

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/13/2016
NAME OF PROVIDER OR SUPPLIER PHILIP NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 503 WEST PINE POST OFFICE BOX 790 PHILIP, SD 57567	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Surveyor: 35237 A revisit health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 9/13/16. Philip Nursing Home was found not in compliance with the following requirements: F167, F248, F314, F368, F371, and F520.	{F 000}	*Addendums noted with an asterisk per 10/7/16 per email with facility administrator. CHKV/SDDO/HJEL	
{F 167} SS=D	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, and plan of correction (POC) review from the 7/13/16 survey, the provider failed to ensure the most recent survey results were readily accessible to the residents. Findings include: 1. Observation on 9/13/16 at 11:00 a.m. revealed: *The survey results had been posted in a binder by the nurses station. *Those survey results had been from 9/16/15 and was not the most recent survey from 7/13/16.	{F 167}	F 167 The 2016 DOH Survey results will be placed in a public area. The administrator or designee will notify residents 1 & 7 that the survey results are available and answer any survey questions they may have. The administrator or designee will verify that the survey results are available monthly for three months. The administrator or designee will educate staff regarding the need/requirement of posting the DOH annual survey results. The administrator or designee will report findings to the Quality Assurance Process Improvement team monthly for three months for review and recommendation. *Monitoring will be conducted weekly for the first month, then monthly for three months. CHKV/SDDO/HJEL	*CHKV/SDDO/HJEL [REDACTED] *CHKV/SDDO/HJEL [REDACTED] CHKV/SDDO/HJEL *10/12/16 *CHKV/SDDO/HJEL [REDACTED]

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

[Signature] CEO 10-3-16

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

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{F 167}	Continued From page 1 Interview on 9/13/16 at 11:50 a.m. with resident 1 revealed: *She was aware survey results were posted by the nurses station and were from 2015 and not from the most recent survey. *She wanted to see the survey results from 2016. *The director of nursing (DON) told her she would bring her a copy and had not done so. Interview on 9/13/16 at 12:00 noon with resident 7 revealed: *She was aware survey results were posted at the nurses station and were from 2015 and not from the most recent survey. *She wanted to see the survey results from 2016 and had not been able to. Interview on 9/13/16 at 5:00 p.m. with the DON confirmed the posted survey results had not been the most recent survey. She could not remember if she had posted the 2016 survey results at the nurses station. She confirmed they had not followed their POC. Review of the provider's POC with a completion date of 8/1/16 from the 7/13/16 survey revealed "The 2015 nursing home survey was copied and placed into the three ring-binder. The survey for 2016 will be placed for public reading in the binder next to the nurses' station. Copies will be given to those residents who are alert and oriented for their personal review."	{F 167}			
{F 248} SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	{F 248}			

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{F 248}	Continued From page 2 the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on interview, record review, policy review, and plan of correction (POC) review from the 7/13/16 survey, the provider failed to complete their POC for activities based on residents' individual needs related to: *Care plans for three of five sampled residents (1, 6, and 7). *A focused activity assessment for one of five sampled residents (4). *Audits for the POC had been completed. Findings include: 1. Review of residents 1, 6, and 7's activity care plans and the 9/1/16 POC for the 7/13/16 survey revealed: *Resident 1's activity care plan had been initiated on 5/6/16 and reviewed on 8/8/16. -It had not been "...updated to reflect receiving RT twice daily, outdoor activities 3-5 times weekly" as indicated in their POC. *Resident 6's activity care plan had been initiated on 8/18/16. -It had not been "...updated to reflect inability to participate in group activities R/T physical decline..." as indicated in their POC. *Resident 7's activity care plan had been initiated on 4/18/16. -It had not been "...updated to reflect activities of her preference, which include going outside 3-5 times weekly and morning activities 3-5 times weekly" as indicated in their POC.	{F 248}	F 248 The administrator or designee will review and update activity care plans for residents 1,3,4,6 & 7. By interviewing these residents the administrator or designee will include individual preference of activities that enhance their daily routine and enjoyment. The administrator or designee will review and update each Philip Health Services resident activity care plan to ensure individual preference of daily activities is included in the care plan. The administrator will meet with the resident council to determine their preference of daily activities and when activities should be scheduled. The administrator or designee will include the recommended activities in the activity schedule. The administrator or designee will educate staff regarding the need/ requirement to schedule and provide activities that meet resident preference. The administrator or designee will review the activity schedule and activities being conducted monthly for three months for compliance with the schedule. The administrator or designee will report audit results to the Quality Assurance Process Improvement team monthly for three months for further recommendation.	*CKV/SDOCH/EL [REDACTED] *CKV/SDOCH/EL [REDACTED] *CKV/SDOCH/EL [REDACTED] *10/12/16 CKV/SDOCH/EL [REDACTED] *CKV/SDOCH/EL [REDACTED]	

