional interventions related to her weight loss.</p> <p>Review of resident 1's current undated care plan revealed: *A focus area of "potential nutrition problem (weight loss) R/T poor intake and appetite,</p>	F 325			

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F 325	<p>Continued From page 29</p> <p>impaired cognitive function and need for assistance with eating."</p> <p>*Undated interventions that included:</p> <ul style="list-style-type: none"> <li>-Invite the resident to activities that promote additional intake.</li> <li>-Monitor/record/report to MD as needed any signs or symptoms of malnutrition.</li> <li>-Provide and serve supplements as ordered.</li> <li>-Nutritional drink 8 ounces twice daily.</li> <li>-Afternoon and bedtime snacks.</li> <li>-Provide and serve diet as ordered.</li> <li>-Monitor intake and record every meal.</li> <li>-Resident needs assistance eating from staff.</li> </ul> <p>*There was no date to indicate when those above interventions had been implemented or revised.</p> <p>*A 5/18/16 quarterly care plan evaluation note by the MDS coordinator related to the 5/4/16 MDS stated "She is assisted by staff with eating and consumed 70% food and 57% fluid at meals of a house diet. BMI is 16 and weight is 89 lbs. She is down 6% in 1 month, 12% in 3 months and 8% in 6 months. She only drank 10% of her nutritional drinks she takes 2 times a day. Family tried to give us some ideas at care plans about foods she usually likes to try to get her to get more calories. Family has decided to stop taking her to eye appointments as it causes her more stress and confusion. Continue current care plan."</p> <p>-There was no mention of changes in her nutritional interventions related to her weight loss.</p> <p>3. Review of resident 4's medical record revealed:</p> <ul style="list-style-type: none"> <li>*She was admitted on 11/11/11.</li> <li>*Her diagnoses included: congestive heart failure, GERD, dementia, constipation, and heart disease.</li> <li>*Her weights from November 2015 through August 2016 ranged from 103 to 120 pounds.</li> </ul>	F 325		
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F 325	<p>Continued From page 30</p> <p>*On her 5/4/16 significant change MDS assessment she had an unplanned weight loss that was identified.</p> <p>*Her nutritional assessment form had been completed by the CDM on 11/5/15, 2/4/16, 5/5/16, and 8/4/16.</p> <p>*Her interdisciplinary progress notes included: -CDM notes on 11/5/15, 2/4/16, 5/5/16, and 8/4/16. -RD note on 10/28/15.</p> <p>*Those RD notes or assessments had not been completed monthly or following the 5/4/16 MDS.</p> <p>Refer to F281, finding 2.</p> <p>Review of resident 4's interdisciplinary progress notes from 12/15/15 through 8/16/16 revealed no: *Mention of the her weight changes other than the CDM and RD notes above. *Follow-up assessments from nursing or dietary to evaluate: -If the weights were accurate. -If the resident had any other signs of weight change such as edema, breathing concerns, or dehydration. *Mention of: -Performing re-weighs to evaluate the accuracy of her weights. -Adding or changing nutritional interventions related to her weight loss.</p> <p>Review of resident 4's current undated care plan revealed: *A focus areas of "Resident has a potential nutritional problem (weight loss) R/T history of weight loss, poor intake at times and refusal of nutritional supplements." *Undated interventions had included: -Invite the resident to activities that promote</p>	F 325			

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F 325	<p>Continued From page 32</p> <p>been done the next day when a weight was a three or more pound change from a previous one. *They confirmed residents 1 and 4 had weight changes of more than three pounds several times, and there had been no documented: -Follow-up weights the next day. -Nursing assessments of their conditions including edema, breathing, or signs of dehydration. -Evidence some of those weights might not have been accurate. *There was no specific policy they followed. *They did not have specific professional references they would have followed. *Residents at significant nutritional risk including weight losses or gains should have: -Been assessed monthly by the RD. -Had interventions implemented or changed to address the weight changes. *They confirmed there was no consistent follow-up or assessments by the RD for residents 1 or 4's weight changes.</p> <p>Phone interview on 8/17/16 at 8:50 a.m. with the RD regarding residents' weights revealed: *She was aware of weight changes in residents 1 and 4. *Sometimes she asked nursing to re-weigh residents if she felt the weight was not accurate. *She was unsure of their system to follow-up on weight changes. *If a resident had a significant weight change from the previous weight she would have expected a re-weigh and nursing assessment. *She: -Should have followed-up on any significant weight changes. -Should have completed an assessment and made recommendations for nutritional</p>	F 325			

