

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

ORIGINAL

PRINTED: 07/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/13/2016</b>
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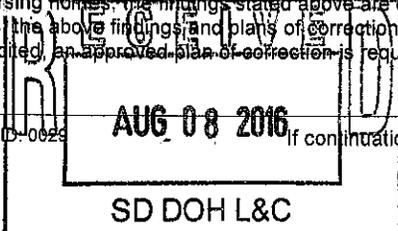
NAME OF PROVIDER OR SUPPLIER  <b>PHILIP NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 WEST PINE POST OFFICE BOX 790 PHILIP, SD 57567</b>
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F 000	<p><i>* Addendums noted with an INITIAL COMMENTS asterisk per 08/11/16 per telephone with facility nurse manager.</i></p> <p>Surveyor: 35237</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/11/16 through 7/13/16. Philip Nursing Home was found not in compliance with the following requirements: F167, F176, F221, F248, F281, F314, F315, F368, F371, and F514.</p>	F 000		
F 167 SS=D	<p><b>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</b></p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation and interview, the provider failed to ensure the most recent survey results were readily accessible to the residents. Findings include:</p> <p>1. Observations on 7/11/16 at 1:30 p.m. and on 7/12/16 at 8:15 a.m. revealed: *The survey results had been posted in a binder by the nurses station. *Those survey results had been from 9/10/14 and was not the most recent survey.</p>	F 167	<p>F 167</p> <p>1. 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.</p> <p>QI: The DON or designee will monitor the survey twice weekly for four weeks, then once monthly for 6 months. Findings will be reported to QA committee by the DON or designee quarterly until corrected.</p>	8/1/16

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kent Eason</i>	TITLE <i>CEO/ADMINISTRATOR</i>	(X6) DATE <i>8/2/16</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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F 167	Continued From page 1 *The last survey had been done on 9/16/15.  Confidential interview on 7/12/16 at 10:15 a.m. with a group of eight residents revealed: *They were aware survey results were posted by the nurses station. *A few residents stated they were old results from 2014 and not from the most recent survey. *They would have liked to have seen the survey results from 2015.  Interview on 7/13/16 at 10:10 a.m. with the director of nursing confirmed the posted survey results had not been the most recent survey. She agreed the 2015 survey results had not been accessible to all residents. She could not remember if she had posted the 2015 survey results at the nurses station.  Surveyor: 32573 Interview on 7/13/16 at 10:30 a.m. with resident 1's daughter revealed: *The 2015 state survey results had not been posted. *She had wanted to read it and had only found the 2014 survey.	F 167		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Surveyor: 36413	F 176	F 176  1. a. For resident 11 and all residents who receive nebulizer medication and are unable to self-administer the nurse will remain in the room to observe the treatment for a minimum of 10 minutes. LPN D and all nursing/UAP	8/1/16

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F 176	<p>Continued From page 2</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure four of six observed nebulizer treatments for three of three sampled residents (8, 11, and 12) had been monitored according to the provider's policy. Findings include:</p> <p>1a. Observation on 7/11/16 at 4:00 p.m. of licensed practical nurse (LPN) D administering a nebulizer treatment to resident 11 revealed she: *Placed the liquid medication in the chamber of the nebulizer. *Checked resident's 11 pulse and lungs. *Placed the mask on the resident and turned the machine on. *Told the resident she would return in ten minutes and exited the room.</p> <p>b. Observation on 7/11/16 at 4:08 p.m. of LPN D administering a nebulizer treatment to resident 12 revealed she: *Checked resident 12's pulse and lungs. *Placed the liquid medication in the chamber of the nebulizer. *Placed the mask on the resident and turned on the machine. *Told the resident she would return and exited the room.</p> <p>c. Interview at that time with LPN D revealed: *She had been unsure if residents 11 or 12 had been assessed for self-administering the medication. *She routinely left residents alone during a nebulizer treatment.</p> <p>Review of residents 11 and 12's medical records revealed: *No physician's orders were found that either</p>	F 176	<p>staff will be educated to follow this procedure.</p> <p>QI: DON or designee will observe nursing staff administer nebulizer treatments twice weekly for four weeks than once weekly for one month, than monthly for four months. Findings will be reported DON or designee to QA committee quarterly until corrected.</p> <p>b., c. For resident 12 and all residents who receive nebulizer medication and are unable to self-administer the nurse will remain in the room to observe the treatment for a minimum of 10 minutes. LPN D and all nursing/UAP staff will be educated to follow this procedure.</p> <p>QI: DON or designee will observe nursing staff administer nebulizer treatments twice weekly for four weeks than once weekly for one month, than monthly for four months. Findings will</p>	

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F 176	<p>Continued From page 3</p> <p>resident could self-administer their own medications. *A self-administration assessment had been completed on 4/21/16 for both residents, and they had been declared not competent to self-administer medications.</p> <p>d. Observation on 7/12/16 at 2:22 p.m. and on 7/13/16 at 8:10 a.m. of resident 8 revealed: *She had been observed using a mouth piece nebulizer in her room without staff observation. *She frequently spoke to her roommate while taking the mouthpiece out for the conversation.</p> <p>Review of resident 8's medical record revealed: *No physician's order was found that resident 8 could self-administer her own medications. *A self-administration assessment had been completed on 4/28/16 that she had been declared not competent to self-administer medications.</p> <p>e. Interview on 7/13/15 at 11:10 a.m. with the director of nursing revealed: *It was routine nursing staff would start the nebulizer, leave the room, return to shut the machine off, and take off the mask. *She was aware the above residents did not have the ability to self-administer medications. *She did not think nurses would have time to monitor nebulizer treatments.</p> <p>Review of the provider's March 2009 Self-Administration of Medication by Residents policy revealed: *An assessment would be conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability. *The resident's ability to continue to safely self-administer medications must have been</p>	F 176	<p>be reported by DON or designee to QA committee quarterly until corrected.</p> <p>d. For resident 8 and all residents who receive nebulizer medication and are unable to self-administer the nurse will remain in the room to observe the treatment for a minimum of 10 minutes. LPN D and all nursing/UAP staff will be educated to follow this procedure. QI: DON or designee will observe nursing staff administer nebulizer treatments twice weekly for four weeks than once weekly for one month, than monthly for four months. Findings will be reported DON or designee to QA committee quarterly until corrected.</p> <p>e. The DON will educate all nursing August 3, 2016 at the monthly staff meeting. UAP staff will be educated during</p>		

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F 176	Continued From page 4 reviewed periodically.	F 176	the state directed in-service on August 5 <sup>th</sup> .		
F 221 SS=D	<p><b>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</b></p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, interview, and policy review, the provider failed to assess: *One of one sampled resident (5) with a pommel cushion for use as a restraint or positioning device. *One of one sampled resident (6) quarterly for the continued use of a lap buddy on his wheelchair that could have been a restraint. Findings include:</p> <p>1. Observation on 7/12/16 at 2:20 p.m. or resident 5 revealed he had a pommel cushion in the seat of his wheelchair.</p> <p>Review of his medical chart revealed: *No assessment for the use of the pommel cushion. *No assessment if the pommel cushion had been used as a restraint or if it had helped with positioning. *There had been no mention of the pommel cushion anywhere in the chart. *No physician's order for the use of the pommel cushion.</p>	F 221	<p>F 221</p> <p>1. An assessment will be conducted for the use of a pommel cushion for resident 5 and all residents who use pommel cushions for positioning only. A new policy and assessment for pommel cushions will be implemented. Use of pommel cushion will be placed on resident 5's care plan and all residents who use this type of cushion. QI: DON or designee will review residents using pommel cushions for appropriate assessment and documentation on care plans once monthly for six months. Findings will be reported by DON or designee to QA committee quarterly or until corrected.</p> <p>2. Resident 6's restraint assessment reviewed and all residents with restraints and will be reviewed Q 90 days. Consent for restraints obtained for resident 6 and all</p>	9/1/16	

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F 221	<p>Continued From page 5</p> <p>Review of his current care plan revised 4/4/16 revealed there had been no mention of the pommel cushion.</p> <p>Interview on 7/12/16 at 4:42 p.m. with nurse manager B revealed: *There was no pommel cushion assessment for resident 5. *The provider did not do assessments for pommel cushions. -There should have been an assessment for safety and intended use.</p> <p>Surveyor: 36413</p> <p>2. Observation on 7/11/16 at 8:20 a.m. of resident 6 revealed he had a lap buddy on his wheelchair.</p> <p>Review of his medical chart revealed: *On 3/22/16 a physical restraint elimination assessment had been completed and a lap buddy was placed as needed for his safety to reduce his fall risk. *Instructions for that assessment were to be reviewed at least quarterly, and he had not been assessed since 3/22/16. *On 11/10/15 an order for a lap buddy to be used as needed had been written but never signed by the physician.</p> <p>3. Review of the provider's April 2012 Restraint policy revealed: *Staff must have completed the restraint assessment tool to determine if the resident was a candidate for the restraint. *The charge nurse must have had a consent signed and placed in the chart. *The quarterly review must have been completed every three months and reviewed at team care conference.</p>	F 221	<p>residents. Physician's order for restrain signed by physician for resident 6 and all applicable residents. DON will educate nursing staff at the monthly staff meeting on August 3, 2016 and other staff during the state directed in-service Aug. 5<sup>th</sup>.</p> <p><u>QI: DON or designee will review</u> resident charts for appropriate assessment, signed consent for restraints, physician order for restraint monthly 6 months. DON or designee will report findings to QA committee quarterly or until corrected.</p>	