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{F 248}	<p>Continued From page 3</p> <p>2. Review of resident 4's medical record and the 9/1/16 POC for the 7/13/16 survey revealed: *The POC had stated "...a focused activity assessment conducted with resident 4 and all residents" would have been completed. *Her last activity assessment had been completed on 1/16/15.</p> <p>3. Review of the August 2016 activity calendar revealed: *On Mondays, Fridays, Saturdays, and Sundays there was only one activity listed at 2:30 p.m. -On Saturday the 13th there was no activity listed. *On Tuesdays, Wednesdays, and Thursdays there were two activities listed at 10:15 a.m. and 2:30 p.m. *Twice there was music on Tuesday at 6:30 p.m. *There were no outdoor activities listed. *There were only three days each week with a morning activity listed.</p> <p>Review of the September 2016 activity calendar revealed: *On Saturdays and Sundays there was only one activity listed at 2:30 p.m. -On Saturday the 10th there was no activity listed. *On Monday through Friday there were two activities listed at 10:15 a.m. and 2:30 p.m. *Twice there was music on Tuesday at 6:30 p.m. *There was one outdoor activity listed on the 12th.</p> <p>Review of the 8/2/16 and 9/6/16 Residents Council Meeting notes revealed: *"Staff asked residents in attendance if they had any ideas for new activities since they have requested more activities during the day. They would like to just be outdoors in general and visit or just enjoy the fresh air. We will individually talk</p>	{F 248}	<p>*resident #4 activity assessment has been completed. All residents activity assessments will be complete by 10/12/16. These will be completed by the designated licensed nurse. Monitoring will be conducted weekly for the first month, and then monthly for three months.</p> <p>CHKV/SDDOK/EL</p>	

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{F 248}	<p>Continued From page 4</p> <p>to those residents who can voice an opinion for any new ideas." *"We have been going outdoors usually 2x weekly, weather permitting. Everyone seems to enjoy the fresh air. We do not have this activity on the calendar it will be a day to day decision." *There was no mention of: -How the residents felt about the current activities schedule, other than the outdoors activity. -If the residents thought activities were better with the changes since the survey.</p> <p>Review of the Quality Improvement Indicator Report sheet for the activities audit revealed: *They should have been monitoring morning and outside activities offered three to five times weekly, monitoring that weekly for four weeks, and then monthly for five months. *There were no dates those audits had been completed since the survey on 7/13/16.</p> <p>4. Interview and record review on 9/13/16 at 10:00 a.m. with activity coordinator D regarding the above findings revealed: *There were no activities scheduled approximately one day a month, because they did not have enough staff to work. *Activities staff were also responsible for nursing duties including the restorative program. *Some days there was only one of them working. *It was hard to get activities done with all the other work they had to do. *They tried to focus on getting the one-to-one activities done with some residents. *She confirmed: -Residents 1, 6, and 7's care plans had not been updated as indicated in the POC. -Resident 5's activity assessment had not been completed as indicated in the POC.</p>	{F 248}		

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{F 248}	<p>Continued From page 5</p> <p>-The POC audits from the 7/13/16 survey had not been completed.</p> <p>Interview on 9/13/16 at 11:45 a.m. with certified nursing assistant N regarding residents' activities revealed:</p> <ul style="list-style-type: none"> *There were two activity staff members. *She thought more outdoor and one-to-one activities had been happening than prior to the 7/13/16 survey. *She was unsure if they had made any other changes to activities. <p>Interview on 9/13/16 at 11:50 a.m. with resident 1 revealed:</p> <ul style="list-style-type: none"> *There were only two activity staff members. *There was still no activity director. *She felt there was no change with the activities offered to the residents since prior to the July 2016 survey. *They had specifically wanted more morning and outdoor activities. -The morning activities were the same as before the survey. -There might have been more outdoor activities than before; she was unsure. <p>Interview on 9/13/16 at 12:00 noon with resident 7 revealed:</p> <ul style="list-style-type: none"> *There usually were no activities on Saturdays. *Activities had not changed much since the July 2016 survey. *She thought the morning church activity that day had been canceled. *She was unsure but thought they had maybe gone outdoors three times since the survey. <p>Interview on 9/13/16 at 12:15 p.m. with licensed practical nurse D regarding resident activities</p>	{F 248}			

