

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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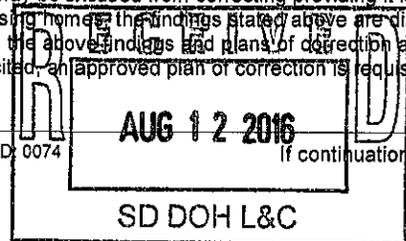
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F 000	INITIAL COMMENTS Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/18/16 through 7/20/16. Southridge Health Care Center was found not in compliance with the following requirement(s): F244, F281, F309, F323, F371, F441, and F514.	F 000	*Addendums noted with an asterisk per 8/18/16 per telephone with facility administrator, director of nursing, and assistant administrator. CS/SDDOH/EL	
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based interview, meeting minutes review, and policy review, the provider failed to ensure resident group and individual concerns regarding the timeliness of answering call lights was resolved. Findings include: 1. Telephone call on 7/18/16 at 10:30 a.m. with the ombudsman revealed: *He had attended the resident council meeting on 7/18/16. *The residents had concerns about how slowly the call lights were being answered. Interview on 7/19/16 at 10:00 a.m. with six residents in a group interview revealed:	F 244	All Resident call lights are to be answered in a timely fashion. All staff re-educated that it is everyone's responsibility to answer call lights. All staff will be re-educated on the importance of answering call lights by 8-13-16 and will be held responsible for any future complaints related to call light answering. Quality care rounds will be conducted weekly on 5 random residents related to call lights. Administrator will monitor call light wait times daily. The DON and/or designee will do an observation audit on each wing weekly to physically monitor by whom and when call lights are being answered. The facility policy/procedure on answering the call light was reviewed on 8-4-16 by the DON and the interdisciplinary team. The DON and/or designee will educate all facility staff on the updated policy and procedure by 8-13-16. Quality care round audits will be conducted weekly for 1 month on 5 *by social services director CS/SDDOH/EL	*8/13/16 CS/SDDOH/EL

*through the electronic call light system.
CS/SDDOH/EL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CFO	(X6) DATE 8-11-2016
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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 244	<p>Continued From page 1</p> <p>*They had concerns about how quickly call lights were answered. *It was not uncommon to wait twenty minutes for their call light to be answered. -It was more common around meal times. *They had talked about this in resident council many times. -Every time they were told they were working on it. -It had not gotten any better.</p> <p>Review of resident council meeting minutes revealed the following issues regarding call lights had been identified: *4/4/16: "Long wait times for call lights--STILL AN ISSUE. -In the evenings more of an issue. -In between supper and at shift change. -Certified nursing assistants (CNA) goofing off/wandering to do different wings to avoid answering call lights." *5/23/16: One resident stated "Need more CNAs as there aren't enough too long of wait times." -Another resident stated "CNAs ignoring call lights for half an hour or more." *7/28/16: "All lights do not get answered in a timely fashion."</p> <p>Interview on 7/20/16 at 8:15 a.m. with the emergency permit holder (EPH) revealed: *They were aware residents had concerns about how quickly call lights were being answered. *Their electronic audit of call lights revealed they were usually only on about three to four minutes. -Sometimes it was longer around meal times. *They had talked about the resident's concerns at their staff meeting. *He could not say for sure if they had done any observational audits of how quickly call lights</p>	F 244	<p>random residents, then monthly for 3 months on 10 random residents. Observation audits will be conducted weekly for 3 months on each wing to monitor call lights. The audits will be conducted by the DON and/or designee who will also be responsible for overall compliance. Any concerns brought up with audits or administrator monitoring call light times will be addressed immediately upon hearing/seeing concern.</p> <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 3 months and then as deemed necessary by the QAPI committee.</p>		

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F 244	<p>Continued From page 2 were answered.</p> <p>A confidential resident interview on 7/20/16 at 8:40 a.m. revealed: *Call lights were not answered in a timely manner. *A CNA might answer the light shortly after it was turned on, but they would turn it off and leave. -They did not help you at that time. -They told you they would be right back or they would send someone else in to help you. -Sometimes it took twenty minutes for them to come back, or they forgot. "I time them." -"I ask them not to turn the light off but they say they have to because the administrator gets a report that tells him how long a light was on, and they will get into trouble."</p> <p>Interview on 7/20/16 at 1:20 p.m. with the director of nursing (DON) and the assistant director of nursing/staff development coordinator revealed: *They had monitored call light response times through their electronic audits. *They were unaware that staff would have told residents about the administrator monitoring call lights. *Their social worker was completing ten quality of life interviews weekly. -They had not heard of any recent concerns from those interviews. *They knew call light wait times were longer around meal times. -The CNAs were all in the dining room at that time, leaving only the bath aide to answer lights. -There was no way the bath aide could get to everyone that might turn their call light on in a timely manner. *It was the DON's expectation that any staff who walked by a call light that was on would answer</p>	F 244			