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F 221	Continued From page 6	F 221			
F 248 SS=E	<p>*A physicians's order must have been obtained and included the type of restraint, reason for application, and specific time to be used.</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to offer activities based on residents' individual needs for five of nine sampled residents (1, 3, 4, 6, and 7) and for eight confidential residents interviewed. Findings include:</p> <p>1. Confidential interview on 7/12/16 at 10:15 a.m. with a group of eight residents revealed: *There were only two activity staff members. *There had been an activity coordinator, but she had left in February. *Fewer activities had been scheduled for the residents since that time. *They specifically wanted more morning and outdoor activities.</p> <p>Record review of the May, June, and July 2016 activity calendars revealed: *On Mondays, Fridays, Saturdays, and Sundays there was only one activity listed at 2:30 p.m. *On Tuesdays, Wednesdays, and Thursdays</p>	F 248	<p>F 248</p> <ol style="list-style-type: none"> <li>Philip Nursing Home will continue with two activity staff that function both in activities and restorative 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. Findings will be reported to QA committee by Activity Coordinator or designee quarterly or until corrected.</li> <li>A focused activity assessment completed with resident 3 and all residents. Activity care plan</li> </ol>	9/1/16	

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F 248	<p>Continued From page 7</p> <p>there were two activities listed at 10:15 a.m. and 2:30 p.m.</p> <p>*Twice in May and July and once in June there was music on Tuesday at 6:30 p.m.</p> <p>*There were no outdoor activities listed.</p> <p>*There were only three days each week with a morning activity listed.</p> <p>Interview on 7/12/16 at 4:40 p.m. with certified nursing assistant A regarding resident activities revealed:</p> <p>*There were two activity staff members.</p> <p>*The same residents usually went to the group activities.</p> <p>*The music program on the schedule for that evening had been canceled.</p> <p>Interview and record review on 7/12/16 at 4:55 p.m. with activity coordinator D revealed:</p> <p>*There were two activity staff members, and they were both coordinators.</p> <p>*They had been through the state activity coordinator training course.</p> <p>*There used to be three activity staff, but they had not had three for several months.</p> <p>*Both activity staff also performed other nursing duties, such as restorative therapy (RT).</p> <p>*She confirmed four days a week only one activity was scheduled on the calendar for July.</p> <p>-That was because there was only one activity staff working, or they also were doing RT.</p> <p>*She was not aware the residents wanted more morning or outdoor activities.</p> <p>*They did not always have good group activity attendance, and they also tried to get all their one-to-one activities done.</p> <p>Interview on 7/13/16 at 10:10 a.m. with the director of nursing (DON) regarding resident</p>	F 248	<p>updated to reflect activity needs for resident 3 and all residents. One-to-one activities goal for resident 3 will be changed from 3-5 times to 4-7 times weekly.</p> <p>QI: Activities Coordinator or designee will document one-to-one activity shared with resident 3 weekly for four weeks, then monthly for five months and findings reported to QA committee quarterly or until corrected.</p> <p>3. A focused activity assessment completed with resident 7 and all residents. Resident 7's activity care plan updated to reflect activities of her preference, which include going outside 3-5 times weekly and morning activities 3-5 times weekly.</p> <p>QI: Activities Coordinator or designee will document outdoor and morning activities offered weekly for four weeks, then monthly for five months and findings will be reported to the QA committee quarterly or until corrected.</p>	

*hand monitor JMS/DPH/EL*

*hand monitor JMS/DPH/EL*

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F 248	<p>Continued From page 8 activity revealed she: *Confirmed there were only two activity staff members currently, and they also had other duties to complete. *Agreed there were four days a week where only one activity was scheduled on the calendar. *Confirmed activities should have been scheduled and completed based on residents' needs.</p> <p>2. Random observations of resident 3 throughout the survey on 7/11/16 from 1:15 p.m. through 6:10 p.m., on 7/12/16 from 7:45 p.m. through 6:00 p.m., and on 7/13/16 from 7:45 a.m. through 3:45 p.m. revealed she: *Had been in bed in her room other than when she received a bath on 7/12/16. *Rested with her eyes closed frequently. *Received room trays for all her meals. *Was able to talk with the staff when they were assisting her with personal care or helping her to eat or drink. *Had the TV turned on most of the time. *Only had interactions with the staff during her personal care, such as repositioning, skin care, and during meals.</p> <p>Review of resident 3's medical record revealed: *She was admitted in December 2011. *Her 5/16/16 Brief Interview for Mental Status score was five. That indicated she had severe cognitive impairment. *Her diagnoses included chronic pain, anxiety, congestive heart failure, dementia, and depression.</p> <p>Review of resident 3's 5/11/16 activity care plan revealed: *A focus area of "Resident shows little interest in</p>	F 248	<p>4. A focused activity assessment completed with resident 1 and all residents. Residents 1's activity care plan updated to reflect receiving RT twice daily, outdoor activities 3-5 times weekly. QI: Activities/Restorative Coordinator or designee will document RT conducted and <u>outside activities offered</u> weekly for four weeks, than monthly for five months and findings reported to QA committee quarterly or until corrected.</p> <p>5. A focused activity assessment conducted with resident 4 and all residents. Resident 4's activity care plan updated to reflect 3-5 1:1 visits with staff. QI: Activities Coordinator or designee will document 1:1 interactions conducted by staff weekly for four weeks, than monthly for five months and findings will be reported to QA committee quarterly or until corrected.</p> <p>6. A focused activity assessment completed with resident 6 and all</p>	

*Hand monitor JM/Sprinkel*

*Hand monitor JM/Sprinkel*

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F 248	<p>Continued From page 9 scheduled activities." -The goal was "resident will be involved in activities of choice in room daily." -Interventions included: --"Offer to turn on the TV to cooking shows, Golden Girls, and the country music channels daily. --Resident enjoys staff watering her plants in her room weekly. --Resident enjoy watching birds at bird feeder outside her window." *A focus area of "Resident is bed ridden d/t non-healing fractures of right femur and right humerus (pain and anxiety). -The goal was "Resident will accept 1:1 activities in room 3-5 weekly." -Interventions included: --"Offer lotion therapy and massage. --Read local newspapers weekly. --Reminise about her former pets (cats). --Offer devotional reading."</p> <p>Interview on 7/12/16 at 4:40 p.m. with CNA A regarding resident 3 revealed she: *Had only been working there a few months and had been primarily working evenings and nights. *Was unsure of what activities the resident had received. *Had not seen activity staff in her room when she was on duty. *Thought most of the CNAs talked with her during meals, and they played music for her on the TV.</p> <p>Interview and record review on 7/12/16 at 4:55 p.m. with activity coordinator D regarding resident 3 revealed: *Activities staff had been doing one-to-one visits three to five times weekly and tried to get in there more often if they could.</p>	F 248	<p>residents. Resident 6's activity care plan updated to reflect inability to participate in group activities R/T physical decline and 1:1 activities will be conducted by staff 3-5 times weekly. QI: Activities Coordinator or designee will document 1:1 activities conducted weekly for one month, then monthly for 5 months and report findings to QA committee quarterly or until corrected.</p> <p>7. Activities policy reviewed and updated to reflect the most current program available. Policies and procedures will be reviewed annually by the Activities Coordinator. Resident Activity assessment will be reviewed Q 90 days during the MDS process. QI: Activities Coordinator will review and update policy and procedure manual on annual basis and initial/date each policy reviewed, resident Activity assessments will be reviewed Q 90 days when their MDS is due</p>	

*and monitor JM/SBOOTH/EL*

*\*and the DON JM/SBOOTH/EL*

*the DON JM/SBOOTH/EL  
by the let team JM/SBOOTH/EL*

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F 248	<p>Continued From page 10</p> <p>*She agreed the resident did not have visitors, was on bedrest, was unable to leave her room, and her only interactions would have been with staff.</p> <p>*She confirmed the nursing staff interactions during personal care and meals should not have been her only activities during the day.</p> <p>*There were only two activity staff who had other duties, and it was difficult to get the one-to-one visits done more often than three to five times a week.</p> <p>*She agreed one-to-one visits should have been done more than three to five times a week.</p> <p>Interview on 7/13/16 at 10:10 a.m. with the DON regarding resident 3's activity revealed she:</p> <p>*Confirmed it was difficult for activity staff to do one-to-one visits more often than three to five times a week due to all their other duties.</p> <p>*Agreed resident 3's only social interaction would have been with the nursing staff during care and meals on the days she had not had an activity staff visit.</p> <p>3. Random observations and interviews with resident 7 throughout the survey on 7/11/16 from 1:15 p.m. through 6:10 p.m., on 7/12/16 from 7:45 p.m. through 6:00 p.m., and on 7/13/16 from 7:45 a.m. through 3:45 p.m. revealed she:</p> <p>*Was alert and able to make her needs known.</p> <p>*Utilized a wheelchair to move around and could do that with or without staff assistance.</p> <p>*Attended activities that she liked.</p> <p>*Wanted more morning activities.</p> <p>*Would have liked more outdoor activities.</p> <p>Review of resident 7's July 2016 activity flow sheet from 7/1/16 through 7/12/16 revealed:</p> <p>*Her activities included:</p>	F 248	and report findings to QA committee quarterly or until corrected.	