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{F 248}	<p>Continued From page 6</p> <p>revealed she:</p> <ul style="list-style-type: none"> *Thought residents' activities seemed about the same to her since she had started working in June 2016. *Was aware they had several church activities available. *Thought they might have had more outdoor activities but was not sure. <p>Record review and interview on 9/13/16 at 10:00 a.m. and again at 5:00 p.m. with the director of nursing regarding resident activity and the POC revealed she confirmed:</p> <ul style="list-style-type: none"> *There were only two activity staff members currently, and they also had other duties to complete. *There were a few days a week where only one activity was scheduled on the calendar. *Activities should have been scheduled and completed based on residents' needs. *They had not updated residents 1, 6, and 7's care plans as indicated in the POC. *They had not completed resident 4's focused activity assessment as indicated in the POC. *The audits had not been completed according to the POC and they should have been. *The Scheduling of Activities policy was the only policy in the activities policy book that had been reviewed since the survey. -That was reviewed in August 2016 by the DON. -The activities coordinator had not reviewed any of the activities policies. *They had not completed their POC as indicated for review of the activities policies. <p>Review of the provider's 9/1/16 POC for the 7/13/16 survey revealed:</p> <ul style="list-style-type: none"> **1. [Provider name] will continue with two activity staff that function both in activities and restorative 	{F 248}			

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{F 248}	Continued From page 7 therapy. Focused assessments will be conducted with residents 1, 3, 4, 6, and 7 and all residents to determine which morning activities they would like to have offered. Outside activities will be offered three times per week depending on weather. Saturday and Sunday activities will be offered once daily." **"QI: Activities coordinator or designee will monitor offered activities once weekly for four weeks, than once monthly for 5 months..." **"7. Activities policy reviewed and updated to reflect the most current program available. Policies and procedures will be reviewed annually by the Activities Coordinator and the DON..."	{F 248}			
{F 314} SS=D	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 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, policy review, and 9/1/16 plan of correction review (POC) from the 7/13/16 survey, the provider failed to follow their POC for one of one sampled resident (3) with a pressure ulcer related to her care plan, repositioning documentation, and staff education. Findings include:	{F 314}			

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{F 314}	<p>Continued From page 8</p> <p>1. Observation on 9/13/16 at 11:45 with resident 3 in her room revealed she: *Was laying on her back in bed with pillows under her right side. *Had an air mattress on her bed.</p> <p>Review of resident 3's medical record revealed: *She had originally been admitted in December 2011. *Her diagnoses included general weakness, poor oral intake, history of a left buttock ulcer, arthritis, osteoporosis, chronic pain, heart disease, dementia, history of a right humerus and left hip fracture, congestive heart failure, and anxiety. *On 11/16/15, 2/16/16, and 5/16/16 her Braden pressure ulcer risk assessment score was 11. That indicated she was a high risk for developing pressure ulcers. *She had a history of a left buttock surgical wound for years and pressure ulcers to her coccyx and left lower leg. *She was on bed rest due to her history of fractures and left buttock wound. *The nurses were currently treating the left buttock wound.</p> <p>Review of resident 3's revised 8/19/16 care plan regarding her skin and pressure ulcers revealed: *She had: -A potential for pressure ulcer development related to her history of them and immobility. -An old surgical wound and various rash areas from bed confinement. -A stage 2 open ulcer on the backside of her lower left leg, redness under her underarms, and abdominal fold skin breakdown. *The goal was for the resident to have intact skin free of redness, blisters, or discoloration by the</p>	{F 314}	<p>F 314 Resident 3's care plan has been reviewed and updated with appropriate skin interventions. Each resident care plan has been reviewed and updated to ensure appropriate interventions are implemented to prevent and/or heal pressure ulcers.</p> <p>DON or designee will monitor 5 residents care plans monthly to include skin interventions if needed and revise PRN. Audit findings will be reported for three months by the DON or designee to the Quality Assurance/Process Improvement team for further recommendations.</p> <p>Resident 3 will be repositioned according to facility policy to ensure appropriate pressure reduction and wound healing. The DON will educate staff regarding appropriate repositioning schedule and the need/requirement to document appropriately.</p> <p>DON or designee will monitor resident 3's Turning and Repositioning schedule and 4 additional residents Turning and Repositioning schedules for appropriate documentation once weekly for four weeks, than once monthly for three months and report findings monthly to the Quality Assurance/Process Improvement Team for further recommendation.</p> <p><i>*Monitoring will be conducted weekly for the first month, then monthly for three months.</i></p>	<p><i>*CHKV/SDDO/H/EL</i></p> <p><i>*CHKV/SDDO/H/EL</i></p> <p><i>*CHKV/SDDO/H/EL</i></p> <p><i>*10/12/16</i></p> <p><i>*CHKV/SDDO/H/EL</i></p>