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F 244	Continued From page 3 that light. -That included professional nurses. -They had not completed any kind of observational review to make sure licensed nurses actually answered the lights. Review of the provider's 1/22/16 Resident Council policy revealed: **Minutes include names of the council members and any guests present; issues discussed; recommendations from the council to the Administrator; and follow-up on prior issues. *The Administrator reviews the minutes and any responses from departments within the facility. Responses are presented at the next meeting or sooner, if indicated."	F 244	*All residents receiving fluid restrictions were reviewed on 8/4/16 to ensure physician orders were on EMAR/ETAR along with fluid monitoring each shift. Resident #14 has passed away. [REDACTED] CS/5004/EL All residents, new and long term, with fluid restrictions will be placed on EMAR/ETAR on day of order or day of admit along with how many cc's each department measures. All Residents EMARS/ETARS, care plans and pocket care plans will be updated by 8-13-16 for those that use or have fluid restrictions. Fluid restrictions will be documented in each of the resident's EMR and included on each EMAR/ETAR, care plan, and pocket care plan after the physician orders are obtained. The facility policy/procedure on Medication orders and when orders and treatments should be carried out was review/revised on 8-4-16 by the DON, interdisciplinary team and the Pharmacy Consultant. The DON and/or designee educated all facility staff who are responsible to assess, implement, and monitor the use of fluid restrictions on the updated policy and procedure by 8-13-16. [REDACTED] CS/5004/EL and noted orders to be sure orders are in place and being followed; that nurses, med techs, and all others that monitor fluid restrictions are following the Medication order
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: 33265 Based on interview, record review, and policy review, the provider failed to ensure one of one physician's order regarding fluid restriction for one of one sampled resident (14) was initiated in a timely manner. Findings include: 1. Review of resident 14's medical record revealed: *The resident had been admitted on 6/29/16 with heart failure and chronic obstructive pulmonary disease. *On 7/12/16 at 3:00 p.m. a physician ordered a	F 281	[REDACTED] CS/5004/EL *8/13/16 CS/5004/EL

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F 281	Continued From page 4 1200 milliliter fluid restriction. -The order was noted on 7/12/16, but the time that had been done was not documented. *No fluid measurement documentation was found until 7/14/16. Interview on 7/20/16 at 2:30 p.m. with the director of nursing (DON) revealed she would have expected a physician's order would be acted upon when written. A policy regarding physicians' orders was requested from the DON on 7/20/16 at 1:30 p.m. An undated policy regarding medication orders was the policy provided. Treatment orders had been listed in the policy but were not specific as to when orders were to have been acted on.	F 281	policy/procedure, that care plans and pocket care plans are up to date with fluid The audits will be conducted by the DON and/or designee who will also be responsible for overall compliance. [REDACTED] [REDACTED] The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 3 months and then as deemed necessary by the QAPI committee.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, policy review, and interview, the provider failed to ensure a signed contractual agreement was in place for one of one dialysis service provider. Findings include: 1. Review of the provider's 7/18/16 Facility	F 309	The facility will obtain/maintain contracts with all outside providers that it utilizes. Contract for Dialysis has been obtained from Sanford. Administrator and/or designee will review all contracts currently held for accuracy and compliance, and obtain new contracts for any new services provided by outside services. Administrator and/or designee will review all contracts currently held for accuracy and compliance, and obtain new contracts for any new services provided by outside services by 10-1-16. Dialysis policy/procedure was reviewed/revised on 8-4-16 and contract obtained by 8-13-16. The Administrator and/or designee will report findings of accuracy of contracts to QAPI committee in the month of October 2016, and monthly thereafter.	*8/13/16 CS/SDOCT/EL	