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F 248	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-Reminisce/resident council four times.</li> <li>-Outings/going outside five times.</li> <li>-Games three times.</li> <li>-Programs twice.</li> <li>-Alternative activities six times.</li> <li>*Her one-to-one activity documentation sheet from 5/2/16 through 7/12/16 revealed most entries were family visits or outings.</li> <li>-Only one out of the twenty-nine entries was related to a staff involved activity.</li> </ul> <p>Resident 7's 4/18/16 activity care plan revealed:</p> <ul style="list-style-type: none"> <li>*A focus area of "Resident is very aware of her surroundings and gets frustrated when other residents who have dementia are allowed to do things she feels are inappropriate."</li> <li>-The goal was "resident will attend one group activity daily of her choice without angry outburst."</li> <li>-Interventions included: <ul style="list-style-type: none"> <li>--"Offer to place her in the activity setting away from those individuals that are upsetting to her.</li> <li>--Offer Friday entertainment.</li> <li>--Offer Bingo.</li> <li>--Offer Devotions and church."</li> </ul> </li> <li>*A focus area of "Resident has mood r/t history of anxiety disorder and depression."</li> <li>-The goal was "Resident will be content with her surroundings in the nursing home."</li> <li>-Interventions included: <ul style="list-style-type: none"> <li>--"Offer manicure.</li> <li>--Family visits often.</li> <li>--Offer the newspaper or magazines."</li> </ul> </li> </ul> <p>Surveyor: 32573</p> <p>4. Review of resident 1's complete medical record revealed:</p> <p>*She had a 5/6/16 activity care plan that called for offering the following activities:</p>	F 248		

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F 248	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>-Devotions.</li> <li>-Table bowling.</li> <li>-Bingo.</li> <li>-Independent activities.</li> </ul> <p>Review of her 5/9/16 care plan revealed interventions of:</p> <ul style="list-style-type: none"> <li>*"Assist the resident in developing/provide the resident with a program of activities that is meaningful and of interest."</li> <li>*"Encourage and provide opportunities for exercise, physical activity."</li> <li>*"Range of motion with am/pm care and restorative therapy daily."</li> </ul> <p>Review of her one-to-one (1:1) documentation from 4/19/16 to 7/10/16 revealed:</p> <ul style="list-style-type: none"> <li>*Four of thirty-six documented 1:1 activities had been a friend or her daughter had come to visit.</li> <li>*Two of thirty-six documented 1:1 activities had been staff interacting with the resident.</li> </ul> <p>Review of her activity flow sheet from 7/1/16-7/12/16 revealed she had not been offered exercise activities any of those days.</p> <p>Interview on 7/13/16 at 10:30 a.m. with resident 1 revealed:</p> <ul style="list-style-type: none"> <li>*She did not think she had been getting her therapy as she was supposed to.</li> <li>*She wished there had been more activities.</li> <li>*There had been no activity director, and she had really liked the last one.</li> <li>-The last activity director had done lots of fun activities with residents.</li> <li>*Lots of activities were canceled now.</li> <li>*"They [the facility] needed a change, something different."</li> </ul>	F 248		

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F 248	<p>Continued From page 13 Surveyor: 36413</p> <p>5. Review of the resident 4's medical records revealed: *Resident 4 had sixteen entries for May activities, and seven of those were family visits. *Resident 4's activity flow sheet had an activity six of the first twelve days in July.</p> <p>Review of resident 4's 4/5/16 care plan revealed: *Resident would be offered one to three scheduled group activities weekly. *Resident would be offered 1:1 activities three to five times weekly.</p> <p>6. Review of resident 6's medical record revealed: *Resident 6 had seventeen entries for June activities, and eleven of those were family visits. *Resident 6's activity flow sheet had activities documented eight of the first twelve days in July.</p> <p>Review of resident 6's 2/3/16 care plan revealed: *Resident would be offered scheduled group activities two to three times a week. *Resident would be offered 1:1 activities three to five times a week.</p> <p>Surveyor: 35237</p> <p>7. Review of the provider's revised January 2006 Scheduling of Activities policy revealed: *"The activity director is responsible for the scheduling of all activity functions and programs." *"2. Activity programs must be coordinated with nursing, therapy, and housekeeping services." *"5. Activities will be scheduled at various times, seven (7) days a week."</p> <p>Review of the provider's revised January 2006 Activity Program Staffing policy revealed:</p>	F 248		
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F 248	Continued From page 14 **Our activity program is staff with personnel who have appropriate training and experience to meet the needs and interests of each resident." **"Sufficient activity personnel will be on duty to meet the needs of the residents and the functions of the activity program."  Review of the provider's revised January 2006 Activity Program policy revealed: **"An ongoing program of activities is designed to meet the needs of each resident." **"Our activity program consists of individual, and small and large group activities which are designed to meet the needs and interests of each resident..."	F 248			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on record review, interview, and policy review, the provider failed to report to the state agency a fall that resulted in a serious injury for one of two sampled residents (6). Findings include:  1. Review of resident 6's medical record revealed: *He had a fall on 3/21/16 at 6:00 p.m. while sitting in his wheelchair with his wife in his room. -That fall had resulted in a laceration to his head. *No mention in the incident report or nurses notes that the above fall with injury was reported to the	F 281	F 281  DON will reeducate nursing staff on August 3, 2016 during monthly staff meeting policy for reporting falls with significant injury and have SDDOH resource available at nurse's station. An incident report must be filled out with all falls and given to the DON.  QI: DON or designee will monitor all fall reports and nursing documentation of falls for appropriate reporting per policy and report findings to QA committee quarterly or until corrected.	9/1/16	

\*Unable to correct prior non-compliance for resident 6.  
JM/SDDOHEL

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F 281	Continued From page 15 state agency.  Interview on 7/13/16 at 11:10 a.m. with the director of nursing revealed: *Resident 6's fall on 3/21/16 had not been reported to the state agency. *Charge nurses normally completed the reports with her help as needed. *She confirmed that fall with serious injury should have been reported to the state agency.  Review of the provider's reviewed May 2015 Reporting and Investigating Resident Abuse and Misappropriation of Property policy revealed: "Any alleged abuse, neglect, or misappropriation will be reported to the Department of Health, Licensure and Certification within 24 working hours after an internal investigation has been completed and determined that a possible reportable incident occurred. The appropriate state mandated Abuse Investigation form will be completed and sent within 24 hours. The follow up report will be completed within 5 working days by the Director of nursing (does not include weekends or holidays). In the event the completion of the investigation will exceed 5 working days, the Department of Health, Licensure and Certification must be contacted and informed of the reason for the delay."	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	F 314	F 314  1. Resident [redacted] and all resident MD orders and care plans reviewed. Resident [redacted] revised to reflect repositioning Q 1-2 hrs and PRN. CNA's F and G and all care staff re-educated to reposition and	9/1/16	

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F 314	<p>Continued From page 16</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to: *Reposition one of three sampled residents (3) with pressure ulcers according to her care plan, physician's orders, and individual needs. *Follow the physician's order for one of three observed dressing changes for a one of three sampled residents (3) with pressure ulcers. *Implement interventions to promote healing and prevent reoccurring pressure ulcers from developing for one of three sampled residents (3). *Have registered nurses (RN) conduct wound assessments for three of three sampled residents with pressure sores (3, 4, and 6). Findings include:</p> <p>1. Random observations and interviews on 7/11/16 from 1:50 p.m. through 6:15 p.m. of resident 3 revealed she: *Was in her bed. *Did not leave her room. *Required assistance of two staff members to reposition in bed. *Needed one staff member to assist her with eating and drinking. *Was repositioned at 4:50 p.m. During that repositioning: -Certified nursing assistants (CNA) F and G assisted her to move up in the bed. -They stated she had pressure sores, a pressure</p>	F 314	<p>document accordingly Q 1-2 hrs and PRN. RN E and all nursing staff re-educated to follow dressing change treatments as ordered by physician. Air mattress applied to resident bed and dietician will complete a nutrition assessment. Resident 6 and all residents with wounds will be sized and staged weekly by an RN. DON will educate nursing staff at monthly staff meeting on August 3, 2016 and state directed in-service August 5<sup>th</sup>.</p> <p>2. QI:</p> <p>1. DON or designee will monitor residents with repositioning schedules and documentation twice weekly for four weeks, than once weekly for four weeks, than monthly for three months.</p> <p>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</p>	<p><i>JK33 JMDDOYEL</i></p>