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{F 314}	<p>Continued From page 9 next review date on 11/16/16. *Interventions had been initiated on 11/16/15 and included the following: -"The resident requires the bed as flat as possible to reduce shear. The resident prefers to be repositioned with at least 2 people and needs repositioned Q 2 hours. Lift used for all transfers. -Administer skin treatments as ordered and monitor for effectiveness. -Administer medications as ordered. Monitor/document side effects and effectiveness. -Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. -Continue with Foley catheter to keep skin free from further excess moisture. Turn and reposition and check and change as necessary for skin integrity. Use TENA products. -Pressure relieving mattress placed on bed. Gel cushion in w/c." *On 2/22/16 there was a handwritten intervention for "See Tx record for pressure & skin tears & surgical wounds." *There was no mention of her air mattress, additional wound healing interventions, or additional nutritional interventions to promote wound healing. *It had not been updated to reposition her every one to two hours and mentioned in their POC with a completion date of 9/1/16. *Her care plan had not been updated as indicated in the provider's POC with a completion date of 9/1/16.</p> <p>2. Observation, interview, and review of the Turn and Reposition sheet for September 2016 on 9/13/16 at 11:50 a.m. with certified nursing</p>	{F 314}			

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{F 314}	<p>Continued From page 10</p> <p>assistant (CNA) N in resident 3's room revealed: *The resident was laying in her bed on her back. *She stated the resident was always in bed and should have been repositioned every two hours by staff. *She worked the day shift and had repositioned the resident around 10:00 a.m. according to the sheet. *She agreed the sheet had a minimal number of staff initials and did not prove repositioning had occurred every two hours. *She thought staff had not documented all the times they had repositioned her, and they should have. *She confirmed on 9/10/16 and 9/11/16 there was no documentation from 12:00 noon through 11:00 p.m. and only three initials from 12:00 midnight through 11:00 a.m. -That indicated repositioning had not occurred every two hours.</p> <p>Interview and record review on 9/13/16 at 12:15 p.m. with licensed practical nurse D regarding resident 3 revealed: *She should have been repositioned at least every two hours due to her risk of pressure ulcers. *Repositioning should have been documented each time it had been done. *She agreed resident 3's September Turn and Reposition sheet had a lack of documentation that repositioning had been completed every two hours.</p> <p>Interview and record review on 9/13/16 at 4:30 p.m. with the director of nursing related to the above findings revealed: *She agreed resident 3's care plan had not been updated according to their POC and should have</p>	{F 314}		

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{F 314}	<p>Continued From page 11 been. *She confirmed resident 3's September 2016 Turn and Repositioning sheet had several missing staff initials and a lack of documentation to prove she had been repositioned every two hours. *Some staff had not completed the education from the 7/13/16 survey and they should have. -CNAs F and G and registered nurse (RN) E had not completed the education. *The audits for the POC had not been completed as indicated. *She confirmed they had not completed their POC as indicated, and that should have been done on or before 9/1/16.</p> <p>3. Review of the provider's revised August 2016 Pressure Ulcers policy revealed: **"Based on assessment findings, interventions will be implemented to reduce and/or prevent the risk of pressure ulcer development." **"7. The residents care plan will be updated to identify if they are at risk for pressure ulcers, interventions and treatment." **"8. Interventions to reduce pressure ulcers will be implemented and may include but not limited to: -Nutrition. -Hydration. -Repositioning. -Support surfaces. -Pressure redistribution. -Resident education." **"c. All interventions put in place will be documented in the patient/resident chart in the nurses notes."</p> <p>Review of the provider's POC audits for monitoring toileting sheets, repositioning sheets,</p>	{F 314}			