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F 309	Continued From page 5 Resident Dialysis information form revealed they had three residents receiving dialysis at the same location. Interview on 7/18/16 at 5:00 p.m. with the administrator revealed they did not have a contract with that dialysis provider. Review of the provider's 2/9/15 Care of Resident Receiving Dialysis services policy revealed it had not addressed the need for a signed contract for that service.	F 309	The Administrator and/or designee will be responsible for overall compliance. The results will be brought to the monthly QAPI meeting, starting in October 2016, by the Administrator and/or designee on a monthly basis for one year and then as deemed necessary by the QAPI committee if no further patterns persist.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, policy review, and Material Safety Data Sheet (MSDS) review, the provider failed to ensure chemicals were secured in five of five cleaning carts. Findings include: 1. Observation at the following times and dates revealed Quat disinfectant floor cleaner on the top shelf of the housekeeper's cleaning cart that had been left unattended: *7/19/16 at 7:30 a.m. near the east hallway public	F 323	All housekeeping carts have been replaced with new top locking carts. Environmental services cleaning guideline policy reviewed/ revised by 8-13-16. Administrator and/or designee will audit housekeeping carts and closets to ensure all are locked and all chemicals are secure. This audit will be done weekly x1 month then monthly x3. Administrator and/or designee will audit housekeeping carts and closets to ensure all are locked and all chemicals are secure. This audit will be done weekly x1 month then monthly x3. All staff affected will be educated on new/updated policy/procedure by 8-13-16. The Administrator and/or designee will be responsible for conducting audits and for overall compliance. The Administrator and/or designee will report audit findings at the monthly QAPI meeting for 3 months and then as deemed necessary by the QAPI committee	*8/13/16 CS/DOO/HCL

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F 323	Continued From page 6 bathroom. *7/19/16 at 7:45 a.m. in the east hallway. *7/19/16 at 10:05 a.m. outside resident room 301. *7/19/16 at 1:15 p.m. outside resident room 220. *7/19/16 at 1:40 p.m. outside resident room 105. *7/20/16 at 8:10 a.m. outside resident room 210. *7/20/16 at 8:30 a.m. by the east hall nurses station. *7/20/16 at 10:45 a.m. outside room 303. Interview on 7/20/16 at 8:10 a.m. with housekeeping staff K revealed the floor cleaner had been routinely kept on the top shelf of the housekeeping cart unsecured. Interview on 7/20/16 at 11:10 a.m. with the housekeeping supervisor revealed the floor cleaner routinely had been kept on the top shelf of the housekeeping cart. Review of the provider's undated Environmental Services Cleaning Guideline policy revealed: *All chemicals must be either in your possession or in a locked appropriate cabinet at all times. -That was to protect the residents who were confused from the potential exposure to hazardous chemicals. Review of the MSDS for the Quat floor cleaner revealed: *Might cause chemical eye burns. *Might cause chemical skin burns. *Might cause chemical gastrointestinal burns. *Contained a chemical or chemicals that could cause cancer. *Might be harmful or fatal if swallowed.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 7 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: 26180 Based on observation, interview, and policy review, the provider failed to ensure sanitary practices by two of four observed certified nursing assistants (CNA's) (I and J), and two of two dietary cooks (A and B) during two of two observed meal services. Findings include: 1. Observation of the supper meal on 7/18/16 in the memory care unit (MCU) revealed two CNA's (I and J) were distributing all of the supper trays to the residents. *CNA J: -Wore disposable gloves throughout the meal service. -Assisted several residents in setting up their trays. -Re-cued residents with eating if they stopped by them by taking their already used eating utensil and assisted them with taking a bite until they did it on their own again. -Sat down and fed resident 3. -Did not do any hand hygiene throughout the meal and wore the same pair of gloves. *CNA I:	F 371	CNA J and I were educated on a 1:1 basis on glove use, hand hygiene, and safe handling of food during meal times on 7-21-16. All CNA's educated on proper hand hygiene, glove use, and safe ways to carry dishes and handle food, with an in service by 8-13-16. Cook A and B were educated on a 1:1 basis about hand hygiene on 7-21-16. All other dietary staff educated on hand hygiene with meal service with an in service by 8-13-16. Hand Hygiene policy reviewed/ revised 8-4-16 and given to all staff to review and sign by 8-13-16. Policy on safe handling of food and dietary infection control reviewed/ revised on 8-9-16 and all staff updated on policy by 8-13-16. Audits will be conducted by DON and/or designee on CNA I and J and 3 other CNA's on safe/sanitary meal service and hand hygiene at meal times weekly x1 month then monthly x3. Audits will be conducted by dietary manager and/or designee on dietary staff Cook A and cook B and 3 other dietary aides for hand hygiene and safe/sanitary meal service weekly x1 month then monthly x3. DON and/or designee will be responsible for overall compliance. The DON, dietary manager, and/or designees will be responsible for overall compliance. Audits will be brought to QAPI x3 months then as deemed necessary by the QAPI committee.		

