

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2016
NAME OF PROVIDER OR SUPPLIER EASTERN STAR HOME OF SOUTH DAKOTA, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 126 W 12TH AVENUE POST OFFICE BOX 150 REDFIELD, SD 57469	
(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	<p><i>*Addendums noted with an asterisk per 3/8/16 per telephone with KR facility administrator</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 22452</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/25/16 through 1/27/16. Eastern Star Home of South Dakota, Inc. was found not in compliance with the following requirements: F176, F278, F281, F309, and F441.</p>	F 000		
F 176 SS=E	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure the licensed nurse completed an assessment for the self-administration of medication for two of two sampled residents (4 and 5). Findings include:</p> <p>1. Review of resident 4's 4/9/15 and 12/8/15 physician's orders revealed "May self-administer Albuteral [medication for asthma or chronic obstructive pulmonary disease] nebulizer every four hours as needed [PRN] once set-up by staff."</p> <p>Review of resident 4's 5/6/15 physician's progress notes revealed: ***She is just completing a nebulizer treatment." ***She has pulled the nebulizer tube connection off."</p>	F 176	<p>F 176 RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>(1) On 2-16-16 an initial Self Administration of Nebulizer Treatment Assessment was completed by the Director of Nursing on Resident #4. The results of this assessment revealed that Resident #4 does not meet the criteria for self administration due to significantly impaired memory as per BIMS score. Resident #4's primary physician signed off on the assessment and Resident #4's care plan and MAR were updated on 2-16-16 to reflect this change.</p> <p>(2) On 2-16-16 an initial Self Administration of Nebulizer Treatment Assessment was completed by the Director of Nursing on Resident #5. The results of this assessment revealed that Resident #5 does not meet the criteria for self administration due to significantly impaired memory as per BIMS score. Resident #5's primary physician signed off on the assessment and Resident #5's care plan and MAR were updated on 2-16-16 to reflect this change.</p> <p>Since all residents have the right to self administer medications if deemed safe, the following actions were instituted to ensure safety of self administration of nebulizer treatments once set up by the nurse:</p> <p>- On 2-16-16 the Director of Nursing and Administrator reviewed and revised the Nebulizer Treatment Policy and Procedure to include the following changes: Removal of the per standing order indicating that residents may self administer nebs once set up by the nurse. Refer to the resident's Self</p>	

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

Mary Rice O'Donnell

TITLE

Administrator

(X6) DATE

2/18/2016

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.

FEB 22 2016

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F 176	<p>Continued From page 1</p> <p>"She had the mask twisted on her face and she does not like to do the nebulizer treatments at all."</p> <p>Review of resident 4's medical record revealed a nursing assessment had not been completed for the self-administration of the Albuteral nebulizer.</p> <p>2. Review of resident 5's medical record revealed.</p> <p>*Physician's orders signed and dated on 1/26/16 "May self-administer nebulizer once set up by staff."</p> <p>*Orders on the January 2016 medication administration record: - "May self administer nebulizer [breathing treatment] once set up by nursing staff." -"Albuterol 0.083% Inhal. [Inhalation] PRN [as needed] QID [four times a day]."</p> <p>*No assessment for self-administration of medication had been completed for the resident..</p> <p>3. Interview on 1/27/16 at 10:00 a.m. with the director of nursing (DON) regarding the self-administration of nebulizers revealed: *They did not do self-administration assessments on any residents who used nebulizers. *It was part of their standing orders that any resident could self-administer nebulizers once they were set-up. That meant the resident would be left alone in their room until all the medication in the nebulizer was completed. *The nurse would go back in after the medication in the nebulizer was completed, shut off the nebulizer machine, and rinsed the cylinder the medication was put in. *They had no problems with residents removing the mask when they were left alone in the room.</p>	F 176	<p>Administration of Nebulizer Treatment Assessment to determine if the resident is deemed capable of self administration of the nebulizer treatment once set up by the nurse.</p> <p>- Effective 2-16-16 the Director of Nursing will administer the Self Administration of Nebulizer Treatment Assessment to all residents having scheduled or PRN nebulizer treatment orders. This assessment will be administered initially upon receiving the order, quarterly and with significant change in condition. This assessment will include memory, identification of nebulizer treatment and physical limitations. The results of the assessment will be reviewed by the resident's primary care provider. If the resident is able to safely self administer nebulizer treatments once set up by a nurse, an order will be placed on the resident's MAR and the care plan will be updated.</p> <p>- The Director of Nursing will be responsible for completion of all Self Administration of Nebulizer Treatment Assessments and providing results of the assessment to each resident's primary care provider.</p> <p>- On 2-18-16 all nursing staff were trained in the newly revised Nebulizer Treatment and Self Administration of Nebulizer Treatment Policy and Procedure.</p>	<i>*currently K. J. JOHNSON</i>

