ORIGINAL

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

PRINTED: 08/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435120		08/10/2016

NAME OF PROVIDER OR SUPPLIER
PIONEER MEMORIAL NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
315 NORTH WASHINGTON ST POST OFFICE BOX 368
VIBORG, SD 57070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/8/16 through 8/10/16. Pioneer Memorial Nursing Home was found not in compliance with the following requirements: F278, F279, F363, and F371.	F 000	*Addendums noted with an asterisk per 9/12/16 per telephone with facility administrator. KR/SDOH/EL	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	Resident 5's staff assessment mood scores were reviewed on 8/18/16 with provider and psychotropic drug review team and medication changes were made. A procedure change was made to have all changes in resident mood assessment scores completed through staff observation reviewed by both licensed social workers (LSWs). Significant score changes will be taken to the interdisciplinary care team and psychotropic drug review team. The interdisciplinary care team meets weekly and the psychotropic drug review team meets monthly. Once a significant mood score change is noted, LSW will complete an addendum progress note to include the change. Director of Social Services will monitor all resident mood assessment scores completed through staff observations monthly for three months. The results will be taken to the Performance Improvement Committee monthly by the Director of Social Services until the Performance Improvement Committee determines compliant. Staff observed resident mood assessment education will be provided to all nurses on 8/31/16. The Director of Social Services will be responsible for completion of the Plan of Correction. *KR/SDOH/EL *9/19/16 KR/SDOH/EL *A licensed Social worker will review all residents with mood assessment scores completed through staff observation for a significant change from the previous assessment. KR/SDOH/EL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas V Rible
TITLE: Chief Executive Officer
(X6) DATE: 08/26/2016

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

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and record review, the provider failed to accurately assess and code a significant change in depressive symptoms for one of eight sampled residents (5) with depression. Findings include: 1. Observations on 8/9/16 at various times throughout the day from 8:10 a.m. through 5:00 p.m. of resident 5 revealed: *She spent her day primarily at meals or in her room. *She had a flat affect and did not respond to conversation with this surveyor. Review of resident 5's 4/23/16 quarterly Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status (BIMS) assessment score of 99, meaning she was unable to complete the interview. Per staff assessment she was moderately impaired. *A depression severity score of 9 which was mild depression. Review of resident 5's 7/16/16 annual MDS assessment revealed: *Her BIMS was unchanged. *Her depression severity score was now 20 which showed severe depression. *That was a significant change from the previous three months. Review of resident 5's medical record revealed: *She was admitted on 10/9/13.	F 278		

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F 278	Continued From page 2 *Her diagnoses included dementia with behavior disturbances and depression. *She was on medication to treat those issues. *Counseling had been tried in the past but was no longer effective. *There were activities and social services involvement. *Per nurses and physician's notes there had not been much change in her depression. *A 7/25/16 psychotropic drug review meeting note revealed no changes in her depression or treatment. -That meeting was held nine days after the significant change assessment. Interview on 8/9/16 at 2:10 p.m. with the director of nursing (DON) and the MDS coordinator regarding resident 5 revealed: *The physician had not increased her medication for depression because of excessive sleepiness. *Social services completed the MDS assessment portion for mood and behaviors that included an assessment of depression. *They were unaware there had been a significant change in resident 5's MDS coding for depression. Interview on 8/9/16 at 4:30 p.m. with licensed social worker (LSW) A regarding resident 5's MDS depression assessment revealed: *She thought they were currently doing all they could for her depression. *She was unaware of the significant change in assessment. *The other LSW who completed the assessment was not currently available. Interview on 8/10/16 at 10:45 a.m. with certified nurse practitioner D regarding resident 5	F 278		

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F 278	Continued From page 3 revealed: *She verified the medication had not been increased due to excessive sleepiness of the resident. *She had attended the 7/25/16 psychotropic drug review meeting. *She was unaware there had been any change in resident 5's depression and had thought it was better. Interview on 8/10/16 at 12:30 p.m. with the DON, MDS coordinator, and LSWs A and C regarding resident 5's significant change in her MDS depression severity score revealed: *LSW C completed the assessment based on the seven day lookback from staff. -She had missed the change and had not thought to look into it further by questioning the staff's assessment. *None of them had been aware of the significant change in the assessment. -Such a change should have been assessed for causes, and changes should have been made for the resident if needed. *They agreed that should have been looked into. *Per the DON they had no policy other than the MDS manual to address the above situation.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		