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{F 314}	<p>Continued From page 12</p> <p>and bedtime snack documentation revealed: *They had been completed for the weeks of 8/14/16 to 8/20/16 and 8/21/16 to 8/27/16. -Both weeks the repositioning sheets had a 0% completion rate. -There was nothing written in as to what was done related to that 0% completion rate. *The audits should have been completed twice a week for four weeks then monthly. -The 8/28/16 to 9/3/16 and 9/4/16 to 9/10/16 weeks had not been completed.</p> <p>Review of the provider's POC audits for monitoring repositioning and toilet schedules for ten randomly reviewed residents revealed: *They had been completed on 8/19/16, 8/20/16, 8/23/16, and 8/25/16. -In the comments was written "Needs improvement" with resident initials. *The audits had not been completed on 8/30/16, 8/31/16, 9/6/16, and 9/8/16 according to the documentation.</p> <p>Review of the provider's POC audits related to dressing change observations and wound sizing and staging documentation by the RN revealed they had not been completed since 9/2/16. They should have been done weekly for four weeks and then monthly.</p> <p>Review of the provider's 9/1/16 POC from the 7/13/16 survey revealed: *"Resident 3's and all resident MD orders and care plans reviewed. Resident 3's revised to reflect repositioning Q 1-2 hrs and PRN. CNA's F and G and all care staff re-educated to reposition and document accordingly Q 1-2 hrs and PRN. RN E and all nursing staff re-educated to follow dressing change treatments as ordered by</p>	{F 314}			

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{F 314}	Continued From page 13 physician. Air mattress applied to resident 3's bed and dietitian will complete a nutrition assessment." **"DON will educate nursing staff at monthly staff meeting on August 3, 2016 and state directed in-service August 5th." **"1. DON or designee will monitor 10 random residents with repositioning schedules and documentation twice weekly for four weeks, than once weekly for four weeks, than monthly for three months." **"2. DON or designee will observe nursing perform dressing changes to assure that treatments are conducted as ordered twice weekly for four weeks, than once weekly for four weeks, than monthly for three months." **"3. DON or designee will observe size and staging by RN's for all wounds Q week for four weeks, than monthly for 5 months." **"QI: DON or designee will monitor all residents with wound size and staging documentation conducted by RN's only weekly for four weeks, than monthly for five months. Findings will be reported to QA committee by DON or designee quarterly or until corrected."	{F 314}			
{F 368} SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	{F 368}			

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{F 368}	<p>Continued From page 14</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on interview, plan of correction (POC) review from the 7/13/16 survey, and observation, the provider failed to ensure the new snack policy was followed and education was implemented for offering a nutritious supplement to the residents in the evening. Findings include:</p> <p>1. Interview on 9/13/16 at 9:30 a.m. with cook J revealed he was aware the prior survey had a citation for evening snacks served to the residents. He stated "The kitchen staff prepares cookies or bars to hand out at night, but that is all they do."</p> <p>Interview on that same day at 11:35 a.m. with dietary aide L revealed "The certified nurse assistants (CNA) get cookies from the kitchen and then get packaged snacks from the pantry. They (the kitchen staff) didn't help the CNAs pass the snacks."</p> <p>Interview on that same day at 11:40 a.m. with resident 10 revealed he would get snacks, but it was chips, cookies, ice cream, or rice crispy treats. He stated he had not received a snack the past two nights. He was alert and oriented to time, place, and event.</p>	{F 368}	<p>F 368</p> <p>The administrator or designee will ensure resident #10 is offered a HS snack of their choice each evening.</p> <p>The administrator or designee will ensure all Philip Health Services residents are offered a snack each evening. Snacks offered will be suitable to meet residents varied preferences. The administrator or designee will educate staff regarding the need/requirement to offer HS snacks to each resident.</p> <p>The administrator or designee will monitor the HS snack pass weekly for a month and monthly for three months.</p> <p>The administrator or designee will communicate audit results to the Quality Assurance Process Improvement team monthly for three months for further recommendation.</p> <p><i>*All staff were in-serviced on 10/5/16. Any staff not present will be educated by the DON by 10/12/16.</i></p>	<p><i>*CHV/SDDO/H/EL</i></p> <p><i>*CHV/SDDO/H/EL</i></p> <p><i>*CHV/SDDO/H/EL</i></p> <p><i>*10/12/16</i></p> <p><i>CHV/SDDO/H/EL</i></p>