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F 371	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Assisted several residents in setting up their trays. -Re-cued residents with eating if they stopped by taking their already used eating utensil and assisted them with taking a bite until they did it on their own again. -Put her hands on the back of chairs, touched the shoulders of residents, picked up already used eating utensils, and handed them to residents. -On two occasions picked up sandwiches with her bare hands and handed them to the residents. -Performed no hand hygiene throughout the meal service. <p>Interview of CNA I on 7/20/16 at 9:30 a.m. revealed she confirmed she should have performed hand hygiene during the meal. She state should not have touched ready-to-eat food with her bare hands they would have been soiled.</p> <p>Interview on 7/20/16 at 11:00 a.m. of the certified dietary manager revealed: *The CNAs should have performed hand hygiene during that meal service. *They should not have touched ready-to-eat foods with their bare hands.</p> <p>Surveyor: 29354 2. Observation on 7/18/16 at 5:40 p.m. in the kitchen revealed dietary cook A plated the food for the memory care unit. Placed the plates into the cart and delivered the cart to the unit. She</p>	F 371		

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F 371	<p>Continued From page 9</p> <p>then returned to the kitchen and without washing her hands began preparing food for the Warren dining room.</p> <p>3. Observation on 7/19/16 at 11:50 a.m. in the kitchen revealed dietary cook B bent over and picked up the covers from the thermometer wipes from the floor, discarded the covers into the garbage, and without washing her hands began preparing food for the upcoming meal.</p> <p>4. Interview on 7/20/16 at 7:30 a.m. with the certified dietary manager regarding dietary cooks A and B revealed her expectations would have been to do hand hygiene before continuing with the food preparation.</p> <p>Review of the provider's 2015 Hand Hygiene policy revealed: *"Hand hygiene must be performed to avoid transfer of microorganisms to other residents, personnel, equipment and/or the environment. Specific examples include but are not limited to: -2. When hands are visibly soiled. -8. Before and after handling food. -9. Before and after assisting a resident with meals. -10. Before and after touching food to be given to a resident."</p> <p>Review of the provider's undated Use of Hand Antiseptic policy and procedure revealed: *"Policy: Staff will wash hands as frequently as needed throughout the day following the proper hand washing procedures." *"Procedure: Clean hands and exposed portions of arms immediately before engaging in food preparation including working with exposed food. -1. When to Wash Hands:</p>	F 371		

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F 371	Continued From page 10 --After handling soiled equipment or utensils. --During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. --When switching between working with raw food and working with ready to eat food. --After engaging in other activities that contaminate the hands." Review of the provider's undated Dietary Cook job description revealed: **Duties: -Be knowledgeable of Federal, State, and facility's rules, regulations, policies and procedures. -Follow defined safety codes while performing all duties."	F 371			
F 441 SS=E	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	F 441	CNAs C and D have been individually in-serviced on the hand washing policy and both employees have demonstrated correct hand washing technique to the infection control nurse on 7-21-16. In-service for all staff will be conducted by 8-13-16 on policy/procedure of isolation precautions, and hand hygiene. CNA E was individually in-serviced on proper whirlpool cleaning instructions by the infection control nurse on 7-21-16. Policy and procedure for cleaning whirlpool tub reviewed/revised on 8-8-16. All staff to be in serviced by 8-13-16 on updated policy/procedure. Employee F was individually in-serviced by the dietary manager on policy/procedure of isolation rooms on 7-21-16. In-service for all staff will be conducted by 8-13-16 on policy/procedure of isolation precautions, and hand hygiene.	*8/13/16 CS/SDD/HFC	