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F 176	Continued From page 2 Review of the provider's 10/17/12 Self-Administration of Medication policy revealed: *"Residents have the right to request self-administration of their prescription or non-prescription medications." *"The interdisciplinary team determines if self-administration of medication is appropriate for residents." *"The interdisciplinary team will determine if the resident is capable of self-administration in a safe manner and if this is in the best interest of the resident."	F 176	The Restorative Nurse will be responsible for completing a minimum of one spot check per month to ensure that no residents are self administering nebulizer treatments without proper assessment and notation on the MAR and care plan. The Restorative Nurse will report findings to the QIC Committee a minimum of quarterly until the QIC Committee advises otherwise. Completion Date: 2-18-16	
F 278 SS=E	Surveyor: 29162 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	F 278	F 278 ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (1) Effective 2-17-16 Resident #1 will no longer be coded on the MDS as being on a urinary toileting program. (2) Effective 2-17-16 Resident #2 will no longer be coded on the MDS as being on a urinary toileting program. (3) Effective 2-17-16 Resident #9 will no longer be coded on the MDS as being on a urinary toileting program. (4) Effective 2-17-16 Resident #4 will no longer be coded on the MDS as being on a urinary toileting program. (5) Effective 2-17-16 Resident #6 will no longer be coded on the MDS as being on a urinary toileting program. Effective 2-17-16 no residents at this facility will be coded on the MDS as being on a urinary toileting program unless a specific individualized plan has been developed and implemented.	

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F 278	<p>Continued From page 3</p> <p>resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and manual review, the provider failed to ensure the Minimum Data Set (MDS) assessment had been completed accurately for five of nine sampled residents (1, 2, 4, 6, and 9). Findings include:</p> <p>Surveyor: 35121 1. Review of resident 1's 11/17/15 MDS assessment revealed she was: *On a urinary toileting program that had resulted in decreased wetness. *Frequently incontinent of urine.</p> <p>2. Review of resident 2's 12/1/15 MDS assessment revealed she was: *On a urinary toileting program that had resulted in decreased wetness. *Frequently incontinent of urine.</p> <p>3. Review of resident 9's 12/29/15 MDS assessment revealed he was: *On a urinary toileting program that had resulted in decreased wetness. *Frequently incontinent of urine.</p> <p>Surveyor: 22452 4. Review of resident 4's 1/16/16 annual MDS</p>	F 278	<p>On 2-17-16 the Director of Nursing developed a new Bowel and Bladder Policy and Procedure concerning the care of the nursing home residents at this facility. As per the policy, residents will be toileted or changed upon rising, before and/or after meals, at bedtime, during night rounds and PRN. Residents do not have specific bowel and bladder toileting programs unless specific individualized needs have been identified and individualized care plans have been developed and implemented. Documentation will be maintained on the Bowel and Bladder Flow Sheets noting that residents have been toileted or changed. Daily documentation will continue on the daily BM Log to prevent constipation.</p> <p>The Director of Nursing will be responsible for conducting a minimum of 2 spot checks monthly to ensure that residents are not coded on the MDS as being on a urinary toileting program unless a specific individualized plan has been developed and implemented. The DON will report findings to the QIC Committee a minimum of quarterly until the QIC Committee advises otherwise.</p> <p>Completion Date: 2-18-16</p> <p><i>*All residents have been assessed for urinary and bowel training programs. We currently have no residents on bowel and bladder training programs. KHS/SPD/HCL</i></p>	

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F 278	<p>Continued From page 4 assessment revealed she was: *On a urinary toileting program that resulted in decreased wetness. *Frequently incontinent of urine.</p> <p>Review of resident 4's January 2016 bowel and bladder flowsheet completed by the certified nursing assistants (CNA) revealed: *She was to have been assisted to the commode (portable toilet) upon arising, before and after meals, night rounds, bedtime, and as needed. *There was no documentation if she was continent or incontinent of urine each time she was assisted to the commode.</p> <p>Review of resident 4's 10/20/15 quarterly validation and 1/12/16 annual validation documentation by the MDS coordinator revealed: *"Currently on a toileting program of upon rising, before and after meals, bedtime [HS], night rounds, and as needed [PRN]." *"Resident is frequently incontinent of urine and bowels for this assessment."</p> <p>Interview on 1/26/16 with CNAs A and B regarding resident 4 revealed she: *Was almost always incontinent of urine when she was assisted unto the commode at the times documented on the bowel and bladder flowsheet. *Wore disposable underwear. Staff totally assisted her with changing them and providing perineal care.</p> <p>Surveyor: 29162 5. Review of resident 6's annual and quarterly MDS assessments revealed: *On 9/22/15 she was: -On a urinary toileting program that had resulted in decreased wetness.</p>	F 278		