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F 314	<p>Continued From page 17</p> <p>relieving mattress, and staff repositioned her every two hours.</p> <p>-She had two dressings in place to her buttocks area that the nurses took care of.</p> <p>-She had a urinary catheter to drain her urine</p> <p>*She had a room tray for supper and was assisted by CNA G.</p> <p>-Her meal included a carton of whole milk, a glass of water, corn bread casserole, three-bean salad, and strawberries.</p> <p>-There were no supplements or additional protein included in that meal.</p> <p>-She consumed 75% of the food and drank the milk.</p> <p>Review of resident 3's medical record revealed:</p> <p>*She had originally been admitted in December 2011.</p> <p>*Her most recent re-admission from the hospital was on 3/30/14.</p> <p>*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.</p> <p>*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.</p> <p>*She had a history of a left buttock surgical wound for years.</p> <p>*She was on bed rest due to her history of fractures and left buttock wound.</p> <p>*She currently had three areas the nurses had been treating. Those were on her:</p> <p>-Left buttock, surgical wound.</p> <p>-Coccyx, pressure ulcer.</p> <p>-Left lower leg, pressure ulcer.</p>	F 314	<p>three months.</p> <p>3. DON or designee will observe size and staging by RN's Q week for four weeks, than monthly for 5 months.</p> <p>4. DON or designee will monitor resident charts for appropriate nutrition assessments Q month for 6 months.</p> <p>Findings for items 1-4 will be reported by the DON or designee to the QA committee quarterly or until corrected.</p> <p>3. For resident 6 and 4 DON reviewed charts/TARS (treatment administration record) and found size and staging had been conducted by an LPN. DON reviewed all resident charts for wound size and staging. Re-educated LPN staff that comprehensive assessments will be conducted by RN staff only. This will be addressed in the monthly staff meeting August 2<sup>nd</sup> and state directed in-service on August 5<sup>th</sup>. Treatment records for residents 6 and 4 and all</p>	

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F 314	<p>Continued From page 18</p> <p>Review of resident 3's physician's orders and July 2016 treatment administration record (TAR) revealed:</p> <p>*Her most recent physician visit was on 6/29/16 with the following orders:</p> <ul style="list-style-type: none"> <li>- "Stage 3 wound - left buttock wound... Size &amp; Stage wound Q [every] week."</li> <li>- "Stage 2 wound - left lower leg wound... Size and Stage wounds Q week."</li> <li>- "Foot pillows to bilateral feet to prevent pressure on heels while in bed, foot board to bed to prevent pressure on toes, position change Q 1-2 hrs..."</li> <li>- "Diet as tolerated - push fluids - special plate."</li> </ul> <p>*On 7/10/16 treatment was started to her coccyx pressure sore. That order stated:</p> <ul style="list-style-type: none"> <li>- To cleanse the area daily with Saf-clens (wound cleaner).</li> <li>- Apply SSD 1% (silvadene) cream.</li> <li>- No dressing or tape since it was contraindicated due to moisture and location.</li> </ul> <p>Review of resident 3's 5/19/16 care plan regarding her skin and pressure ulcers revealed:</p> <p>*She had:</p> <ul style="list-style-type: none"> <li>- A potential for pressure ulcer development related to her history of them and immobility.</li> <li>- An old surgical wound and various rash areas from bed confinement.</li> <li>- A stage 2 open ulcer on the backside of her lower left leg, and redness of her underarms and abdominal fold skin breakdown.</li> </ul> <p>*The goal was for the resident to have intact skin, free of redness, blisters, or discoloration by the next review date on 11/16/16.</p> <p>*Interventions had been initiated on 11/16/15 and included the following:</p> <ul style="list-style-type: none"> <li>- "The resident requires the bed as flat as possible to reduce shear. The resident prefers to be</li> </ul>	F 314	<p>residents will be updated to reflect size and staging performed by "RN only".</p> <p>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.</p> <p>4. DON reviewed and updated Pressure Ulcer Policy and procedure. Job descriptions for RN's and LPN's reviewed and updated reflect scope of practice for wound care assessment.</p> <p>Nursing staff will be educated on updated policy and procedure and job descriptions on August 2<sup>nd</sup> at monthly staff meeting and 5<sup>th</sup> at state directed in-service.</p> <p>QI: DON or designee will review policies and procedures annually and update PRN. Job descriptions for RN/LPN's will be reviewed annually.</p>		

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F 314	<p>Continued From page 19</p> <p>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 &amp; skin tears &amp; surgical wounds." *There was no mention of an air mattress, additional wound healing interventions, or additional nutritional interventions to promote wound healing.</p> <p>Review of resident 3's wound care measurement and assessment forms from June 2016 through 7/12/16 revealed: *On 6/3/16: -A stage 2 pressure ulcer to her left ankle. -A stage 2 surgical ulcer to her left buttock. *On 6/11/16: -Three stage 2 pressure ulcers to her left ankle. -The surgical area to her left buttock had no stage listed. *On 6/18/16: -A stage 2 left outer calf pressure ulcer. -A stage 3 coccyx pressure ulcer. -There was no assessment for the long-term left</p>	F 314		

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F 314	<p>Continued From page 20                      buttock surgical area.                      *On 6/26/16 there were new stage 2 left lower buttock and right lower buttock pressure ulcers.                      *On 6/27/16:                      -The long-term left buttock surgical area had no stage listed.                      -A stage 2 pressure ulcer to her left lower leg.                      -There was no mention of the coccyx pressure ulcer.                      *On 7/3/16:                      -A stage 1 pressure ulcer to her left lower leg.                      -A stage 2 right buttock ulcer and there was no mention of the left buttock ulcer from 6/26/16.                      -There were no assessments for the long-term left buttock surgical area or the coccyx pressure ulcer.                      *On 7/10/16:                      -The stage 3 long-term left buttock surgical area.                      -The stage 2 coccyx pressure ulcer.                      -The stage 2 left lower leg pressure ulcer.                      -There was no mention of the right buttock pressure ulcer.                      *Of those above assessments the following dates had been completed by LPNs and not RNs:                      -6/18/16.                      -6/26/16.                      -7/3/16.                      -7/10/16.</p> <p>Review of resident 3's nurses notes from 2/15/16 through 7/12/16 revealed:                      *A 2/15/16 LPN note stated "...Skin is intact with exceptions of surgical wound on left buttocks and stage II wound on back of lower left leg. Sore to left upper post thigh, right lower buttocks, right upper buttocks, and skin tear to coccyx. All areas treated per wound care protocol with PCP [primary care physician] orders. All areas are assessed daily with dressing change and staged</p>	F 314		

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F 314	<p>Continued From page 21 and sized weekly..."</p> <p>*A 2/16/16 RN note stated "...Needs extensive to total assist of two staff to accomplish ADLs [activities of daily living]...resident continues to receive dressing changes daily for old surgical wound on L buttock. Has developed stage III pressure ulcer to LL leg...has pressure reducing mattress on bed and cushion in w/c. Also, is on turning/repositioning program to help prevent further pressure ulcers..."</p> <p>*A 3/18/16 registered dietitian note stated "Dietary - [resident name] continues to receive regular diet. Eats in her room - appetite often poor. Current weight is 127# [down arrow] 5% for the quarter. BMI is 23. Treatment continues to L buttock wound and L ankle. She does not receive adequate nutrition to foster skin healing per her choice. She can have any foods she may request. Family requests comfort care." -There was no mention of trying different interventions for nutrition for wound healing, such as vitamins, supplements, increasing protein, or changes or additions to her diet, meals, or snacks.</p> <p>*A 3/18/16 RN note stated "Resident is confused most of the time. Oriented to self only...Remains in bed and only occ gets up (once weekly for tub baths). Extensive assist needed for eating, will occ pick up something and eat it. Dependent on staff totally for other ADLs...Has slowly healing surgical wound to L buttocks and also open area to L leg. Buttocks area red daily and Nutrashield is applied."</p> <p>*A 5/16/16 dietary manager note stated "Resident is on a DAT [diet as tolerates] diet and takes all meals in room. Resident is unable to feed herself. Appetite is poor, usually eats 25% of meals, unable to obtain weight do to pain while moving...Will continue to monitor and provide</p>	F 314		

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F 314	<p>Continued From page 22 special requests." -There was no mention of trying different interventions for nutrition to promote wound healing. *A 5/16/16 LPN/RN note stated "...Is usually in bed 24/7 except for use of bath chair when given a tub bath...Needs extensive assistance...Is checked and changed Q [every] 2 hours...Has an old surgical wound on L buttocks et a stage II sore on LLE. Buttocks et peri-area has MASD [moisture associated skin damage] et is treated per MD orders. Mattress on bed is pressure reducing..." *A 6/3/16 RN note stated "skin assessment done with bath. Red area under L breast and L arm pit. Wound remains to L buttock. L leg wound OTA [open to air]." *A 6/11/16 RN note stated "Open area to L leg noted. This is same area that was recently resolved. Size and staged. See wound care sheet..." *A 6/27/16 RN note stated "Two small open areas found buttocks on R side. Skin fragile. Will apply SSD 1% cream and not put dry drsg as this will cause more damage with tape. Will F/U with next shift." *A 7/10/16 LPN note stated "Verified with previous nurse skin to buttocks R and L lower buttocks are healed. D/C [discontinue] wound assessment. Size/stage wound areas completed to Lt buttocks, Lt calf/leg. New wound care measurement &amp; assessment noted to the coccyx area stage II. Approx 3 cm X 1 cm. Cleansed with NS &amp; SSD 1% cream applied. Unable to keep a dry drsg to this area contraindicated, i.e. moisture will continue to monitor &amp; report any further changes..." *There was no mention of other interventions they had implemented or tried to promote healing and</p>	F 314		