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

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2016
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F 441	Continued From page 11 (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 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Isolation procedures were followed according to the facility policy by one of one dietary aide (F) who had been in contact with one of one resident (18) with isolation precautions. *Manufacturer's instructions were followed for disinfecting one of one whirlpool tub during cleaning by one of one certified nursing assistant (CNA) (E). *Manufacturer's instructions were followed for glucometer cleaning by one of one licensed	F 441	Employee H was individually in-serviced on proper way to clean and disinfect glucometer between residents by DON on 7-21-16. Policy/procedure reviewed/revise on 8-8-16 and all nurses and med-techs in-serviced by 8-13-16 on policy/procedure of glucometer cleaning and disinfecting by DON and/or designee. CNAs C and D have been individually in serviced on the hand washing policy and both employees have demonstrated correct hand washing technique to the infection control nurse on 7-21-16. In-service for all staff will be conducted by 8-13-16 on policy/procedure of isolation precautions, and hand hygiene. CNA E was individually in-serviced on proper whirlpool cleaning instructions by the infection control nurse on 7-21-16. Policy and procedure for cleaning whirlpool tub reviewed/revise on 8-8-16. All staff to be in serviced by 8-13-16 on updated policy/procedure. Employee F was individually in-serviced by the dietary manager on policy/procedure of isolation rooms on 7-21-16. In-service for all staff will be conducted by 8-13-16 on policy/procedure of isolation precautions, and hand hygiene. Employee H was individually in-serviced on proper way to clean and disinfect glucometer between residents by DON on 7-21-16. Policy/procedure reviewed/revise on 8-8-16 and all nurses and med-techs in-serviced by 8-13-16 on policy/procedure of glucometer cleaning and disinfecting by DON and/or		

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

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OMB NO. 0938-0391

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F 441	<p>Continued From page 12 practical nurse (LPN) H. *Maintain hand hygiene for one of one sampled resident (2) during personal care by two of two CNAs (C and D). Findings include:</p> <p>1. Observation on 7/20/16 at 8:40 a.m. with dietary aid F revealed she: *Had entered resident 18's room without putting on gloves or a gown. *Emptied her water glass and brought that glass out to the hallway to fill with ice from a cooler on a cart. *Touched the top of the glass with the ice scoop. *Returned the ice scoop to the tray beside the cooler. *Returned to the resident's room and without gloves or a gown on, filled the glass with water. *Proceeded to next resident's room using the same ice scoop and ice in cooler. *Filled the resident's glass with ice while touching the scoop to the top of the glass. *Returned the glass to the resident's room and filled it with water.</p> <p>Interview on 7/20/16 at 8:50 a.m. with dietary aid F revealed she: *Was unaware resident 18 was on contact precautions. *Was unaware she should not have touched the glass with the ice scoop. *Had not seen the contact isolation sign or the gloves and gowns hanging on the door when she had entered the room.</p> <p>Interview on 7/20/16 at 9:10 a.m. with the dietary manager revealed: *She was unaware resident 18 was on contact isolation.</p>	F 441	<p>DON and/or designee will audit CNA C and D and 5 other random CNAs for proper hand washing techniques and appropriate times for hand washing weekly x 1 month then monthly x3 months.</p> <p>DON and/or designee will audit CNA E and 5 other random bath CNAs for proper whirlpool disinfecting techniques weekly x1 month then monthly x3 months.</p> <p>Dietary manager will audit dietary staff F and 5 other random dietary aides passing room trays and ice water to isolation rooms weekly for 1 month then monthly x3 months.</p> <p>DON and/or designee will audit Employee H and 5 other random Nurses or med-techs for proper cleaning and disinfecting of glucometers weekly x1 month then monthly x3 months.</p> <p>All staff will be educated on updated policies/procedures related to above by 8-13-16 by DON and/or designee.</p> <p>The DON, dietary manager and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report all audit findings at the monthly QAPI meeting for 3 months and then as deemed necessary by the QAPI committee.</p>	

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

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 13</p> <p>*Nursing had not informed her of the isolation precautions for that room.</p> <p>Interview on 7/20/16 at 9:20 a.m. with the infection control nurse revealed: *Everyone should have put gloves and a gown on when entering resident 18's room. *Staff were all educated on contact precautions. -Dietary aid F had attended an infection control in-service on 1/19/16. -The initial infection control inservice checklist which should have been completed upon hire could not be found in dietary aid F's file.</p> <p>Interview on 7/20/16 at 11:30 a.m. with the director of nursing (DON) revealed everyone should have put gloves and a gown on when entering a resident's room with any isolation precautions.</p> <p>Review of resident 18's complete medical record revealed: *On 6/22/16 the resident had moved to this room on the east wing. -She was on contact precautions at this time. *The resident had been on contact precautions since 2/5/16.</p> <p>Review of the provider's Infection Prevention and Control Orientation guidelines revealed to *Wear gloves when entering a room with contact precautions. *Gown if contact with immediate environment.</p> <p>Surveyor: 35121 2. Observation and interview on 7/19/16 at 8:12 a.m. with CNA E during disinfection of the center wing whirlpool revealed:</p>	F 441		