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F 325	<p>Continued From page 33</p> <p>interventions for those residents during her monthly visits.</p> <p>-Had not assessed resident 4 since 4/27/16.</p> <p>-Thought she had assessed resident 1 in July 2016 but was unsure why there was no documentation.</p> <p>-Was usually called by the CDM with any weight changes or new pressure ulcers.</p> <p>-Discussed weight changes and pressure ulcers during her monthly visits.</p> <p>-Confirmed she had not completed monthly assessments on residents identified at significant risk or with unplanned weight losses or gains.</p> <p>Interview on 8/17/16 at 12:45 p.m. with registered nurse A regarding residents' weights revealed:</p> <p>*If their weight was three or more pounds different than the previous weight they should have been re-weighed the next day.</p> <p>*The nurse should have assessed the resident with those weight changes and documented that in their medical record.</p> <p>Review of the provider's Nutritional Drink list provided by the CDM on 8/16/16 revealed:</p> <p>*Resident 1 should have received 4 ounces of Berry Resource supplement twice a day.</p> <p>*Residents 3 and 4 were not listed to receive anything.</p> <p>Review of the provider's revised 9/20/06 Nutritional Assessments policy revealed:</p> <p>***The re-assessments are done by the RD. These are reviewed quarterly and the goals re-evaluated."</p> <p>***Monthly charting is done on those residents who show a 5% or greater monthly weight loss, &gt;7% quarterly weight loss or &gt;10% semi-annual weight loss. Those residents who have pressure ulcers</p>	F 325			

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F 325	Continued From page 34 or on any residents that the FSS [food service supervisor] requests."  Review of the provider's undated Identifying Residents at Risk for Nutritional Problems policy revealed: *Residents at risk included: -Significant weight loss. -Pressure ulcers. -Consistently poor food/fluid intake. **"4. The Dietary Manager will contact the RD consultant by phone when a resident presents with a pressure ulcer, dehydration, or significant weight loss diagnosis. The RD will evaluate the information and provide nutrition advice to the Dietary Manager for the resident(s) in question." **"5. On the next visit the RD consultant will document the nutritional needs and plan of care to meet those needs for the resident in question plus any other residents she has determined to be at nutritional risk." *There was no mention of: -RD assessments being done monthly. -What the expectation for follow-up of weights would have been.	F 325		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 35  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, testing, manufacturer's instructions review, and policy review, the provider failed to maintain a rinse temperature (temp) of 180 degrees Fahrenheit (F) for one of one dishwasher in the kitchen. Findings include:  1. Observation, interview, and testing of the dishwasher on 8/16/16 at 7:40 a.m. with the certified dietary manager (CDM) in the dishroom of the kitchen revealed: *They used a dishwasher with hot temp sanitization for all dishes. *The wash temp should have been over 150 degrees F, and the rinse temp should have been over 180 degrees F. *She ran the dishwasher three times to get the water up to the correct temperature. -The first time the wash temp was 154 degrees F and the rinse temp was 94 degrees F. -The second time the rinse temp was 138 degrees F. -The third time the rinse temp was 185 degrees F. *She stated: -It had not run that morning yet. -Sometimes they had to run it more than once to get it to the proper temp.  Review of the manufacturer's instruction label on the front of the dishwasher for hot temperature sanitization revealed: *The minimum wash temp should have been 150 degrees F. *The minimum rinse temp should have been 180	F 371	F-371 Temperatures of the dishwasher have been meeting Health standards. The Hobart maintenance checked the dishwasher for temperature on 8/18/16 and calibrated the temperatures. Training was completed with Dietary Staff on 8/18/16 to ensure all staff are aware of the process of taking the dishwasher temperature. Another reinforcement training was held on 8/31/16 with all staff on taking of dishwasher temperatures. CDM will monitor the temperature chart one time a week for one month, then one time a month until 100% compliance. All new hired Dietary Staff will be trained upon hire and start of employment in Dietary Department.  <i>*report to QI on a quarterly basis. HG/SDOHHEL</i>	10/6/16