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F 314	<p>Continued From page 23 prevent further pressure sores from developing.</p> <p>Interview on 7/12/16 at 9:00 a.m. with RN E regarding resident 3's wound assessments revealed: *Her pressure sores were scheduled to be sized, staged, and assessed by the nurse weekly. *Sometimes the charge nurse was an LPN. *If the wound assessments were scheduled for a day that an LPN was the charge nurse then they would have completed it.</p> <p>Observation, interview, and TAR review, on 7/12/16 from 1:15 p.m. through 1:40 p.m. with RN E during resident 3's dressing changes and repositioning revealed: *CNA H assisted her with repositioning the resident. *She completed dressing changes to her left lower leg sore, left buttock surgical sore, and her coccyx pressure ulcer. *During the dressing change to her coccyx ulcer: -She did not use Saf-clens to clean the area. -Applied the SSD cream. -Applied a gauze dressing to cover the area. -Used tape around all four edges to secure the gauze. -The Saf-clens was available and sitting on the bedside table with the other supplies. *When asked about the gauze dressing and using the tape she stated the area needed to be covered to protect it. *She confirmed she had not: -Followed the physician's order on the resident's TAR for the coccyx dressing change. -Performed the coccyx dressing change properly. *RN E confirmed: -The resident was on a pressure reducing mattress.</p>	F 314		

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F 314	<p>Continued From page 24</p> <p>-She had an air mattress at one time but was unsure what had happened to it.</p> <p>-She was high risk for pressure ulcers.</p> <p>-She had some pressure areas resolve, and she continued to develop new pressure ulcer at times too.</p> <p>-Staff were to reposition her at least every two hours.</p> <p>*After they completed the dressing changes they assisted her onto her back in bed, positioned pillows under her lower legs, assisted to position her blankets, and then left the room.</p> <p>Interview on 7/12/16 at 2:55 p.m. and again on 7/13/16 at 8:50 a.m. with RN/nurse manager B regarding resident 3 revealed:</p> <p>*She had been a resident in the facility for years.</p> <p>*They had been treating the left buttock surgical wound for years, and it was improving.</p> <p>*She continued to develop other pressure ulcers at times.</p> <p>*She had an air mattress at one time and was unsure why she did not have one now.</p> <p>-She felt that could have benefited her.</p> <p>*She confirmed the resident was a high risk for developing pressure ulcers and needed to be repositioned more often because of that.</p> <p>*The minimum repositioning should have occurred at least every two hours.</p> <p>*She was on comfort care per her family's request.</p> <p>*Even though she was on comfort care they should have continued to heal her current pressure ulcers and attempted to prevent future pressure ulcers from developing.</p> <p>*She confirmed wound assessments should have been completed by an RN and not an LPN.</p> <p>*They had a wound certified nurse available to help them with pressure ulcers and skin issues.</p>	F 314		

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F 314	<p>Continued From page 25</p> <p>-That wound nurse did not have designated hours or times she was available since she also worked in the hospital.</p> <p>*She thought the resident had been on nutritional supplements and had dietary interventions to promote wound healing in the past, but that had been quite awhile ago.</p> <p>-Now she received a regular diet as tolerated.</p> <p>*She confirmed the resident's Turn and Reposition sheet for July 2016 had minimal documentation by the staff.</p> <p>-That sheet did not prove she had been turned at least every two hours.</p> <p>Observations on 7/12/16 at 2:45 p.m., at 3:15 p.m., and at 4:10 p.m. revealed resident 3 was in the same position on her back in her bed as she had been when RN E and CNA H had left her during the treatment above at 1:40 p.m.</p> <p>Observation, interview, and review of the Turn and Reposition sheet for July 2016 on 7/12/16 at 4:40 p.m. with CNA A in resident 3's room revealed:</p> <p>*The resident was laying in her bed on her back in the same position from the above observation with CNA H and RN E.</p> <p>*CNA A stated the resident was always in bed and should have been repositioned every two hours by staff.</p> <p>*Her shift had started at 2:00 p.m., and she had not been told when her last repositioning had been done or when it was due.</p> <p>*She had not repositioned the resident yet since her shift had started.</p> <p>*She referenced and reviewed the resident's Turn and Reposition sheet that was hung on the wall in her bathroom. She confirmed there was no documentation she had been repositioned since</p>	F 314		

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F 314	<p>Continued From page 26 7/10/16 at 1:00 p.m.</p> <p>*She agreed the sheet had a minimal number of staff initials and did not prove repositioning had occurred every two hours.</p> <p>*She thought staff had not documented all the times they had repositioned her, and they should have.</p> <p>Interview on 7/13/16 at 10:10 a.m. with the director of nursing regarding resident 3 revealed:</p> <p>*RNs not LPNs should have done or overseen all the wound assessments.</p> <p>*Dressing changes should have been completed as ordered by the physician.</p> <p>*The resident used to be on an air mattress for pressure relief. It had broken down, and they had not replaced it.</p> <p>*Her repositioning should have been completed at least every two hours due to her current pressure sores and high risk for developing new pressure sores.</p> <p>*The wound certified nurse worked in the hospital and did not have scheduled time in the facility to oversee the wounds.</p> <p>*She agreed:</p> <ul style="list-style-type: none"> <li>-The wound assessments lacked consistency due to several nurses completing them.</li> <li>-It was difficult to track an area from the time it started until it healed, because the nurses had labeled, measured, and sized them differently.</li> <li>-They had not implemented nutritional interventions to promote healing.</li> <li>-Overall they could have done more to prevent new pressure ulcers from developing.</li> </ul> <p>Phone interview on 7/13/16 at 1:13 p.m. with the consultant registered dietitian regarding resident 3 revealed:</p> <p>*All her documentation would have been in the</p>	F 314		

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F 314	<p>Continued From page 27</p> <p>nurses notes.</p> <p>*She confirmed her last assessment and documentation for the resident had been on 3/18/16.</p> <p>*The resident was on comfort care.</p> <p>*They had not gotten any weights on her since March 2016, so she had not done any further assessments.</p> <p>*She was not aware of her recent open area to her coccyx.</p> <p>*The facility did not contact her in-between her monthly visits.</p> <p>-They could have notified her of new pressure sores or weight changes when they occurred instead of waiting for her monthly visit.</p> <p>*She would not have known about resident 3's other pressure sores without reviewing her record herself on her monthly visits.</p> <p>*She confirmed they had not tried recent diet changes or nutritional interventions to promote wound healing in quite awhile.</p> <p>*Even though the resident was on comfort care they could have utilized interventions such as supplements or increased protein items to promote wound healing.</p> <p>-Those types of interventions had not been recommended or started.</p> <p>Surveyor: 36413</p> <p>2. Review of resident 6 complete medical chart revealed:</p> <p>*The resident's initial sizing and staging and assessment of the ulcer on his buttock on 7/9/16 had been completed by a LPN.</p> <p>-His wound had been assessed as a stage two on 7/9/16.</p> <p>-On 7/12/16 a registered nurse had noted the wound was healed and a reddened area remained.</p>	F 314		

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F 314	<p>Continued From page 28</p> <p>Observation on 7/12/16 at 10:30 a.m. with RN E and resident 6 revealed he had a wound that was intact and the area appeared to be red in color.</p> <p>3. Review of resident 4's complete medical record revealed initial sizing and staging of his ulcer on his buttock was a stage two on 7/9/16. That assessment had been completed by a LPN.</p> <p>Observation on 7/12/16 at 10:40 a.m. with RN E with resident 4 revealed he had a wound that was intact and the area appeared to be red in color.</p> <p>Interview on 7/13/16 at 11:15 a.m. with the director of nursing revealed she did not expect a licensed practical nurse (LPN) to complete an initial assessment on pressure ulcers.</p> <p>Interview on 7/13/16 at 1:10 p.m. with registered nurse B revealed she agreed the initial assessment included the sizing and staging of the wound should not have been done by a LPN.</p> <p>Surveyor: 35237</p> <p>4. Review of the provider's revised April 2010 Pressure Ulcers policy revealed: *"Residents will be assessed for risk of pressure ulcers upon admission and ongoing throughout their stay." *"Based on assessment findings, interventions will be implemented to reduce and/or prevent the risk of pressure ulcer development." *"The residents care plan will be updated to identify if they are at risk for pressure ulcers, interventions and treatment." *"Interventions to reduce pressure ulcers will be implemented and may include but not limited to: -Nutrition.</p>	F 314			

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F 314	<p>Continued From page 29</p> <ul style="list-style-type: none"> <li>-Hydration.</li> <li>-Repositioning.</li> <li>-Support surfaces.</li> <li>-Pressure redistribution.</li> <li>-Resident education."</li> </ul> <p>***Pressure ulcers will be treated as ordered by the physician and documented in the medical record. Measurements and wound characteristics will be documented weekly..."</p> <p>Review of the provider's wound care resource book available at the nursing station had a January 2015 article from American Medical Technologies titled "Pressure Ulcers at Previous Pressure Ulcer Sites - Staging and Prevention" that revealed:</p> <p>***...persons with closed full-thickness pressure ulcers, or any wound on a pressure bearing area, remain at risk for future pressure ulcers due to the reduced tensile strength of scar tissue..."</p> <p>***Patient's/resident's circumstances such as immobility, inadequate offloading or pressure redistribution techniques, inadequate nutrition, the presence of medical comorbidities such as diabetes, medications and lifestyle choices such as smoking all impact the likelihood of reoccurrence."</p> <p>***Scars are weaker on previously wounded tissues, therefore it is critical that strategies be implemented (or put in place) to protect newly closed wounds, flaps and grafts."</p> <p>***An overview of prevention strategies for persons at risk for pressure ulcers includes, but it not limited to the following:"</p> <ul style="list-style-type: none"> <li>-"Individuals at-risk for pressure ulcers should be placed on a pressure redistribution surface."</li> <li>-"Schedule regular repositioning and turning for bed and chair bound patients taking into consideration the support surface in use, the</li> </ul>	F 314		