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F 279	Continued From page 4 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans had been updated and revised as changes occurred for: *One of one sampled resident (1) with a catheter. *One of eight sampled residents (4) with depressive symptoms. *Findings include: 1. Review of resident 1's medical record revealed a Foley catheter had been inserted on 6/25/16. Interview on 8/8/16 at 8:25 a.m. with registered nurse J regarding resident 1 revealed she: *Had a Foley catheter. *Had needed that catheter due to a recent fracture with possible surgery. Review of resident 1's revised 8/1/16 care plan revealed there was no documentation she had a Foley catheter.	F 279	Resident 1's care plan was updated on 8/10/16 to include indwelling catheter. All other residents with indwelling catheters care plans were reviewed and were in compliance. Resident 4's care plan was updated on 8/24/16 to include fluctuating mood score. The interdisciplinary team will continue to monitor care plans quarterly and when resident needs change according to Care Planning Process Policy NH303. A random care plan audit will begin 9/1/16 and include the review of five percent (5%) or residents care plans per week. The care plan audit will be conducted by interdisciplinary team. The DON will take audit results to the Performance Improvement Committee monthly and this committee will determine how long the audit will continue. Education will be provided to all nursing staff on 8/31/16 by DON, nurse educator, and MDS coordinator. The Director of Nursing will be responsible for completion of the Plan of Correction.	09/19/2016

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F 279	Continued From page 5 Observation on 8/10/16 at 8:50 a.m. with certified nursing assistant (CNA) B in resident 1's room revealed the resident had a catheter. Interview on 8/10/16 at 8:05 a.m. with the director of nursing (DON) regarding resident 1 revealed: *She had a Foley catheter. *She agreed her care plan contained no documentation she had a catheter. *She stated nursing should have updated her care plan to have included the use of a catheter. *She confirmed the placement of a catheter needed to have been in her care plan. 2. Review of resident 4's medical record revealed she had: *Diagnoses that included: -Alzheimer's disease. -Dementia. -Anxiety disorder. -Chronic fatigue. -Osteoarthritis. Interview and observation on 8/9/16 at 12:15 p.m. with CNA I regarding resident 4 revealed: *She was seated in a wheelchair in the dining room. *CNA I was assisting her with eating. *The resident mumbled a sound when asked how she was doing. *CNA I stated "she was unable to speak a lot." Review of resident 4's 7/2/16 quarterly Minimum Data Set (MDS) assessment in section D, Mood revealed: *She had increased in symptom frequency of: -Little interest or pleasure in doing things. -Feeling tired or having little energy. -Poor appetite or overeating.	F 279		

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F 279	Continued From page 6 -Trouble concentrating on things. *She had increased in the severity score of symptom frequency: -From the 1/16/16 quarterly assessment score of 5 (mild) and the 4/9/16 quarterly assessment of 8 (mild). -To the above 7/2/16 quarterly MDS assessment score of 15 (moderately severe). *She had increased from mild to moderately severe in her severity score of symptom frequency. Review of resident 4's revised 7/14/16 care plan revealed: *She had difficulty expressing her needs. *She had a history of pain from arthritis. *She had impaired communication with difficulty expressing herself. *There was no documentation she had depressive symptoms including any established goals and interventions for it. Interview on 8/9/16 at 1:30 p.m. with the DON and licensed social worker (LSW) A regarding resident 4 revealed: *Her mood had fluctuated at times. *Both agreed her most recent MDS assessment section D results had increased in symptom frequency. *Depressive symptoms had not been on her care plan. *LSW A stated her physician needed to have been alerted regarding her increase in depressive symptoms. *Both confirmed addressing her increase in symptom frequency along with goals and interventions needed to have been on her care plan. *Interventions should have been on her care plan.	F 279		