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F 371	<p>Continued From page 36 degrees F.</p> <p>Interview with the CDM following the above observation and review of the provider's June, July, and August 2016 daily dishwasher temperature log sheet in the dish room revealed: *The rinse temp was below 180 degrees F for: -Nineteen days in June. -Twenty days in July, with seven days of no rinse temp recorded. -Twelve days in August so far, with two days of no rinse temp recorded. *Of those days with less than 180 degrees F rinse temps there were temps ranging from 146 to 164 degrees F. *She confirmed: -There were several days when the temp did not reach 180 degrees F. -The dishes would not have been sanitized properly if the temp was below 180 degrees F. -She had not reviewed the log recently and had not been aware the temps were recorded below 180 degrees F.</p> <p>Interview on 8/16/16 at 11:45 a.m. with cook D in the dishroom regarding the dishwasher revealed: *He thought the wash temp should have been 180 degrees F, and the rinse temp should have been 150 degrees F. *Staff should have re-run the dishwasher if the temp did not get up to 180 degrees F. *He confirmed the dishes would not have been sanitized properly if the dishwasher did not meet the recommended 180 degrees F.</p> <p>Interview on 8/17/16 at 7:40 a.m. with the director of nursing and the assistant director of nursing confirmed when the dishwasher had not met the 180 degree rinse temp then the dishes would not</p>	F 371		
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F 371	Continued From page 37 have been sanitized properly.	F 371		
F 425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, and policy review, the provider failed to ensure medications were properly secured including narcotics, creams, and prescription medications in one of</p>	F 425	<p>F425 Prescription Silvadene cream for resident 6 is locked in a locked cupboard in the nurses' station and all prescription creams are locked in a locked cupboard in the nurses' station. The Hydrocodone/Apap med card, that has not been discontinued, was placed in the double locked med cart on 8/17/16 and is being counted at shift change along with all other narcotics. The medication Fludrocortisone was locked in the black cabinet until returned to pharmacy. The DON will monitor that all medications are securely locked per policy 3 random times per week x 3 months, then 1 random time weekly until 100% compliance achieved. The DON will report to Qi meetings on a quarterly basis.</p>	10/6/16

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F 425	<p>Continued From page 38</p> <p>one nursing station and for one of one randomly selected resident (6). Findings include:</p> <p>1. Observation and interview on 8/16/16 at 11:00 a.m. with registered nurse (RN) A regarding resident 6 revealed: *Her prescription 6 silvadene cream had been stored in the resident's unlocked closet. *RNA stated it was routinely kept there with her dressing change items in a basket.</p> <p>2. Observation on 8/17/16 at 2:00 p.m. of the nurses station revealed: *Their medication storage consisted of free standing cabinets in the nurses station. -That area did not have a door and was attached to hallways where the public and residents were frequently going by. -The nurses station was used by all staff. *A medication card with thirty tablets of the narcotic. -Hydrocodone/Apap had been stored in a cabinet with other stock medications and not with other accounted for narcotics. -That narcotic had arrived on 8/12/16 and had not been accounted for. -The narcotic record sheet was attached to medication. *A medication card with fluidrocortisone acetate had been stored on an open shelf at the nurses station.</p> <p>Interview on 8/17/16 at 2:10 p.m. with RN A revealed: *She agreed the above mentioned narcotic should have not been in that cabinet, and it should have been counted at change of shift twice daily. *She agreed no medications should have been</p>	F 425		

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F 425	<p>Continued From page 39 kept on an open shelf at the nurses station.</p> <p>Interview on 8/17/16 at 3:45 p.m. with the director of nursing revealed: *She had known that narcotic had been delivered, and the resident did not need it. *Medications were usually not checked in by a nurse at the time of delivery, so that medication had not been refused by staff on 8/12/15. *She agreed it should have been stored with other narcotics and accounted for at every change of shift until the pharmacist came for the destruction of it. *She agreed no medications should have been kept on an open shelf in the nurses station. *The provider did not have any professional standard references that were used narcotic storage.</p> <p>Review of the provider's undated Medication policy revealed resident's medication must be properly stored in a locked cabinet at the nurses' station.</p> <p>Review of the provider's reviewed 6/2/14 Recording and Accounting for Narcotics policy revealed: *Place record sheet in the medication notebook. *Reconcile number with the record sheet daily.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis. Mo., 2005, p. 839, revealed nurses must make sure that all medications are in locked containers in a room or are in constant surveillance.</p>	F 425		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		