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F 314	<p>Continued From page 30</p> <p>individual's tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, and assessments of the individual's skin condition."</p> <p>Review of the South Dakota Board of Nursing administrative rules 20:48:04:01 regarding the nursing scope of practice revealed:                      *(a) The registered nurse shall utilize the following recurring nursing process:                      -(i) Make nursing assessments regarding the health status of the client;                      -(ii) Make nursing diagnoses which serve as the basis for the strategy of care;                      -(iii) Develop a plan of care based on assessment and nursing diagnosis;                      -(iv) Implement nursing care; and                      -(v) Evaluate responses to nursing interventions;                      *(b) The registered nurse shall recognize and understand the legal implications of delegation and supervision. The nurse may delegate to another only those nursing interventions which that person is prepared or qualified to perform and shall provide minimal or direct supervision to others to whom nursing interventions are delegated. The registered nurse may only delegate nursing tasks to unlicensed assistive personnel in accordance with the standards in chapter 20:48:04.01."                      *(a) The licensed practical nurse shall assist the registered nurse or physician in the recurring nursing process as follows:                      -(i) Contribute to the nursing assessment;                      -(ii) Participate in the development of the nursing diagnoses;                      -(iii) Participate in care planning;                      -(iv) Participate in the implementation of nursing interventions;                      -(v) Contribute to the evaluation of responses to</p>	F 314		

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F 314	Continued From page 31 nursing interventions; *(b) The licensed practical nurse may practice as follows in two general settings: -(i) With at least minimal supervision when providing nursing care in a stable nursing situation; and -(ii) With direct supervision when providing nursing care in a complex nursing situation."  Review of the provider's undated registered nurse job description revealed they had the responsibility to perform comprehensive physical, functional and psychosocial assessments of the residents.  Review of the provider's undated licensed practical nurse job description revealed they should have contributed to the ongoing assessments of assigned residents.	F 314			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review,	F 315	F 315  1. Toileting program reviewed for resident 2 and all residents and updated to reflect individual needs. The toilet program will be discussed with resident 2 to assure maximum participation. CNA A and all other care staff will be educated regarding the individualized plan for resident 2 and all residents and importance of appropriate supporting documentation. MDS coordinator will review toilet	9/1/16	

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F 315	<p>Continued From page 32</p> <p>and policy review, the provider failed to ensure five of five sampled residents (1, 2, 4, 5 and 6) had been on toileting programs based on their individual needs. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *He had been admitted on 8/13/15. *His diagnoses included benign prostatic hyperplasia and constipation. *His Brief Interview for Mental Status (BIMS) assessment score was fifteen. Indicating he had no cognitive impairment.</p> <p>Observation and interview on 7/11/16 at 1:45 p.m. with resident 2 in his room revealed: *On the floor beside his recliner there was a urinal half-full of urine sitting in a bucket. *Staff helped him move around and to the bathroom since he was unable to do it by himself.</p> <p>Review of resident 2's 2/8/16 and 5/9/16 Minimum Data Set (MDS) assessments revealed he was: *On a urinary toileting program that resulted in decreased wetness. *Not on a bowel toileting program. *Frequently incontinent of urine and bowels.</p> <p>Review of resident 2's 5/12/16 care plan revealed he: *Was able to use the toilet independently and used the urinal as needed. *Was on a prompted toileting plan and had occasional incontinence of urine and bowels. -Staff were "to prompt to toilet upon rising, before and after meals and activities, at bedtime, and as indicated. Staff to assist with peri-care with each incontinence episode."</p>	F 315	<p>plans Q 90 days and make adjustments PRN.</p> <p>2. Toileting program reviewed for resident 1 and all residents and updated to reflect individual needs. The toilet program will be discussed with resident 1 to assure maximum participation. All care staff will be educated regarding the individualized plan for resident 1 and all residents and importance of appropriate supporting documentation. MDS coordinator will review toilet plans Q 90 days and make adjustments PRN.</p> <p>3. Toileting program reviewed for resident 5 and all residents and updated to reflect individual needs. Due to resident's impaired cognition a three day voiding diary placed in bathroom. All care staff will be educated regarding the individualized plan for resident 5 and all residents and importance of appropriate supporting documentation. MDS coordinator will review toilet plans Q 90 days and make adjustments PRN.</p>		

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F 315	<p>Continued From page 33</p> <p>Review of resident 2's July 2016 Toileting Schedule sheet in his bathroom revealed: *His schedule was "prompt to toilet upon arising, before et after meals et activities, at HS et PRN. Staff assist with peri-care as needed." *From 7/1/16 through 7/12/16 there were several blanks in the documentation. *There was documentation related to staff assisting him with toileting: -One time on 7/3 and 7/10. -Two times on 7/6, 7/11, and 7/12 by 4:00 p.m. -Three times on 7/1, 7/5, 7/7, 7/8, and 7/9. -Five times on 7/2 and 7/4.</p> <p>Interview on 7/12/16 at 4:40 p.m. with certified nursing assistant (CNA) A regarding resident 2's toileting program revealed he: *Did not use the toilet often. *Was usually incontinent of bowels and urine. *Needed staff to help him with his incontinence. *Used the urinal on his own and staff emptied it. *Was not on an individual toileting program. *Was taken to the bathroom usually in the morning, before and after meals, at bedtime, and as needed. -That was the standard toileting plan for most residents.</p> <p>Interview on 7/3/16 at 9:05 a.m. with MDS/licensed practical nurse B regarding resident 2 revealed: *He was coded on his MDS assessments as being on a urinary toileting program. *His program was for the staff to prompt him to the bathroom upon rising, before and after meals, at bedtime, and as needed. -That was the standard toileting process for most of the residents.</p>	F 315	<p>4. Toileting program reviewed for resident 4 and all residents and updated to reflect individual needs. Due to impaired cognition a three day voiding diary placed in bathroom. All care staff educated regarding the individualized plan for resident 4 and all residents and importance of appropriate supporting documentation. MDS Coordinator will review toilet plans Q 90 days and make adjustments PRN.</p> <p>5. Toileting program reviewed for resident 6 and all residents and updated to reflect individual needs. Due to resident 6's debilitate health he is designated as "check and change". Care staff will be educated regarding the individualized plan for resident 6 and all residents and importance of appropriate supporting documentation. MDS coordinator will review toilet plans Q 90 days and make adjustments PRN.</p>	
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F 315	<p>Continued From page 34</p> <p>*She agreed his toileting program had not been individualized to meet his needs. *She confirmed his toileting schedule sheet lacked documentation to support he had been toileted according to his care plan and toileting program.</p> <p>Interview on 7/3/16 at 10:10 a.m. with the director of nursing regarding resident 2 and his toileting program confirmed he was not on an individualized program to meet his needs. His program would have been considered the standard toileting schedule for most residents.</p> <p>Surveyor: 32573 2. Review of resident 1's complete medical record revealed: *She was on diuretics. *She was wheelchair bound. *A 2/8/16 quarterly MDS assessment was coded as: -She needed extensive assistance of one person to use the restroom. -She was on a toileting program. -She was occasionally incontinent. -She had a BIMS of fifteen, indicating no cognitive impairment. *Her annual 5/9/16 MDS assessment was coded as: -She needed some set-up help by staff to use the restroom. *She was on a toileting program. -She was frequently incontinent. *Her incontinence had increased from 2/8/16 to 5/9/16.</p> <p>Her revised 5/9/16 care plan revealed: *She needed extensive assistance to use the</p>	F 315	<p>QI: for items 1-5 DON or designee will monitor three random toilet plans and supporting documentation twice weekly for four weeks, than once weekly for four weeks, than monthly for three months. DON</p> <p>or designee will report findings to QA committee quarterly or until corrected.</p> <p>6. Toileting program policy reviewed and updated. Those residents who are unable to participate in the individualized toilet programs will be placed on a standardized toileting schedule. DON will educate staff of policy up state directed in-service on August 5<sup>th</sup>.</p>	

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F 315	<p>Continued From page 35</p> <p>restroom. *An intervention of "Prompted toilet plan. Upon rising, before and after meals, activities before bed and as needed."</p> <p>The care plan and most recent 5/9/16 MDS assessment had not had matching information in regards to toileting and assistance needed.</p> <p>Interview on 7/13/16 at 10:30 a.m. with resident 1's daughter revealed: *Staff did not have her on any toileting program she had been aware of. *Her mother had to push a call light and wait to toilet. *She had waited so long she had had an accident before.</p> <p>3. Review of resident 5's complete medical record revealed: *His most recent 4/10/16 quarterly MDS assessment had coded him as on a toileting program. *He was occasionally incontinent. *He needed extensive assistance of one person to use the restroom. *He had a BIMS of nine, indicating moderately impaired thinking.</p> <p>Review of his most recent care plan updated 4/14/16 revealed: *He had limited mobility and required limited assistance of one for using the restroom. *A 1/27/16 intervention of "On prompted toilet schedule, upon rising, before and after meals and activities, at bedtime and as needed."</p> <p>The care plan and most recent 4/10/16 MDS assessment had not had matching information in</p>	F 315			