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{F 368}	<p>Continued From page 15</p> <p>Review of the HS (hour of sleep) snack list for 9/11/16 through 9/17/16 revealed resident 10 had been checked as receiving a snack.</p> <p>Continued interview on that same day at 11:42 a.m. in the cafeteria with three unidentified residents revealed:</p> <ul style="list-style-type: none"> *The snacks were really good for a while, and they had a cart with a lot of variety. Now it was back to the same old thing again, cookies. *One resident was diabetic and liked sugar free pudding. She stated she had to continually remind the CNAs to bring her sugar free pudding and not the regular pudding. *Two of the three residents stated they had not been offered or received snacks the last two nights. <p>-All three residents were alert and oriented to time, place, and event.</p> <p>Interview on that same day at 11:30 a.m. with CNA M revealed "I used to work nights about a year ago and there was a cart we took from room-to-room. It had a lot of variety and sandwiches too."</p> <p>Observation on that same day at 12:40 p.m. of the snack tray in the employees refrigerator in the employee break room revealed:</p> <ul style="list-style-type: none"> *Two sandwiches dated "9/11." No indication if that was the made by date or the expiration date. *Four cheese sticks. *Three yogurts. *Two puddings. <p>A plastic tub the size of a coffee can sat on top of the refrigerator and held packaged snacks. Two employees insulated lunch carriers sat on top of the snack tray.</p>	{F 368}		

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{F 368}	<p>Continued From page 16</p> <p>Surveyor: 35237 Interview on 9/13/16 at 11:50 a.m. with resident 1 regarding HS snacks revealed she received string cheese in the evenings now. She stated that was okay with her. She was unsure what else was available as a snack.</p> <p>Interview on 9/13/16 at 11:55 a.m. with resident 7 regarding HS snacks revealed: *The HS snacks were better for a little while. *Now they were back to just being offered cookies again. *She did not feel there was a variety of HS snacks available to them.</p> <p>Review of the provider's August 2016 HS snack policy revealed: **"Evening snacks will be offered to all residents by nursing home staff to supplement their diet." **"Nursing home staff will offer residents various snacks including but not limited to: -Cookies. -Yogurt. -Fresh/canned fruit. -Sandwiches. -Cheese. -Pudding. -Jello. -Crackers/chips." **"Once snacks have been passed staff will document on 'HS Snack' sheet."</p> <p>Review of the provider's 8/5/16 and 8/10/16 staff education related to the 7/13/16 survey revealed the directed in-service included "Snacks must be offered that are varied and nutritious to all residents. Surveyors interviewed eight residents and reviewed snack documentation which</p>	{F 368}		

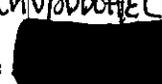
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{F 368}	Continued From page 17 revealed that there was a lack of documentation that snacks had been offered. Nursing staff and CNA staff is able and encouraged to offer snacks from the items delivered by our dietary staff." Review of the provider's POC audits for HS snack distribution and documentation revealed: *It should have been completed three times weekly for four weeks, then once weekly for four weeks, and then monthly for four months. *It had only been completed for 8/18/16, 8/20/16, and 8/21/16. Review of the provider's POC with a completion date of 9/1/16 from the 7/13/16 survey revealed: ***Documentation will be maintained of snacks offered to residents daily. Education will be provided to nursing home and dietary staff during state directed in-service August 5th." **QI: DON or designee will monitor snack record three times weekly for four weeks, than once weekly for weeks, than monthly for 4 months and findings will be reported to QA committee quarterly or until corrected."	{F 368}			
{F 371} SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	{F 371}			