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F 520	Continued From page 40  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to have an effective quality assurance (QA) program in place to identify concerns, develop action plans, and implement appropriate interventions to improve performance measures for their facility. Findings include:  1. Review of the provider's 8/2/16 quality improvement minutes revealed infection rates, fall	F 520	F520 The QI process will include pressure ulcers and weight issues and will be reported and ongoing to quarterly QI. A communication flowsheet will be available to staff for ideas of potential/noted issues for the members of the QI team to address. Members of the QI team will seek potential/actual issues and bring to the QI meeting on a quarterly basis. The COO will monitor that a QI process is in effect for pressure ulcers and weight issues monthly and report to the QI meeting on a quarterly basis until 100% compliance is achieved.	10/6/16	

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F 520	<p>Continued From page 41 rates, and other incidents had been addressed. No action plan or interventions had been documented for those issues.</p> <p>Interview on 8/17/16 at 2:00 p.m. with the chief operating officer revealed they had not identified quality measures addressing pressure ulcers or weight issues. The process they used included using the last survey and addressing the issues identified in that report.</p> <p>Review of the provider's undated Quality Improvement policy revealed procedures, methods, and systems were to be used to detect trends, patterns of performance, and potential problems. Necessary action was to be taken to ensure improvement or resolution occurred.</p>	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/16/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KADOKA NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543</b>	
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K 000	INITIAL COMMENTS  Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/16/16. Kadoka Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at K011, K069, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 9/29/16 per telephone with facility administrator. LF/SDDOCH/EL	
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure proper separation was provided between the nursing home and clinic business occupancy at one of one location (cross-corridor doors). Findings include:  1. Observation at 11:15 a.m. on 8/16/16 revealed a set of cross-corridor doors separating the nursing home from the clinic business	K 011	K-011 The doors separating the Nursing Home from the Clinic will be replaced with a 1 1/2 hour fire resistant door with self-closing hardware. This will be replaced by North Central Supply Service. The operation of the door will be monitored weekly for 3 months then monthly till in 100% compliance by the COO.  *This report will be monitored and brought to the quarterly QI for review until 100% compliance. LF/SDDOCH/EL	10/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Director/Administrator* (X6) DATE: *9/9/16*

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

**RECEIVED**  
**SEP 12 2016**  
SERBOW L&C

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

PRINTED: 08/30/2016  
FORM APPROVED  
OMB NO. 0938-0391

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K 011	Continued From page 1 occupancy. The wood doors were provided with door closers and a magnetic hold open that released the door upon activation of the fire alarm. The doors were not labeled indicating they met any United Laboratories (U.L.) listed ninety minute fire rating. The door hardware did not indicate if it was U.L. listed fire rated hardware. Testing of those doors at the time of observation revealed proper latching was not provided. Those doors were able to be pushed open without the use of any unlatching operation. Those doors had the potential to open during a fire situation due to air pressures fluctuations created by fire combustion.  Interview with the maintenance supervisor at the time of the observation revealed he was unaware that door and door hardware did not meet fire barrier opening protection requirements.	K 011		
K 069 SS=B	This deficiency has the potential to affect one of two smoke compartments. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the commercial kitchen hood was maintained. The exhaust fan for the hood venting was not functioning properly. Findings include:  1. Document review at 9:10 a.m. on 8/16/16 revealed a commercial kitchen hood inspection report provided by Shaw Fire and Safety LLC dated 3/15/16. That report indicated the exhaust	K 069		