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F 278	<p>Continued From page 5</p> <p>-Occasionally incontinent of urine.</p> <p>*On 12/22/15 she was:</p> <p>-On a urinary toileting program that resulted in decreased wetness.</p> <p>-Frequently incontinent of urine.</p> <p>Review of resident 6's January 2016 bowel and bladder flowsheet completed by the CNAs revealed:</p> <p>*She was to have been assisted to the commode upon arising, before and after meals, night rounds, bedtime, and as needed.</p> <p>*There was no documentation if she was continent or incontinent of urine each time she was assisted to the commode.</p> <p>Review of resident 6's Bowel & Bladder Elimination Pattern Evaluation form from 9/16/16 through 9/22/16 revealed she called for assistance to the toilet six to nine times per day. She had been continent of urine all of those times.</p> <p>Review of resident 6's current care plan revealed she had been incontinent of bowel and bladder with a toileting plan started on 1/6/15. She had required extensive assistance of one with toileting needs.</p> <p>Review of resident 6's medical record revealed there had not been an individualized toileting plan specific to her toileting needs.</p> <p>7. Interview on 1/26/16 at 4:20 p.m. with the MDS coordinator revealed:</p> <p>*She referred to the Resident Assessment Instrument manual for guidance completing the MDS.</p> <p>*The Bowel and Bladder Flowsheet filled out by</p>	F 278		

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F 278	Continued From page 6 the CNAs had been the same scheduled toileting used for all residents on a toileting plan. *The Bowel & Bladder Elimination Pattern Evaluation assessments completed for the residents at the time of their MDS had not been used to develop individualized toileting plans. *The toileting plans the above residents had been on were not specific and individualized to each resident. Review of the Version 1.13, October 2015, Resident Assessment Instrument (RAI) manual, pages 1 through 5, revealed: *“The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care.” *“The RAI helps nursing home staff look at residents holistically-as individuals for whom quality of life and quality of care are mutually significant and necessary.” The provider did not have a policy for toileting programs. One had been requested and had not been provided by the end of the survey. Surveyor: 22452	F 278		
F 281 SS=D	Surveyor: 35121 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: 22452	F 281		

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F 281	<p>Continued From page 7</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <p>*Professional standards were followed for the documentation of medication administration for nine of ten medication observations.</p> <p>*Physician's orders were followed for the administration of an anti-anxiety medication for one of one sampled resident (11).</p> <p>Findings include:</p> <p>1. Nine medication observations by licensed practical nurse (LPN) F on 1/26/16 from 11:15 a.m. through 5:08 p.m. revealed she documented all medications in the medication administration record (MAR) prior to administering them to the residents.</p> <p>Interview on 1/26/16 at 11:55 a.m. with LPN F regarding medication documentation revealed she:</p> <p>*Always documented medications prior to administering them to the residents.</p> <p>*Did that so she knew she had administered all the medications that had been ordered by the physician.</p> <p>*Was unsure what the policy for medication administration documentation was at the facility.</p> <p>*Had only worked at this facility for about a month.</p> <p>Review of the provider's 10/5/12 Medication Administration Process policy revealed:</p> <p>***"Always follow the RIGHTS of medication administration."</p> <p>***"Administer the medications to the resident. Administer medications to only one resident at a time and ensure the resident swallows the medication."</p> <p>***"Chart the administration on the MAR. This</p>	F 281	<p>F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>(1) On 1-29-16 the Director of Nursing counseled LPN F regarding the importance of following the Rights of Medication Administration as outlined in the facility's Medication Administration Policy & Procedure Guidelines. It was emphasized to LPN F that documentation may never be entered on the MAR prior to medication administration.</p> <p>(2) On 2-4-16 an order was received from Resident #11's primary care provider to discontinue Resident #11's HS order for Alprazolam 0.5 mg po. This order was based on the recommendation by the facility's consultant pharmacist on 1-29-16 during a routine monthly medication review which revealed that no GDR had been completed since 8-6-13.</p> <p>Since all residents are at risk if Medication Administration protocols are not strictly followed, the following actions were instituted:</p> <ul style="list-style-type: none"> - On 2-16-16 the DON and Administrator reviewed and revised the Medication Administration Policy and Procedure to include the following statement "All documentation of medication administration is done at the completion of the resident taking the medication via the prescribed route". - On 2-18-16 all nurses were trained in the newly revised Medication Administration Policy and Procedure. 	