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F 279	Continued From page 7 Interview on 8/10/16 at 8:05 a.m. with the DON regarding resident 4 revealed it was the responsibility of the MDS coordinator or other departments as needed to have updated and revised her care plan as changes occurred. Review of the provider's revised 12/9/13 Care Planning Process policy revealed: *"Using an interdisciplinary approach, each resident will have an individualized plan of care which addresses the resident's needs and severity of condition, impairment, disability, or disease based on the universal care standards identified by the [name of facility] staff as the minimum standards for all residents." *The care plan was to have been revised as the resident's need changed.	F 279		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, record review, interview, and policy review, the provider failed to follow the written menus portion sizes correctly at: *Two of three observed meals for all residents who were to have received regular portions of potatoes on oral diets.	F 363		

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F 363	Continued From page 8 *One of three observed meals for all residents who were to have received fruit servings on oral diets. Findings include: 1. Observation and review of the written menu on 8/8/16 at the evening meal in the kitchen revealed cook E: *Served one-third cup of the mashed potatoes for all residents on regular portions who received the mashed potatoes. -The written menu for that item was to have been one-half cup for the regular/no added salt, reduced calorie, two gram sodium, consistent carbohydrate, heart healthy, liberalized renal, pureed, and mechanical soft diets. *The mashed potatoes serving size had not been followed and served per the written menu for Cycle: Pioneer Revised 3rd week Day Number:16. *At no time during the above serving of the meal was the written menu observed to be reviewed by cook E. 2. Observation and review of the written menu on 8/9/16 at the noon meal in the kitchen revealed cook F: *Served one-third cup of the mashed potatoes for all residents on regular portions who received the mashed potatoes. -The written menu for that item was to have been one-half cup for the regular/no added salt, reduced calorie, two gram sodium, consistent carbohydrate, heart healthy, pureed, and mechanical soft diets. *The mashed potatoe serving size had not been followed and served per the written menu for Cycle: Pioneer Revised 3rd week Day Number:17.	F 363	The consultant dietitian will review all residents' care plans to identify those residents requesting smaller portions and verify that it is documented in the care plan and meal card. The Dietary Manager will inventory all serving scoops and ladles to assure there are sufficient number of utensils and order additional serving utensils to assure sufficient number of each size serving utensil to serve the correct portions. A visual chart was made and posted to assist staff in serving the correct portions. The chart includes scoop color, number of ounces, scoop number and cup size. A copy of the menu will be placed at the serving line for reference by staff. All dietary staff will receive inservice education on 8/31/16 regarding portion sizes and correct service of the written menu according to policy and procedure with those unable to attend having an individual inservice by 9/7/16. Meal service will be observed five times weekly for four weeks following inservice education with results reported to the performance improvement committee. The Dietary Manager will be responsible for the implementation of the Plan of Correction. *The dietary manager is observing the meal service and will be reporting to the performance Improvement Committee and will report monthly. KR/SDDOH/EL	09/19/2016

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F 363	Continued From page 9 *At no time during the above serving of the meal was the written menu observed to be reviewed by cook F. 3. Observation and review of the written menu on 8/9/16 at the evening meal in the kitchen revealed cook G who was training dietary assistant H revealed: *They served one-fourth cup of the fruit serving of cinnamon baked apple slices for all residents that received the fruit. -The written menu for that item was to have been one-half cup for the regular/no added salt, reduced calorie, two gram sodium, consistent carbohydrate, heart healthy, pureed, liberalized renal, and mechanical soft diets. *The fruit serving size had not been followed and served per the written menu for Cycle: Pioneer Revised 3rd week Day Number:17. *At no time during the above serving of the meal was the written menu observed to be reviewed by cook G and dietary assistant H. Interview on 8/9/16 at 4:50 p.m. with cook G regarding the serving of the above fruit portion revealed she "always used the blue one [scoop]" when she had served fruit portions to the residents. Interview on 8/9/16 at 5:00 p.m. with the dietary manager regarding the serving of the fruit portion revealed the above blue scoop was a one-fourth cup serving size. 4. Interview on 8/10/16 at 9:20 a.m. with the dietary manager and the consultant registered dietitian regarding the written menus portion sizes revealed they agreed and confirmed: *The written menu needed to have been followed	F 363		