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K 069	Continued From page 2 fan on the hood ventilation system should have been turned up or moved.  Interview with dietary staff at 10:50 a.m. on 8/16/16 in the kitchen revealed they did not believe any work was done on the exhaust fan. Observation of the exhaust system at the time of the above interview did not reveal any issues with the ventilation system. Testing of the exhaust system was not conducted as proper testing equipment was not available to conduct air velocity testing. Interview with the administrator at 1:00 p.m. during the exit interview confirmed that condition. She indicated she was unaware Shaw Fire and Safety LLC had indicated the exhaust fan was not functioning properly. Interview with the maintenance supervisor at the same time indicated Shaw Fire and Safety LLC might have determined the existing exhaust system was not capable of being turned up and had not provided any information on how to correct the issue.  This deficiency has the potential to affect one of two smoke compartments.	K 069	K-069 The inspection report of the kitchen hook exhaust will be reviewed by the COO and maintenance person after receiving the report. This will be documented and brought to the Quarterly QI meeting by the COO. The kitchen hood exhaust fan will be replaced with a larger fan and will be tested for air velocity. This will be done by the maintenance person and recorded. This information will be brought to quarterly QI meeting for review and discussion until the team feel we are in compliance.	10/6/16
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure the electrical system was maintained in the basement. Electrical equipment was not properly protected and extension cords not properly secured. Findings	K 144		

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K 144	<p>Continued From page 3 include:</p> <p>1. Observation at 10:45 a.m. on 8/16/16 in the non-resident use basement revealed a dehumidifier running. Interview with the maintenance supervisor at the time of the observation revealed the basement frequently flooded due to groundwater. Due to the wet environment created in the basement electrical equipment should have been protected from electrical short circuit. Ground fault circuit interrupter (GFCI) outlets should have been provided for any electrical appliances capable of being submerged in groundwater or subjected to high moisture environment. Testing of the outlet the electrical appliance was plugged into revealed that outlet was not provided with any GFCI.</p> <p>2. Observation also at the above time revealed multiple extension cords improperly secured to the fire sprinkler system piping. Those cords were used to supply temporary power to submersible water pumps needed to remove water during heavy rains. Permanent wiring should have been provided for those submersible pumps. Those pumps were also observed in the previous survey on 9/30/15. It was indicated those pumps were only temporary. Extensions cords shall only be permitted for temporary use and removed when no longer used.</p> <p>Interview with the maintenance supervisor confirmed those conditions. He indicated he was not aware of the requirements for those outlets to be GFCI protected. He indicated he was not aware extensions cords were only permitted for temporary use.</p> <p>This deficiency has the potential to affect two of</p>	K 144	<p>K-144</p> <p>The electrical outlets in the basement will be replaced with GFCI outlets. These will be used for all electrical equipment used in the basement. Extension cords will only be used for temporary needs and will be put away when not in use.</p> <p>No extension cords will be secured to the fire sprinkler system for use. If used, extension cords will be attached to the wall with hooks and removed when done with use of extension cords. The basement will be monitored by the COO on a weekly basis and information brought to the Quarterly QI meeting until 100% compliance.</p>	10/6/16

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K 144	Continued From page 4 two smoke compartments.	K 144			

South Dakota Department of Health

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S 000

**Compliance/Noncompliance Statement**

Surveyor: 32334  
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/15/16 through 8/17/16. Kadoka Nursing Home was found not in compliance with the following requirements: S153, S300, and S301.

S 000

*\*Addendums noted with an asterisk per 9/29/16 per telephone with facility DON and ADON.  
KLG/SDDOTTJEL*

S 153

**44:73:02:11 Plumbing**

Facility plumbing systems shall be designed and installed in accordance with SDCL 36-25-15 and 36-25-15.1. Plumbing shall be sized, installed, and maintained to carry required quantities of water to required locations throughout the facility.

This Administrative Rule of South Dakota is not met as evidenced by:  
Surveyor: 32334  
Based on observation and interview, the provider failed to ensure plumbing fixtures were maintained in one randomly observed location. The hand held hose in the shower stall of the tub room was not provided with a vacuum breaker. Findings include:

1. Observation at 12:15 p.m. on 8/16/16 in the tub room revealed a hand held hose in the shower stall of that room. The hose was not provided with a vacuum breaker. That hose had the potential of back siphon of contaminated water into the potable water system. Review of previous survey documentation revealed that condition was also present when last surveyed.

Interview with the administrator at 12:45 p.m. on 8/16/16 during the exit interview confirmed that condition. She indicated she was not sure why that potential point of water contamination had

S 153

S-153  
Maintenance will monitor all plumbing fixtures, to ensure that all water is not contaminated. A vacuum breaker was installed in the hand held shower to prevent contamination of water. This was installed on 8/18/16 and will be monitored on a monthly basis by maintenance. The COO will monitor one time a month and report information to Quarterly QI meeting until 100% compliance.