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F 281	<p>Continued From page 8 completes the RIGHT documentation."</p> <p>2. Observation on 1/27/16 at 10:45 a.m. of resident 11's bottle of alprazolam 0.5 milligram (mg) in the medication cart revealed there was: *Documentation on the bottle it had been opened on 12/14/15 and had contained ninety pills. *Fifty-four pills remained in the bottle. *There should have been forty-six alprazolam pills left in the bottle if it had been administered according to the 8/6/13 physician's order.</p> <p>Review of resident 11's 12/14/15 through 1/26/16 MAR revealed there was: *Documentation she had received the alprazolam 0.5 mg every bedtime. *No documentation of the alprazolam being held or refused.</p> <p>Interview on 1/27/16 at 10:30 a.m. with the DON regarding resident 11 revealed: *She confirmed there were eight more pills of alprazolam left in the bottle than there should have been. *There should have been forty-six pills of alprazolam left in the bottle instead of fifty-four if it had been administered according to the physician's order. *The resident would not know due to her memory problems if she had received the alprazolam or not. *The additional eight pills left in the bottle were likely medication omissions. *Usually they did not count schedule IV medications every shift even if they were in a bottle if the resident received them routinely. *If a resident received an as needed (PRN) schedule IV medication it was counted every shift and the discrepancy would have been caught</p>	F 281	<p>Since all residents taking anti-anxiety medications are at risk without the facility's strict monitoring and storage of medications dispensed in bottles the following actions were taken.</p> <p>- On 2-16-16 the Director of Nursing and Administrator implemented a RX Bottle Medication Policy and Procedure. This policy and procedure requires that all Schedule III or IV medications that are received in a bottle will be sent to the facility's consulting pharmacy for unit dose (bubble) packing. All prescribed medications received in a bottle are documented on the medication reorder sheet under the "amount received" column with the date, number of pills received and the nurses signature. If the bottle of medication received is a Schedule III or IV, 2 nurses must sign the order form confirming receipt and amount received.</p> <p>- On 2-18-16 all nursing staff were trained in the new RX Bottle Medication Policy and Procedure.</p> <p>The Director of Nursing will be responsible for conducting a minimum of 2 spot checks per week to ensure that proper documentation of medication administrations are being completed per the facility Medication Administration Policy and Procedure. The DON will report findings to the QIC Committee monthly for 3 months and then quarterly until the QIC Committee advises otherwise.</p> <p style="text-align: right;">Completion Date: 2-18-16</p>	

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F 309 SS=G	<p>*They had no specific policy on following physicians' orders.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to assess, monitor, and manage one of one sampled resident's (4) chronic pain. Findings include:</p> <p>1. Observation on 1/26/16 at 2:15 p.m. of resident 4 revealed she: *Was sitting out in the hall outside her room in her wheelchair and voicing discomfort of pain especially in her left shoulder. *Was given her scheduled 2:00 p.m. hydrocodone (narcotic pain medication) by licensed practical nurse F. *Was assisted onto the commode (portable toilet) by certified nursing assistants (CNA) A and B with the use of a mechanical stand-up lift (requires resident to be able to bear some weight on legs). *Was showing facial grimacing while being transferred onto the commode, sitting on the commode, and when assisted off the commode back into her wheelchair.</p>	F 309	<p>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>(1) On 2-2-16 Resident #4 was assessed by the resident's primary care physician and an order was received for a Fentanyl Patch 12.5 mcg every 3 days to control Resident #4's chronic pain. The primary care physician increased Resident #4's Fentanyl Patch to 25 mcg every 3 days on 2-10-16. Resident #4 continues to have an order for Hydrocodone 10/325 1 tab every 4 hours PRN and Hot Wet Packs applied to shoulders PRN.</p> <p>Since all residents have the right to be free of pain and function at their highest level of well being, the following actions were instituted:</p> <ul style="list-style-type: none"> - On 2-16-16 the Director of Nursing and Administrator reviewed and revised the Pain Assessment and Management Policy and Procedure to include the following changes: A Pain Symptoms Monitoring Sheet will be completed 3 times per day by CNA staff. All staff are responsible to notify the Charge Nurse if any resident verbally or physically expresses pain or discomfort. The Charge Nurse is then responsible for further pain assessment and administration of scheduled or PRN pain medications or treatments as prescribed. - On 2-18-16 all staff were trained on the revised Pain Assessment and Management Policy and Procedure and Pain Symptoms Monitoring Sheet. 	