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F 315	<p>Continued From page 36 regards to the resident's toileting needs.</p> <p>Surveyor: 36413</p> <p>4. Review of resident's 4 complete medical record revealed: *Her 4/5/16 care plan revealed: -Bladder retraining program consisted of prompt to toilet upon rising, before and after meals and activities, at hs, and prn. -There was no documentation of an individualized toileting program. *A 7/4/16 annual MDS assessment was coded as: -She needed extensive assistance of one person to use the restroom. -She was on a toileting program. -She was frequently incontinent.</p> <p>Review of resident 4's July toileting schedule revealed she had been checked and changed was documented in a twenty-four hour period as follows: *Five times on 7/1/16, 7/2/16, 7/3/16, 7/7/16, 7/8/16, and 7/11/16. *Four times on 7/6/16 and 7/8/16. *Three times on 7/9/16. *Two times on 7/10/16.</p> <p>5. Review of resident 6's complete medical record revealed: *His July toileting schedule stated he was checked and changed once on 7/9/16. *His 2/3/16 care plan instructed to check and change resident every two hours during the day and as needed at night.</p> <p>Surveyor: 35237</p> <p>6. Review of the provider's revised April 2007 Toileting program policy revealed:</p>	F 315		

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F 315	Continued From page 37 ***To ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections, and to restore as much bladder function as possible. Toileting programs will promote comfort and dignity and diminish the likelihood of skin breakdown." **Evaluate resident within one week of admission and whenever there is a change in cognition or physical ability. Evaluation will consist of observing the resident's toileting pattern and documenting for a three-day period." *When evaluations had been completed a toileting program would be implemented for one of the following: -Prompted toileting. -Scheduled toileting. -Check and change toileting. **Each resident who has been determined to need a toileting program will have one implemented. Effectiveness of plans developed will be evaluated and adjusted by the team approximately two weeks from the date they are enacted. Following this, evaluations will be performed at least quarterly with the MDS assessment, or whenever there is a significant change in the resident's cognition, physical ability or level of incontinence."	F 315			
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	F 368	F 368  1. A policy and procedure will be created to reflect that HS snacks will be passed daily by nursing home staff to all residents. Documentation will be maintained of snacks offered to	9/1/16	

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F 368	<p>Continued From page 38 following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</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: 32573 Based on record review and interview, the provider failed to ensure snacks had been offered to all residents each night for 37 days of the 31 weeks reviewed. Findings include:</p> <p>1. Review of the provider's weekly HS snack list from 11/15/15 through 7/2/16 revealed: *Each resident had a space to mark "Y" or "N" when they had been offered a snack. *There were thirty-seven days where the entire column had been left blank or it had been marked as "missed" or "not offered".</p> <p>Interview on 7/12/16 at 1:45 p.m. with the dietary manager revealed every night the kitchen sent a plate of cookies out to the nursing staff for the residents for HS snack.</p> <p>Interview on 7/12/16 at 1:58 p.m. with nurse manager B revealed any blanks on the HS snack list meant snacks had not been offered that night.</p> <p>RN B and the DON had not provided an HS snack policy as requested by the end of the</p>	F 368	<p>residents daily. Education will be provided to nursing home and dietary staff during state directed in-service August 5<sup>th</sup>.</p> <p>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.</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>PHILIP NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 WEST PINE POST OFFICE BOX 790 PHILIP, SD 57567</b>		
(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 368	Continued From page 39 survey on 7/13/16.	F 368			
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, interview and policy review, the provider failed to ensure a system/process had been in place to monitor: *The proper holding temperatures for hot or cold foods was maintained for two of two observed meal services. *Sanitizing solutions had been at the proper chemical concentrations for cleaning kitchen surfaces in one of one containers used. Findings include:</p> <p>1. Observation on 7/11/16 at 4:45 p.m. of the supper meal preparation revealed: *Cook I took the temperatures of the food as he put it in the steam table. *Food was at the proper temperatures at that time.</p> <p>Observation on 7/11/16 at 5:30 p.m. of the supper meal revealed:</p>	F 371	<p>F 371</p> <p>1. Cook 1 and all dietary cooks educated to temp food right before serving prior to meals to assure proper temperature. If temperature drops below acceptable standards food will be placed back into oven until proper serving temp reached. Policy for Cooking and Storage Foods updated to reflect procedure for temping before serving. All dietary staff will be educated on state directed in-service on August 5<sup>th</sup>. QI: Dietary manager or designee will monitor temperatures once a week for four weeks then once a month for five months. Findings will be reported by the DM or designee to QA committee quarterly or until corrected.</p> <p>2. Dietary Manager educated all staff when and how to change sanitizing solution before cleaning prep surfaces in kitchen to assure that sanitizing solution</p>	9/1/16	

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F 371	<p>Continued From page 40</p> <p>*No one checked the temperature of the food right before it was served to the residents. *It had been at least a half-hour that food had been sitting in the steam table.</p> <p>Interview on 7/12/16 at 10:00 a.m. with the dietary manager revealed staff did not usually take food temperatures right before service.</p> <p>Observation on 7/12/16 at 10:45 a.m. of the noon meal preparation revealed: *Cook I took the temperatures of the food. *Food had been an acceptable temperature. *Porkchops had been at 145 degrees Fahrenheit (F).</p> <p>Observation and interview on 7/12/16 at 11:25 a.m. with the dietary manager (DM) and the lunch service revealed: *Food had gone into the steam table 30 to 45 minutes before service. *This surveyor asked cook I to take the temperature of the food again right before service. *The temperature of the porkchops had fallen to 132 degrees F. -They were put back in the oven until the proper holding temperature had been reached. *The DM agreed temps should have been taken closer to service to ensure food was hot or cold enough. *Staff usually only checked the temperatures of food when it went into the steam table.</p> <p>Review of the provider's April 2013 Cooking and Storage of Food policy revealed: *Hot foods were to have been held at 135 degrees F or higher. *There had been no procedure for when to take</p>	F 371	<p>at 200ppm. The policy Cleaning Equipment updated to reflect when and how to change sanitizing solution and when and how to check ppm to assure adequate sanitizer. All dietary staff will be educated on new policy and procedure at state directed in-service on August 5<sup>th</sup>. QI: Dietary Manage or designee will monitor ppm levels of sanitizing solution once a day for one week then once weekly for four weeks, then once monthly for five months and findings reported to QA committee quarterly or until corrected.</p>	

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F 371	Continued From page 41 the food temperatures.  2. Observation on 7/12/16 at 8:45 a.m. of the sanitizer bucket used to clean kitchen surfaces revealed: *When tested, the quaternary cleaner concentration had been at 50 parts per million (ppm). -It should have been at 200 ppm. *The DM changed out the cleaning solution. *The new solution tested at 200 ppm.  Interview at that time with the DM revealed: *Sanitizer bucket solution was changed out four times a day. *Staff did not check the concentration of the solution, because it had been changed so often.  Observation on 7/12/16 at 11:00 a.m. of the sanitizer buckets used to clean kitchen surfaces revealed: *This surveyor tested the bucket and got 50 ppm. *The bucket's cleaning solution had been changed two hours prior to this testing per prior observation.  Review of the provider's 2006 Cleaning Equipment policy revealed there had been no documentation of when to change the sanitizing buckets or check the cleaning solution concentration.	F 371			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514	F 514  1. For residents 2, 3, 4, and 6 and all residents DON reviewed documentation for turning and repositioning, toileting and	9/1/16	

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F 514	<p>Continued From page 42 accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to ensure four of nine sampled residents (2, 3, 4, and 6) medical records had sufficient documentation related to repositioning, toileting, and bedtime snacks. Findings include:</p> <p>1a. Review of resident 3's July 2016 Turn and Reposition schedule revealed there had been missing documentation turning and repositioning had occurred every two hours as indicated on her care plan. Refer to F314, finding 1.</p> <p>b. Review of resident 2's July 2016 toileting schedule sheet revealed there had been missing documentation toileting had occurred according to his toileting program. Refer to F315, finding 1.</p> <p>Surveyor: 32573 c. Documentation of bedtime snacks had been incomplete thirty-seven days from 11/15/15 to 7/2/16. Refer to F368, finding 1.</p>	F 514	<p>bedtime snacks to assure adequate documentation as directed by the care plan.</p> <p>a. Resident 3's and all resident's documentation and repositioning will be done Q 1-2 hrs. Care plans updated to reflect this.</p> <p>b. Resident 2's and all resident toileting schedule sheets will be reviewed and updated to reflect individualized toilet plans. Care plans updated to reflect this.</p> <p>c. HS snack documentation reviewed and all staff reeducated to offer and document snacks Q HS.</p> <p>d. Resident 4's and all residents toileting schedules reviewed and updated to reflect individualized toilet plans. Care plans updated to reflect this.</p>		

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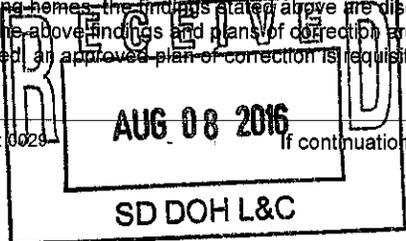
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F 514	Continued From page 43  Surveyor: 36413 d. Documentation on resident 4's toileting schedule for July was not complete. Refer to F315, finding 4.  e. Documentation on resident 6's toileting schedule for July was not complete. Refer to F315, finding 5.  Surveyor: 35237 f. Review of the provider's revised December 2015 Documentation policy revealed "Documenting information on the resident/patient in the medical record provides a means of communication between the physician and other professionals contributing to the resident's/patient's care. It provides a basis for planning resident/patient care, is evidence of the course of a resident's/patient's illness and treatment during each admission, and is a way to record the care received by the resident/patient."	F 514	e. Resident 6's and all residents toileting schedule sheets reviewed and updated to reflect individualized toilet plan. Care plans updated to reflect this. QI: For items a-e DON or designee will monitor three random resident's toileting sheets and turning and repositioning sheets and all HS snack documentation twice weekly for four weeks, than once weekly for four weeks, than once monthly for 6 months. Findings will be reported by DON or designee to QA committee quarterly or until corrected.		