*10/16/16*

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

*[Signature]*

TITLE

*[Signature]*

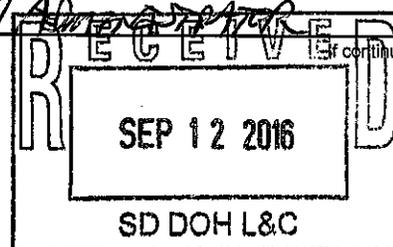
(X6) DATE

*9/9/16*

STATE FORM

6899

SU5W11



If continuation sheet 1 of 10

South Dakota Department of Health

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S 153	Continued From page 1 not yet been corrected.	S 153	S-300 Resident #1 will receive 2-4 oz. nutritional drink a day at meal times started 11/4/15, and 2-4 oz. nutritional drink at P.M. and HS snack daily.	
S 300	<p>44:73:07:15 Nutritional Assessments</p> <p>A registered dietitian shall ensure a nutritional assessment is completed on each new resident upon admission; any resident having a significant change in diet, eating ability, or nutritional status; monthly for any resident receiving tube feedings; and on any resident with a disease or condition that puts the resident at significant nutritional risk. A monthly tube feeding assessment shall include nutritional adequacy of calories, protein, and fluids. An annual assessment shall be completed for each resident.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32335</p> <p>Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to ensure monthly nutritional assessments had been completed by the registered dietitian (RD) for four of five sampled residents (1, 3, 4, and 6) who were identified at significant nutritional risk. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *Her current undated care plan had a focus area of "potential nutrition problem (weight loss) R/T poor intake and appetitive, impaired cognitive function and need for assistance with eating." *Her weights from November 2015 through August 2016 ranged from 88 pounds to 105 pounds.</p>	S 300	<p>Resident #1 is seated at the feeder table and is assisted at all meals. Dietary manager will monitor wt. and nutritional needs. Resident #4 will receive 4 oz. nutritional drink 3 times a day at meal time started on 8/24/16 and 1 oz. liquid protein started 8/31/16. Resident #4 is seated at the feeder table and receives encouragement and assistance at all meals. Dietary Manager will monitor wt. and nutritional needs.</p> <p>Resident #3 is using a built up spoon and fork and a plate guard and is encouraged at all meals. She is consuming 80-90% of food at meals times. Dietary Manager will monitor resident's intake and ability to get food to mouth. ]</p> <p>Resident with wt. loss, nutritional needs and pressure ulcers will be monitored, assessed and charted on by the RD on a monthly basis. A flow sheet has been established and will be used by RD to inform Dietary Manager, DON and COO of residents that she has charted on at Each visit.</p> <p>*The RD completed a nutritional assessment for Res 6 and added on 8oz nutritional supplement. hg/sddo/H/L</p>	

South Dakota Department of Health

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S 300	<p>Continued From page 2</p> <p>*On her 11/4/15 and 5/4/16 significant change Minimum Data Set (MDS) assessments she had unplanned weight losses that were identified. *Her nutritional assessment form had been completed by the certified dietary manager (CDM) on 11/5/15, 2/4/16, 5/5/16, and 8/4/16. *Her interdisciplinary progress notes included: -CDM notes on 11/5/15, 2/4/16, 5/5/16, and 8/4/16. -RD notes on 11/24/15 and 4/27/16. *Those RD notes or assessments had not been completed monthly.</p> <p>2. Review of resident 4's medical record revealed: *Her current undated care plan included focus areas for: -"Resident now has unstageable pressure ulcer to coccyx originally discovered as stage I (5/2/16) and has progressed." -"Resident has a potential nutritional problem (weight loss) R/T history of weight loss, poor intake at times and refusal of nutritional supplements." *Her weights from November 2015 through August 2016 ranged from 103 to 120 pounds. *On her 5/4/16 significant change MDS assessment she had an unplanned weight loss that was identified. *Her nutritional assessment form had been completed by the CDM on 11/5/15, 2/4/16, 5/5/16, and 8/4/16. *Her interdisciplinary progress notes included: -CDM notes on 11/5/15, 2/4/16, 5/5/16, and 8/4/16. -RD notes 10/28/15. *Those RD notes or assessments had not been completed monthly.</p> <p>Surveyor: 32335</p>	S 300	<p>The Dietary manager will monitor monthly and report to quarterly QI meeting until in 100% compliance.</p>	