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F 363	Continued From page 10 for the correct food portion sizes to have been served. *Any deviation from the written menu for each resident needed to have been documented on the menu cards. *The portions had not been consistently served to those residents who received them. *That had been an area that needed improvement for the dietary staff to have followed the scoop serving sizes. *The menu needed to have been reviewed by the dietary staff for the correct serving size. Review of the provider's revised 4/9/14 Menu policy revealed the menu was to have been followed as written unless changes had been approved by the dietary manager.	F 363		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, manufacturer's instructions, and policy review, the provider failed to ensure sanitary conditions were maintained in the kitchen regarding expired foods. Findings	F 371		

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F 371	Continued From page 11 include: 1. Observation on 8/8/16 in the kitchen from 2:50 p.m. through 3:20 p.m. revealed: *A plastic wrap-covered stainless steel bowl that contained: -Approximately two pounds of sliced ham. -That bowl was marked on the top with a handwritten "Ham 7/30/16." *One plastic wrap-covered can of opened Glucerna nutritional drink that was: -Approximately one-third full of liquid. -Marked on the top with a handwritten "7/31/16." *A two quart (qt) plastic covered container that contained: -One qt cheese sauce. -That container was marked on the top with a handwritten "Cheese Sauce 7/29/16." *Ham, Glucerna nutritional drink, and cheese sauce were potentially hazardous foods. Interview on 8/10/16 at 9:20 a.m. with the dietary manager and the consultant registered dietitian confirmed and revealed they agreed: *The sliced ham was a leftover meat, and it should have been used in three days. -That ham had been in the refrigerator for nine days. *The opened Glucerna nutritional drink needed to have been used within forty-eight hours. -That can had been in the refrigerator eight days. *The cheese sauce should have been used within four days. -That sauce had been in the refrigerator ten days. *Potentially hazardous foods had included ham, Glucerna nutritional drink, and cheese sauce. Review of the September 2012 manufacturer's instructions for the recommended storage	F 371	The morning cook will review the food storage area three times weekly for appropriate labeling, dating and length of storage and record the completion of that review. The dietary staff responsible for reviewing the food storage will receive inservice education on 8/31/16 regarding food storage guidelines and use of the audit with those unable to attend having an individual review by September 7, 2016. The dietary manager will check all storage areas for correct food storage weekly. This review will be part of the ongoing quality improvement program and reported to the performance improvement committee monthly. The dietary manager will be responsible for the implementation of the Plan of Correction.	09/19/2016

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F 371	Continued From page 12 guidelines for the opened the Glucerna nutritional drink revealed: *Once the can had been opened it was: -To have been used immediately or refrigerated within two hours. -The refrigerated product was to have been discarded after forty-eight hours. Review of the provider's 10/18/13 Leftovers policy revealed: *Leftover foods were to have been stored and used according to safe food guidelines. *Leftover meat could have been kept in the refrigerator up to three days. Review of the provider's 10/19/13 Food and Supply Storage policy revealed: *All food was to have been stored in a manner that prevented contamination. *Manufacturers' expiration dates were to have been followed. *Potentially hazardous foods included meats and milk products.	F 371		

ORIGINAL

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

PRINTED: 08/23/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435120		08/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER MEMORIAL NURSING HOME	315 NORTH WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070

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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/10/16. Pioneer Memorial Nursing Home was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thomas V Ruba	CEO	8/26/16

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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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10698	A. BUILDING: _____ B. WING _____	08/10/2016

NAME OF PROVIDER OR SUPPLIER

PIONEER MEMORIAL NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

315 N WASHINGTON ST POST OFFICE BOX 368
VIBORG, SD 57070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/8/16 through 8/10/16. Pioneer Memorial Nursing Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas V Riehle

TITLE: CEO

(X6) DATE: 8/26/16