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{F 371}	Continued From page 18 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on interview, plan of correction (POC) review from the 7/13/16 dated survey, and document review, the provider failed to ensure: *Kitchen policies were updated. *Staff education was documented and included a list of topics covered. Findings include: 1. Interview on 9/13/16 at 9:30 a.m. with cook J revealed he had completed temperature and sanitizing solution audits for August. He was now in the process of completing the audits for September. He stated he had been the dietary manager, but had become a cook again in the last month. He stated he had provided education to the other cooks and employees regarding temperatures and sanitizer concentrations. He had not kept track of what he had talked about and would just talk with them at work. He was unsure if the policies were updated, as the new dietary manager was in charge of that part of the plan of correction. Interview on that same day at 2:00 p.m. with the director of nursing (DON) revealed she was not aware the dietary department had not kept track of the education, topics, or who was educated. She was also unaware if the new dietary manager had updated the kitchen policies. Fax transmittal on 9/14/16 at 3:46 p.m. from the DON revealed she could not find the updated kitchen policies.	{F 371}	F 371 The administrator or designee will educate dietary staff regarding Philip Health Services policy to store/prepare/serve food in a safe and sanitary manner. The administrator or designee will document the education provided and the staff members who receive the education. The administrator or designee will have the education attendance records readily available for review upon request. The administrator or designee will monitor meal service to ensure compliance with food safety standards weekly for a month and monthly for 2 months. The administrator or designee will report audit results to the Quality Assurance Process Improvement team monthly for 3 months for further recommendation. <i>*Dietary policies have been updated by the dietary supervisor (DS). All staff have been educated. Any staff not present will be educated by the DS by 10/12/16.</i> <i>CHVISBDOHJEL</i>	<i>*CHVISBDOHJEL</i>  <i>*CHVISBDOHJEL</i>  <i>*CHVISBDOHJEL</i> <i>*10/12/16</i>
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		

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F 520	<p>Continued From page 19 QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on record review, interview, policy review, and review of the plan of correction (POC) from the 7/13/16 survey, the provider failed to ensure an effective quality assurance (QA) program had been completed and had followed their POC to correct quality deficiencies. Findings include:</p> <p>1. Review of the provider's POC revealed: *Monitoring or audits were to have been</p>	F 520	<p>F 520</p> <p>The administrator will review Philip Health Services Quality Assurance/Process Improvement plan to ensure the plan is comprehensive.</p> <p>The administrator or designee will host monthly Quality Assurance/Process Improvement team meetings. The administrator or designee will monitor POC progress, ensuring all audits and monitoring is completed and recommendation for improved care will be provided to the team.</p> <p>The administrator and care team designees will commit to meeting monthly through the year to ensure the Quality Assurance/Process Improvement plan and reporting is implemented and the POC is successful.</p> <p><i>*The administrator or designee will monitor the QAPI process monthly for a quarter and attendance will be monitored. Results will be communicated with the QAPI team monthly for further recommendation. All staff including the QAPI team was educated on 10/5/16 by the administrator to include the QAPI process and its relevance to the POC process. CHV/SDDOH/EL</i></p>	<p><i>*CHV/SDDOH/EL</i></p> <p><i>*10/12/16</i></p> <p><i>CHV/SDDOH/EL</i></p>

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F 520	<p>Continued From page 20</p> <p>completed for each deficiency from the 7/13/16 survey.</p> <p>*Those audits were:</p> <ul style="list-style-type: none"> -Scheduled for specific times for each deficiency. -Assigned to specific personnel, such as the director of nursing (DON), administrator, activities director, or designee. <p>*Findings of those audits were to have been reported to the QA committee until each deficiency was corrected.</p> <p>Interview and record review on 9/13/16 at 4:30 p.m. with the DON regarding the POC revealed:</p> <ul style="list-style-type: none"> *Some audits had not been completed, and she was a week or two behind on some of them. *She confirmed the Activities policies had not been updated as indicated. *Some staff members had not attended the education and in-services and had not made them up. *She had individually educated staff E, F, and G, but that was not documented. *They had a QA meeting right after the survey and before the POC had been completed. -They had not had another meeting since July 2016 to discuss the deficiencies and the plan of correction. *She confirmed their POC had not been completed as indicated, and it should have been. <p>Refer to re-cited tags F167, F248, F314, F368, and F371.</p> <p>Review of the provider's 6/23/11 Quality Improvement Program policy revealed:</p> <ul style="list-style-type: none"> *The purpose included: -"B. To continuously improve the quality and safety of patient care as measured by quality indicators, patient and employee satisfaction 	F 520			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	Continued From page 21 surveys, clinical/functional outcomes, financial outcomes, and reviews performed by independent external organizations." -"C. To ensure Quality Improvement activities are integrated into all departments and services on an ongoing basis and to ensure areas of improvement are identified and corrected." *For quality improvement reporting "The department director will: -1. Report trends of monitoring and data collection, the results of remedial action taken, and the outcome(s) of any action taken. -2. Report all State and Federal required monitoring. -3. Report survey deficiencies and required monitoring as identified in the survey's plan of correction."	F 520			