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S 300	<p>Continued From page 3</p> <p>3. Review of resident 6's skin assessment sheets revealed:                      *On 4/11/16 it was noted "Skin CDI [clean, dry, and intact] except for little redness et peeling of skin between coccyx."                      *On 4/18/16 it was noted "Coccyx area still gets small nickel size areas to both inner cheeks of sloughing of skin/peels away [after] bath, but no soreness when asked."                      *On 5/30/16 it was noted "1 x 1 centimeter open wound to R buttock."                      *On 6/27/16 it was noted "Stg I to L buttock, Stg II to R buttock."                      *She continued to have both pressure ulcers at the time of the survey.</p> <p>Review of resident 6's interdisciplinary progress notes from October 2015 through 8/16/16 revealed:                      *They included:                      -Certified dietary manager (CDM) notes on 10/15/15, 1/14/16, 4/14/16, 6/8/16, and 7/14/16.                      -RD notes on 1/20/16 and 6/16/16.                      -There were no further RD notes or assessments.                      *There was no mention of what interventions had been implemented besides the 1 oz. of liquid protein started in 2013 to prevent the pressure ulcer from developing or worsening.</p> <p>4. Review of resident 3's 5/25/16 MDS assessment revealed she had an unplanned weight loss since her prior MDS assessment on 2/24/16. Her weight was 174 pounds (lb).</p> <p>Review of resident 3's interdisciplinary notes revealed an RD note on 5/18/16 stated she was down 9 lb or 5% for the quarter. She had not made any recommendations at that time. There was no other documentation from the RD. The CDM had written a note on 5/27/16 and stated</p>	S 300		

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S 300	<p>Continued From page 4</p> <p>she needed more encouragement to eat and drink.</p> <p>Review of resident 3's nutritional assessments revealed they had been completed by the CDM.</p> <p>Surveyor: 35237</p> <p>5. Interview on 8/16/16 at 3:00 p.m. with the CDM regarding the nutritional assessments by the RD revealed:</p> <ul style="list-style-type: none"> <li>*She usually called the RD any time a resident had a new pressure ulcer or weight loss to get recommendations from her.</li> <li>*The RD came monthly for her visits.</li> <li>*They talked about the residents with skin issues and weight changes during her monthly visits.</li> <li>*She thought the RD put her assessments into the interdisciplinary progress notes for each resident she reviewed.</li> <li>*She confirmed assessments should have been completed more frequently on residents at significant nutritional risk.</li> <li>*Residents 1 and 4 did not have RD assessments completed monthly.</li> </ul> <p>Interview on 8/17/16 at 7:40 a.m. with the director of nursing and assistant director of nursing regarding nutritional assessments by the RD revealed:</p> <ul style="list-style-type: none"> <li>*She visited monthly.</li> <li>*Her notes/assessments should have been documented on any resident she had reviewed.</li> <li>*Residents at significant nutritional risk should have been assessed monthly by the RD.</li> <li>*They confirmed residents 1 and 4 had not been assessed monthly by the RD.</li> </ul> <p>Phone interview on 8/17/16 at 8:50 a.m. with the RD regarding nutritional assessments revealed she:</p>	S 300		

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S 300	<p>Continued From page 5</p> <p>*Was not aware resident 4 had a pressure ulcer. *Had not assessed resident 4 since 4/27/16. *Thought she had assessed resident 1 in July but was unsure why there was no documentation. *Tried to complete assessments quarterly on some residents. *Was usually called by the CDM with any weight changes or new pressure ulcers. *Discussed weight changes and pressure ulcers during her monthly visits. *Confirmed she had not completed assessments monthly on residents identified at significant risk.</p> <p>Review of the provider's revised 9/20/06 Nutritional Assessments policy revealed: **"The re-assessments are done by the RD. These are reviewed quarterly and the goals re-evaluated." **"Monthly charting is done on those residents who show a 5% or greater monthly weight loss, &gt;7% quarterly weight loss or &gt;10% semi-annual weight loss. Those residents who have pressure ulcers or on any residents that the FSS [food service supervisor] requests."</p> <p>Review of the provider's undated Identifying Residents at Risk for Nutritional Problems policy revealed: *Residents at risk included: -Significant weight loss. -Pressure ulcers. -Consistently poor food/fluid intake. **4. The Dietary Manager will contact the RD consultant by phone when a resident presents with a pressure ulcer, dehydration, or significant weight loss diagnosis. The RD will evaluate the information and provide nutrition advice to the Dietary Manager for the resident(s) in question." **5. On the next visit the RD consultant will document the nutritional needs and plan of care</p>	S 300		