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F 309	<p>Continued From page 10</p> <p>*Was complaining of pain especially in her shoulders and was grabbing onto her left shoulder.</p> <p>Interview at that time with CNAs A and B regarding resident 4 revealed she:</p> <p>*Almost always complained of pain especially in her shoulders during any kind of transfer or movement.</p> <p>*Was assisted onto the commode at a minimum of four times a day and PRN.</p> <p>Review of resident 4's medical record revealed:</p> <p>*A 2/12/15 admission date.</p> <p>*Diagnoses: degenerative joint disease and rheumatoid arthritis.</p> <p>Review of resident 4's 2/12/15 physician's orders revealed:</p> <p>*Hydrocodone 10/325 milligrams (mg) three times a day (TID) at 8:00 a.m., 2:00 p.m., and bedtime (HS).</p> <p>*Hydrocodone 10/325 mg one tablet every four hours as needed (PRN).</p> <p>Review of resident 4's 8/13/15 physician's orders revealed "Hot wet packs PRN to bilateral shoulders."</p> <p>Review of resident 4's 10/20/15 and 1/11/16 Minimum Data Set (MDS) assessments section J regarding pain revealed:</p> <p>*10/20/15:</p> <ul style="list-style-type: none"> -Pain almost constantly in shoulders. -Have you had pain or hurting at any time in the last five days was answered yes. -Has pain made it hard for you to sleep was answered yes. -Has pain limited your day-to-day activities was 	F 309	<p>The Director of Nursing will be responsible for completing a minimum of 2 spot checks weekly to ensure that resident pain symptoms are reported to the Charge Nurse and the notified Charge Nurse has completed all prescribed interventions or reported findings to the resident's primary care physician. The DON will report findings to the QIC Committee monthly for 3 months and then quarterly until the QIC Committee advises otherwise.</p> <p style="text-align: right;">Completion Date: <u>2-18-16</u></p>		

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F 309	<p>Continued From page 11 answered yes.</p> <ul style="list-style-type: none"> -Intensity of worst pain over the last five days was documented moderate pain. *1/11/16:- -Pain almost frequently. -Have you had pain or hurting at any time in the last five days was answered yes. -Has pain limited your day-to-day activities was answered yes. -Intensity of worst pain over the last five days was documented moderate pain. <p>Review of resident 4's 2/12/15 through 1/19/16 nurses' notes revealed:</p> <ul style="list-style-type: none"> *2/12/15, "States she has pain all the time, but that it is tolerable at this time." *3/17/15, "Resident lying in bed, states she went to reach for her water and rolled out of bed onto the floor. States her legs and hips hurt. No complaints of pain when moving." *6/10/15, "Currently up in her wheelchair in her room. Resident offers complaints that she has been having a little more pain in her right middle finger. Doctor expressed to resident that it is arthritis and there really is not much we can do. Resident is currently on scheduled hydrocodone TID and may have a dose PRN. Reinforced to resident that if she is having increased pain needs to ask for something." *7/28/15, "Group exercise is offered and encouraged. She is not consistent with participation, however, when she does participate she tolerates this activity well. New contractures [body limitations] noted to her bilateral elbows." *8/12/15, "Resident examined by doctor. Expresses to doctor that she has been having a lot more pain in her shoulders. Order to have physical therapy [PT]. Scheduled for a PT evaluation [eval] on 8/13/15." 	F 309		

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F 309	Continued From page 12 *8/13/15, "Resident returned with PT instructions recommending hot wet packs to bilateral shoulders PRN and passive range of motion (PROM) and active exercises to bilateral shoulders PRN." 9/15/15, "Resident continues to deny any pain other than her normal arthritic pain. She does have severe arthritis in her left wrist." *9/28/15, "Resident poured water on floor and went to grab bed frame to stand up and wheelchair rolled back and resident slipped to the floor. When assessment was done able to do range of motion [ROM] to all extremities but when asked about pain stated it hurt everywhere including her great toe. Assist of two with gait belt to stand. Continues to complain of pain to left shoulder. She is inconsistent with answers." *10/8/15, "When asked about pain resident states she has pain all over which is her normal [norm]." *10/11/15, "Resident was sitting on the floor in her bathroom. CNA was helping resident to the restroom as her pants were wet. CNA stated she was changing resident's brief and provide perineal [peri] care with resident standing up when resident began to slide to the floor. Resident pleasantly confused." *10/13/15, "Resident currently up in wheelchair and confused per her norm. Resident states that she has pain all over which is also her norm. Resident is unable to explain if her pain is worse since her fall. Has had increased complication with transfers. Will start to use the stand-up aide for all transfers to help prevent injury to resident and staff." *1/12/16, "Group exercise is offered and encouraged, however she is not consistent with this activity. Individual exercises of pulleys and shoulder shrugs are completed four to six times per week. She tolerates these activities well. New	F 309			