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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/13/16. Philip 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 deficiencies identified at K038, K062, K069, K070 and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure one of four exits (west wing) was readily accessible at all times. Findings include:  1. Observation at 9:00 a.m. on 7/13/16 revealed the west wing exit door was equipped with a magnet lock and a sign stating it was a delayed egress-type door. Testing of the door at the time of the observation revealed the door release was not activated by firmly pushing against the bar across the width of the door. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He was unaware that checking the magnetically locked door operation should have been on a preventive	K 038	<b>K 038</b>  Exit door has been inspected and repaired as of 7/25/2016. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.	7/25/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE **CEO / ADMINISTRATOR** (X6) DATE **8/3/16**

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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K 038	Continued From page 1 maintenance checklist.  The deficiency had the potential to affect all occupants in that smoke compartment.	K 038		
K 062 SS=C	Ref: 2000 NFPA 101 Section 19.2, 7.2.1.6.1 NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review, observation, and interview, the provider failed to verify the required maintenance of the sprinkler system (five year internal inspection) had been performed. Findings include:  1. Review of the provider's sprinkler maintenance records on 7/13/16 revealed no documentation the required five year internal obstruction inspection of the sprinkler system had been performed in accordance with NFPA 25. Observation at 9:45 a.m. on 7/13/16 revealed there was not a tag on the fire sprinkler riser indicating a five year obstruction inspection had been performed.  Interview with the maintenance supervisor at 9:45 a.m. on 7/13/16 revealed he was unaware of the five year internal obstruction inspection requirement.  The deficiency affected one of numerous requirements for fire sprinkler system	K 062	<b>K 062</b>  Western States Fire Inspection conducted and completed 5-year internal obstruction inspection on 7/22/2016.	7/22/16

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K 062	Continued From page 2 maintenance.	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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: 18087 Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was tied into the building's fire alarm signaling system for one of one kitchen hood. Findings include:  1. Document review at 9:30 a.m. on 7/13/16 revealed a commercial kitchen equipment inspection report dated 2/15/16. That report was prepared by Armstrong Extinguisher Service, Inc. The report did not confirm the commercial kitchen hood fire suppression system was connected to the building fire alarm signaling system. Interview with the maintenance supervisor at the time of the above observation indicated the fire alarm system had not been activated during that suppression system inspection.  This deficiency affected one of numerous requirements for maintaining the kitchen hood fire suppression system.	K 069	<b>K 069</b>  Kitchen hood fire suppression system will be connected to the building alarm signaling system by 9/1/2016. Simplex has been scheduled to complete this task before 9/1/2016. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.	9/1/16
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by:	K 070	<b>K 070</b>  All resident rooms, to include room 103, will be monitored for the presence of portable space heaters of any type. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.	9/1/16

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K 070	Continued From page 3 Surveyor: 18087 Based on observation and interview, the provider failed to assure the safety of residents from possible burns and/or fire. A portable space heater was located in resident room 103. Findings include:  1. Observation at 8:45 a.m. on 7/13/16 revealed a portable space heater located in resident room 103. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He stated the resident had complained of being cold, so the resident's family had brought the space heater into the building for the resident to use.	K 070			
K 144 SS=C	The deficiency had the potential to affect all occupants in that smoke compartment. 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: 18087 Based on document review and interview, the provider failed to conduct operational inspection and testing for the emergency generator per National Fire Protection Association (NFPA) 110, 1999 Edition between July 2015 and July 2016. Findings include:  1. Document review of the Olympian D150PI diesel generator log revealed no record of percent of loading or exhaust gas temperatures during monthly load tests between July 2015 and	K 144	<b>K 144</b>  Exhaust gas temperatures during the monthly load test will be recorded and monitored by Maintenance Director. Maintenance Director and Administrator will monitor and review as per preventive maintenance plan. Audit sheets will be monitored by the Administrator and submitted by the Maintenance Director at the quarterly QI Committee meeting.	9/1/16	

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K 144	<p>Continued From page 4</p> <p>July 2016. NFPA 110, 1999 Edition, 6-4.2 states that diesel generator sets in service shall be exercised at least once monthly, for a minimum of thirty minutes, using one of the following methods:</p> <p>(1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate rating.</p> <p>(2) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>Diesel-powered EPS installations that do not meet the requirements noted above shall be exercised monthly with the available EPSS load. The generator shall then be exercised annually with supplemental loads at 25 percent of the nameplate rating for thirty minutes, followed by 50 percent of the nameplate rating for thirty minutes, followed by 75 percent of the nameplate rating for sixty minutes, for a total of two continuous hours.</p> <p>Interview with the maintenance supervisor at 10:00 a.m. on 7/13/16 revealed the provider was performing monthly load tests for thirty minute durations, but was unaware of the actual percent loading of the generator. He was unaware if annual load banking was required for the diesel generator. He stated the provider had recently changed contractors for service work requirements for the generator.</p> <p>The deficiency affected one of numerous requirements for generator maintenance and had the potential to affect 100% of the building occupants.</p>	K 144			

## SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10661</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/13/2016</b>
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S 000	Compliance/Noncompliance Statement  Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 7/11/16 through 7/13/16. Philip Nursing Home was found not in compliance with the following requirement: S206.	S 000		
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.	S 206	<b>S 206</b>	a/1/16

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

*Jeff Koon*

TITLE

*CEO/ADMINISTRATOR*

(X6) DATE

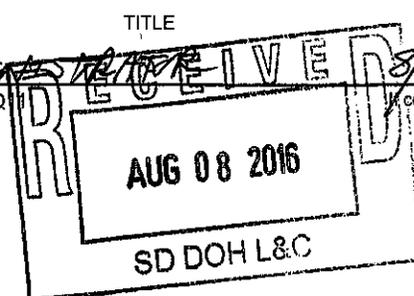
*8/2/16*

STATE FORM

6899

IY20

continuation sheet 1 of 4



SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10661</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/13/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PHILIP NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 W PINE POST OFFICE BOX 790 PHILIP, SD 57567</b>
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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 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the provider failed to ensure all staff had annual training for four of ten mandated annual topics (restraints, care of residents with unique needs, emergency procedures, and dining assistance/nutritional risks/hydration needs). Findings include:</p> <p>1. Review of the provider's 2015 new employee training and annual training revealed there was no documentation training had been provided for all staff that had resident contact for the four topics listed above.</p> <p>Interview on 7/13/16 at 9:00 a.m. with the social services designee revealed: *Each area of staffing provided their own training. *Some staff not in nursing might not have gotten all the training nursing got. *Human resources (HR) had a separate new employee orientation all staff would have gotten in addition to any specific department training.</p> <p>Interview on 7/13/16 at 9:15 a.m. with the DON revealed they had been trying to fill the gaps in their orientation process. HR should have had a training packet for all staff.</p> <p>Interview on 7/13/16 at 10:45 a.m. with the HR training manager revealed the following were not covered in their general orientation: *Emergency procedures. *Restraints.</p>	S 206	<p>months, then annually thereafter. Findings will be documented and brought to the QI meetings quarterly by the DON or designee.</p> <p>Annual mandatory safety training for all 11 required subjects will be conducted on 8/16/2016 by DON or designee. Employees will be required to sign-in to document attendance. Administrator will monitor that annual training is conducted. Findings will be documented and brought to the QI meetings annually by the Administrator.</p>	

SD Department of Health Vital Records

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S 206	<p>Continued From page 2</p> <p>*Care of residents with unique needs. *Dining assistance, nutritional risks, and hydration needs.</p> <p>Review of the nursing initial assessment of competence and orientation checklist revealed nurse aides and nurses were initially trained on: *Emergency procedures training. *Restraints. *Nutrition, hydration, and dining assistance.</p> <p>Interview on 7/13/16 at 1:35 p.m. with the dietary manager revealed: *Dietary staff were not initially trained on nutrition, hydration, or dining assistance. *They were only shown how to chart how much intake a resident might have had. *He was not sure if any other staff besides nurse aides got that training.</p> <p>Interview on 7/13/16 at 1:45 p.m. with registered nurse B revealed: *Hands on training should have provided all required training for nurse aides. *If there was not documentation of training being done in the papers already reviewed, "They probably would not be found." *She was not sure why all required training had not been done/documented.</p>	S 206		
S 000	<p>Compliance/Noncompliance Statement</p> <p>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 7/11/16 through 7/13/16. Philip Nursing Home was found in compliance.</p>	S 000		

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