South Dakota Department of Health

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S 300	Continued From page 6  to meet those needs for the resident in question plus any other residents she has determined to be at nutritional risk." *There was no mention of RD assessments being done monthly.	S 300		
S 301	44:73:07:16 Required Dietary Inservice Training  The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on interview, the provider failed to ensure nine of nine required dietary trainings (food safety, handwashing, food handling and preparation, food-borne illnesses, serving and distribution policies, leftover food handling, time and temperature controls, nutrition and hydration, and sanitation) were completed by all dietary staff. Findings include:  1. Interview on 8/16/16 at 7:35 a.m. with the certified dietary manager regarding dietary staff training revealed she: *Had no records of the above required training having been completed. *Was unsure when the training had been done last. *Was aware staff should have had ongoing training.	S 301	S-301 The RD or CDM will present in-services monthly to cover all of the 9 topics mandated by S-301. All Dietary Staff will be trained in all aspects of Foodservice and safety. New hires will be trained upon hire by the CDM. COO will monitor one time a month and information brought to quarterly QI meeting and will remain in 100% compliance.  → * An inservice training was provided to all dietary staff on 8/29/16 covering the 9 mandatory topics. HG/SDDOHT/EL	10/6/16

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S 301	Continued From page 7  Interview on 8/16/16 at 8:35 a.m. with the chief operating officer confirmed dietary staff training had not been completed since April 2015. They should have provided the ongoing required trainings. There was no policy regarding dietary training.	S 301		
S 000	Compliance/Noncompliance Statement  Surveyor: 35237 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/15/16 through 8/17/16. Kadoka Nursing Home was found not in compliance with the following requirement: S030.	S 000		
S 030	44:74:02:06 Required to Pay Costs of Training/Evaluation  A nursing facility shall pay all costs of nurse aide training and competency evaluation or reimburse the nurse aide for the cost incurred in completing the program if the facility employs the aide within twelve months following completion of the training program. Reimbursement may be made during the first twelve months of employment by installments. A nursing facility is not required to pay the cost of training and competency evaluation of a training program, conducted by an online or non-nursing home based nurse aide training program, if the nurse aide leaves employment or is terminated before completing the facilities probationary period of employment. The nursing facilities probationary period for nurse aides shall be similar to other employees of the nursing home. A nursing facility shall not seek	S 030	<p>→ *The contracts for employees E, F, and G have been removed from their file. HG/SDDO/H/EL</p> <p>S030 The CNA training program curriculum used is the Avera Online Training program and the facility will pay for the training provided. The 1-year contract will be removed from all CNA employee files. The COO will QI that there is no contract in employee files on a monthly basis and report QI on a quarterly basis until 100% compliance is achieved.</p>	10/6/16

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S 030	<p>Continued From page 8</p> <p>restitution for those installments already paid to nurse aide prior to termination. The nurse aide shall not seek payment of training costs if costs have already been paid by another facility where previously employed.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 36413 Based on employee file review and interview, the provider failed to ensure nurse aide training costs were provided for three of three newly hired nurse aide employees (E, F, and G). Findings include:</p> <p>1. Review of employees E, F, and G personnel files revealed they had been hired as nurse aides. Files contained signed employment contracts for certified nurse aide (CNA) education.</p> <p>Review of the employment contract revealed: *The employee agreed to remain employed for at least one year of start date. *If the employee broke the contract, the employee needed to pay back \$1000 to reimburse the moneys spent by the facility during the course. *The employees last paycheck would have been held until the \$1000.00 had been paid. -If payback is not paid within 60 days the last pay check will become void and will no longer be eligible for employment until the full amount is paid back not to include the voided check.</p> <p>Interview on 8/17/16 at 1:00 p.m.. with the assistant director of nursing revealed: *They had problems with nurse aide students not staying after their training had been completed. *They have kept employees last check in the past. *They had all nurse aids that were hired sign this contract.</p>	S 030		

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