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F 309	<p>Continued From page 13 contracture noted to her right knee."</p> <p>Review of resident 4's 6/10/15 through 12/8/15 physician's progress notes revealed: *6/10/15: -"Is having increased pain in the right hands, digits 2, 3, and 4 on the right hand. I did not attempt to try to straighten as even just basic touch increases her pain. Hands have slight contractures." -"We will go ahead and discuss with the nurses of being more liberal with the PRN hydrocodone along with the scheduled." *8/12/15: -"Chronic pain requiring narcotics." -"Complains of bilateral shoulder pain, ongoing and long term. Hands consistent with advanced degenerative joint disease." -"We will see her back in approximately a month to see how well the PT went." *10/6/15: -"Chronic pain requiring narcotics." -"Pain is reasonable well controlled with the daily hydrocodone." *12/8/15: -"The staff have no concerns for her."</p> <p>Review of resident 4's September 2015 through January 2016 MAR revealed documentation PRN hydrocodone was administered: *September 2015: None. *October 2015: Two times. *November 2015: One time. *December 2015: One time. *January 2016: None.</p> <p>Review of resident 4's September 2015 through January 2016 treatment administration records revealed no documentation the PRN hot packs to</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>her shoulders was offered to the resident or refused by her.</p> <p>Review of resident 4's 1/26/16 care plan revealed:</p> <ul style="list-style-type: none"> *Problem of complaints of pain to hips, knees, ankles, and shoulders. *Outcome would be for pain measures to be effective. *Administer pain medication as indicated per order and reposition frequently. *Pain assessment quarterly and PRN. *Assess characteristics of pain and report any changes to the charge nurse. *Monitor verbals and non-verbals (moaning, groaning, facial expressions, and guarding) and report promptly. *Non-medication interventions available and used PRN. *Memory deficit related to disorganized thinking. Is inattentive, forgetful, and confused. <p>Interview on 1/27/16 at 11:00 a.m. with the director of nursing regarding resident 4 revealed she:</p> <ul style="list-style-type: none"> *Was unaware the nursing staff were rarely administering the PRN hydrocodone for her daily pain. *Was unaware the PRN hot packs ordered by the PT had never been used. *Confirmed the physician had not been asked to change her pain medication regimen since her admission and likely should have been asked to. *Revealed the resident always complained about many things and was never satisfied when a problem was resolved. <p>Review of the provider's undated Pain Assessment and Management policy revealed:</p>	F 309		

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F 309	Continued From page 15 **"Purpose is to keep residents comfortable and pain free." **"It is the goal of all staff at this facility to keep residents pain free and comfortable." **"Pain assessments are done quarterly by the MDS coordinator and monthly on a resident's monthly summary by the charge nurse." **"All staff has been educated in pain, signs and symptoms of pain and alternatives for pain management." **"If pain is exhibited by the resident or expressed it is reported to the charge nurse for PRN pain assessment or pain medication.	F 309		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS Since all residents are at risk from the development and transmission of disease and infection, the following actions were instituted to ensure the proper cleaning of the whirlpool tubs and oxygen concentrators: - On 2-17-16 The Director of Nursing and Administrator reviewed and revised the Whirlpool Sanitation Policy and Procedure to follow all Manufacturer Guidelines and Recommendations. All Nursing Department staff are responsible for sanitizing the whirlpool after each use according to the Whirlpool Sanitation Policy and Procedure and properly recording that the sanitation was completed. - On 2-17-16 The Director of Nursing and Administrator reviewed and revised the Oxygen Concentrator Policy and Procedure to include the following change: The Charge	

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F 441	<p>Continued From page 16</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, and policy review, the provider failed to ensure: *Disinfection of two of two observed whirlpool cleanings by two of two certified nursing assistants (CNA) D and E. *The filters on two of four observed oxygen concentrators were cleaned. Findings include:</p> <p>1a. Observation and interview on 1/26/16 at 2:20 p.m. with CNA D regarding the disinfection of the whirlpool tub revealed she had: *Added disinfectant to the whirlpool tub by pushing the disinfectant button located on the side of the tub. *Filled water into the whirlpool tub to cover the seat of the chair. *Stated the disinfectant was set to dispense the proper amount to be mixed with water for disinfecting the whirlpool tub. *Confirmed she had not added any more</p>	F 441	<p>Nurse will be responsible for the monthly cleaning of the air inlet filter of any oxygen concentrator that is in use. The scheduled air inlet filter cleaning will be placed on the MAR and upon the completion of cleaning the air inlet filter the Charge Nurse will sign off on the MAR.</p> <p>- On 2-18-16 all Nursing Department staff were trained in the revised Whirlpool Sanitation Policy and Procedure and the revised Oxygen Concentrator Policy and Procedure. A copy of the revised Whirlpool Sanitation Policy and Procedure was posted in the Whirlpool Room.</p> <p>The Infection Control Nurse will be responsible for completing a minimum of 2 spot checks per week to ensure the proper disinfection of the whirlpool tub. The Infection Control Nurse will report findings to the QIC Committee monthly for 3 months and then quarterly until the QIC Committee advises otherwise.</p> <p>The Infection Control Nurse will be responsible for completing a minimum of 2 spot checks per month to ensure the proper cleaning of the air inlet filters of oxygen concentrators currently in use. The Infection Control Nurse will report findings to the QIC Committee monthly for 3 months and then quarterly until the QIC Committee advises otherwise.</p> <p style="text-align: right;">Completion Date: 2-18-16</p>	