ORIGINAL

PRINTED: 09/26/2016
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/13/2016
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NAME OF PROVIDER OR SUPPLIER PHILIP NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 503 W PINE POST OFFICE BOX 790 PHILIP, SD 57567
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Compliance/Noncompliance Statement Surveyor: 35237 A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 9/13/16. Philip Nursing Home was found not in compliance with the following requirement: S206.	{S 000}	*Addendums noted with an asterisk per 10/7/16 per email with facility administrator. CHKV/SDDOH/EL	
{S 206}	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	{S 206}	S 206 The administrator or designee will ensure employees O, P & Q receive all mandatory education according to the Administrative Rule of South Dakota. The administrator or designee will audit each employee file to ensure all mandatory education is completed upon hire then at least annually as required by the Administrative Rule of South Dakota. The administrator or designee will audit new employee files monthly for 3 months to ensure all required education is complete. The administrator or designee will educate staff regarding the need/requirement of completing mandatory education annually. The administrator or designee will report audit findings to the Quality Assurance/Process Improvement team monthly for three months for continued recommendation. *The administrator or designee will monitor the new hire orientation and annual inservice education process to ensure mandatory education is completed. The administrator or designee will monitor this →	*CHKV/SDDOH/EL [REDACTED] *CHKV/SDDOH/EL [REDACTED] CHKV/SDDOH/EL *10/12/16 [REDACTED] *CHKV/SDDOH/EL [REDACTED]

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

TITLE

(X6) DATE

STATE FORM

6899

RECEIVED 10-3-16

OCT 05 2016

SD DOH LSC

continuation sheet 1 of 3

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/13/2016
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NAME OF PROVIDER OR SUPPLIER PHILIP NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 503 W PINE POST OFFICE BOX 790 PHILIP, SD 57567
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{S 206}	<p>Continued From page 1 facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on interview, plan of correction (POC) review from the 7/13/16 survey, record review, and document review, the provider failed to ensure: *The facility educator initiated and completed annual training with all employee for the annual required topics. *Three of three new employees (O, P, and Q) had completed orientation training including all the required topics. Findings include:</p> <p>1. Interview on 9/13/16 at 2:00 p.m. with the director of nursing revealed the facility educator had set up an all staff meeting for the training. But the educator had never followed through with the training and education. Thus the annual training on all required topics had not been completed.</p> <p>Review of the three new employee's charts revealed: *Employee O had started on 7/15/16, and had worked for one month in the kitchen and dining room. *Employee P had started on 7/27/16 and had worked in the nursing home. *Employee Q had recently started again on 8/27/16. He had quit three times in the past in the summer maintenance department, and then started again.</p> <p>Interview on 9/13/16 at 4:15 p.m. with the human resource manager revealed: *She had made notes to update the current orientation checklist but had not done so as of the</p>	{S 206}	<p>*quarterly for one year and report results to the monthly QAPI team for further recommendation. CHV/SDDOHE/L</p>	
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10661	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/13/2016
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NAME OF PROVIDER OR SUPPLIER PHILIP NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 503 W PINE POST OFFICE BOX 790 PHILIP, SD 57567
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{S 206}	<p>Continued From page 2</p> <p>date of the revisit survey. The new employees O, P, and Q had not signed off nor was there any documentation they had completed the orientation training.</p> <p>Continued interview on that same day at 4:30 p.m. with the director of nursing revealed neither she nor the administrator had completed any audits on the orientation or annual training. And according to the plan of correction they should have been completed by 8/1/16.</p>	{S 206}		