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F 441	<p>Continued From page 17</p> <p>disinfectant to the water after she had filled the whirlpool tub.</p> <p>*Agreed the manufacturer's directions were posted on the bulletin board. She would have referred to them if she was not sure of the correct process.</p> <p>b. Observation and interview on 1/27/16 at 9:40 a.m. with CNA E regarding the disinfection of the whirlpool tub revealed she had:</p> <p>*Sprayed disinfectant on the inside surfaces of the whirlpool tub.</p> <p>*Filled water into the whirlpool tub to cover the seat of the chair.</p> <p>*Scrubbed surfaces with a brush.</p> <p>*Let the water sit with the air jets running for ten minutes.</p> <p>*Drained the water from the whirlpool tub.</p> <p>*Rinsed the inside of the whirlpool tub.</p> <p>*Dried the inside of the whirlpool tub and chair with a clean towel.</p> <p>*Pushed the disinfectant button located on the side of the tub for ten seconds.</p> <p>*Pushed the water button until the water had ran clear from the jets.</p> <p>*Rinsed the inside of the whirlpool tub.</p> <p>*Dried the inside of the whirlpool tub with a clean towel.</p> <p>*Stated:</p> <p>-She was trained to disinfect the whirlpool tub that way by CNAD and had no further training regarding the disinfecting of the whirlpool.</p> <p>-The CNAs had filled the spray bottle with disinfectant from a gallon sized bottle of disinfectant.</p> <p>*Confirmed the:</p> <p>-Directions on the disinfectant bottle stated to mix two ounces of disinfectant with one gallon of water.</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>*Spray bottle contained disinfectant that had not been diluted with water.</p> <p>*Manufacturer's directions were posted on the bulletin board, and she had not followed them.</p> <p>c. Interview on 1/27/16 at 10:55 a.m. with the director of nursing (DON) confirmed the above CNAs had not followed the manufacturer's instructions for disinfection of the whirlpool tub. She also confirmed the above CNAs did not follow the manufacturer's directions for mixing the disinfectant for use in a spray bottle.</p> <p>Interview on 1/27/16 at 11:05 a.m. with the infection control nurse confirmed the above CNAs had not followed the manufacturer's instructions for disinfection of the whirlpool tub. She also confirmed the above CNAs did not follow the manufacturer's directions for mixing the disinfectant for use in a spray bottle.</p> <p>Review of the manufacturer's Whirlpool Tub Cleaning Instructions effective 6/15/09 revealed:</p> <p>*Whirlpool tub cleaning was to be completed after every bath.</p> <p>*Disinfectant was to have been added by pushing the disinfectant button located on the left outer side of the tub until disinfectant flowed from all outlets.</p> <p>*Fresh water was to have been added to the tub until it just covered the intake valve.</p> <p>*They were to turn the pump on to circulate the solution for five to ten seconds, and then turn it off.</p> <p>*They were to use that solution to disinfect the tub and chair with a scrub brush.</p> <p>*Two ounces of disinfectant was to have been added to one gallon of water to spray hard to reach areas if it had been needed.</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>*The cleaning solution was to have remained in contact with all tub and chair surfaces for a minimum of ten minutes for thorough disinfection. *After ten minutes of contact time they were to thoroughly rinse all clean surfaces.</p> <p>Surveyor: 29162 3. Observation on 1/27/16 from 10:15 a.m. through 10:30 a.m. revealed two of four oxygen concentrator filters had been dusty. *In resident room 14 the oxygen concentrator filter was dusty. When it was removed from the concentrator by this surveyor particles of dust flew off of the filter. *The oxygen concentrator by the entrance to the dining room had been dusty. When the filter was removed from the concentrator by this surveyor dust particles flew into the air.</p> <p>Interview on 1/27/16 with licensed practical nurse C revealed she had been unsure when the filters on the oxygen concentrators were to have been cleaned. She stated "The DON would know."</p> <p>Interview and observation on 1/27/15 at 10:45 a.m. with the DON revealed: *The filters on the oxygen concentrators were to have been cleaned monthly. *She agreed when she saw the filter removed from the oxygen concentrator in the dining room it had been dusty.</p> <p>Review of the provider's undated Oxygen Concentrator policy revealed the filter was to have been "Washed in warm, soapy water monthly."</p>	F 441		

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OMB NO. 0938-0391

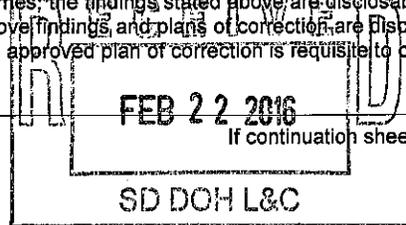
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2016
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NAME OF PROVIDER OR SUPPLIER EASTERN STAR HOME OF SOUTH DAKOTA, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 126 W 12TH AVENUE POST OFFICE BOX 150 REDFIELD, SD 57469
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/26/16. Eastern Star Home of South Dakota, Inc was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Mary Rice Osbonnell TITLE Administrator DATE 2/18/2016

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.



ORIGINAL

PRINTED: 02/10/2016
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2016
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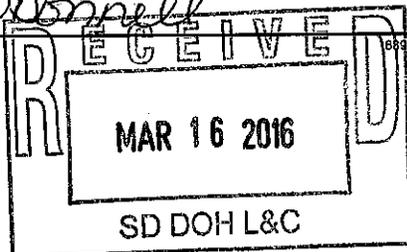
NAME OF PROVIDER OR SUPPLIER EASTERN STAR HOME OF SOUTH DAKOTA, II	STREET ADDRESS, CITY, STATE, ZIP CODE 126 W 12TH AVE POST OFFICE BOX 150 REDFIELD, SD 57469
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/26/16 through 1/27/16. Eastern Star Home of South Dakota, Inc was found not in compliance with the following requirement: S294.	S 000		
S 294	44:73:07:09 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, shall be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or qualified dietitian. Each planned menu shall be approved, signed, and dated by the dietitian for each facility. Any menu changes from month to month shall be reviewed by the dietitian and each menu shall be reviewed and approved by the dietitian at least annually if applicable. Each menu as served shall meet the nutritional needs of the residents in accordance with the physician's, physician assistant's, or nurse practitioner's orders and the Dietary Guidelines for Americans, 2010. A record of each menu as served shall be filed and retained for 30 days. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure written menus had been reviewed, approved, and signed annually by the dietitian. Findings include: 1. Review of the current menus in use revealed they had last been approved by the dietitian on 6/10/14.	S 294	S 294 WRITTEN MENUS On 2-9-16 the Consultant Dietitian signed and dated the current facility menus indicating that she had reviewed and approved them. On 2-18-16 the Dietary Consultant Agreement was revised by the Administrator to clarify that the Consultant Dietitian must review the menus "a minimum of annually". The Assistant Administrator will be responsible for completing one spot check quarterly to ensure that the facility menus are being reviewed and approved by the Consultant Dietitian at least annually. The Assistant Administrator will report findings to the QIC Committee quarterly until the QIC Committee advises otherwise. Completion Date: 2-18-16	

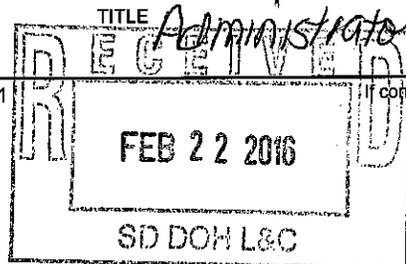
LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Mary Rice Osprey

STATE FORM



HLWC11



TITLE Administrator

(X6) DATE 2-18-2016

If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10670	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/27/2016
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NAME OF PROVIDER OR SUPPLIER EASTERN STAR HOME OF SOUTH DAKOTA, II	STREET ADDRESS, CITY, STATE, ZIP CODE 126 W 12TH AVE POST OFFICE BOX 150 REDFIELD, SD 57469
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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 294	<p>Continued From page 1</p> <p>Interview on 1/26/15 at 4:35 p.m. with the dietary manager revealed they had hired a new dietitian who had started in November 2015. There had been a period of time prior to her starting when they did not have a contracted consultant dietitian. She confirmed the last time the menus had been reviewed, approved, and signed by the dietitian was in June 2014.</p> <p>Interview on 1/26/15 at 4:50 p.m. with the administrator confirmed the above.</p> <p>Review of the provider's revised March 2014 Dietary Consultant policy revealed the consulting dietitian was to approve all menus. That policy did not state how often those menus were to have been approved.</p>	S 294		