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

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 14</p> <p>*After she had scrubbed the whirlpool surfaces with the disinfectant mixture she:</p> <ul style="list-style-type: none"> -Set a timer for ten minutes. -Stated it needed to sit for ten minutes. -Would routinely leave the whirlpool room after she had set the timer. -Agreed there were surfaces of the whirlpool tub and whirlpool chair that had dried. -Did not know the whirlpool tub surfaces were to have remained wet for ten minutes. -Had been trained by another CNA approximately one year ago. -Had not had any additional training regarding disinfection of the whirlpool tub. <p>Interview on 7/20/16 with the infection control nurse confirmed the above CNA had not followed:</p> <ul style="list-style-type: none"> *The provider's whirlpool disinfecting policy. *The manufacturer's instructions for disinfecting the whirlpool. <p>Review of the provider's revised 11/8/12 Whirlpool/Shower Bathing policy and procedure revealed they were to "Disinfect the whirlpool after every use, following the whirlpool disinfecting procedure posted in the whirlpool room."</p> <p>Review of the revised 11/8/12 Whirlpool Disinfecting Procedure posted on the whirlpool room wall revealed they were to "Let disinfectant stay on surface for 10 minutes (or, as recommended by the instructions on the disinfectant concentrate container)."</p> <p>Review of the Penner Patient Care whirlpool disinfectant cleaner instructions revealed to "Wet all surfaces thoroughly. Allow to remain wet for 10 minutes."</p>	F 441			

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

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 15 Surveyor: 33265 3. Observation and review of the glucose monitor manufacturer's instructions on 7/20/16 at 10:55 a.m. with LPN H during a demonstration of cleaning the blood glucose monitor after use revealed: *She used Clorox Germicidal Wipes. *She used one towelette to wipe the monitor three times horizontally and then three times vertically. *She then disposed of the towelette and let the monitor dry three minutes. *She stated that was what the manufacturer's instructions were. *Review of the glucose monitor manufacturer's instructions revealed: -The wiping of the monitor three times horizontally and then vertically was the cleaning step. -The disinfection was described on the next page which LPN H had not been following. *Review of the Germicidal Wipe manufacturer's instructions on the container revealed the surface was to remain wet with the solution for three minutes. Interview on 7/20/16 at 2:30 p.m. with the director of nursing (DON) revealed she agreed LPN H had not been following the manufacturers' instructions for cleaning the glucose monitors after being used. Review of the provider's 1/20/16 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed reusable items were to be cleaned and disinfected or sterilized between residents.	F 441			

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

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 16 Surveyor: 29354 4. Observation on 7/19/16 from 8:10 a.m. through 8:28 a.m. with CNA's C and D assisting resident 2 revealed: *From 8:10 a.m. through 8:25 a.m. both CNAs entered the resident's room. *The resident was lying on her back in bed. *Without performing hand hygiene CNA D put on a pair of gloves and assisted the resident with partially putting on her pants, socks, and shoes. *CNA C washed her hands and put on a pair of gloves. She then: -Placed a wash cloth under water, applied a cleansing cream, and then she: -Placed the wet wash cloth on the side of the bed. -Assisted the resident to reposition turning to her right side. -Unfastened the tape of the brief and partially removed it from her lower perineal (peri) area. -Took the wash cloth and cleansed the front peri area. *CNA D then removed the wet brief discarded it into the garbage. *CNA C then: -Wiped her buttock area with the same wash cloth as above. -Took a bottle of barrier cream, applied it to her gloved hand, and then applied it to her buttock. -Assisted the resident to turn onto her back. *Both CNAs assisted with applying a new brief and adjusting her pants. *CNA C removed her gloves and without performing hand hygiene applied a new pair of gloves. *CNA D removed her gloves and without performing hand hygiene placed a gait belt around the resident's waist. *Both CNAs assisted her to:	F 441		

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

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Transfer from the bed to the wheel chair. -Put on her shirt and sweater. *CNA D took a comb and styled the resident's hair. *CNA C made her bed. <p>At 8:25 a.m. CNA D without performing hand hygiene assisted resident 2 from her room to the dining room. CNA D then:</p> <ul style="list-style-type: none"> -Poured a cup of coffee for the resident. -Continued to get coffee, drinking straws, and beverages for other residents in the dining room. <p>At 8:28 a.m. without performing hand hygiene CNA D sat down beside a random resident in the dining room and began to assist that resident with eating.</p> <p>Interview on 7/20/16 at 10:00 a.m. with the DON and infection control nurse regarding the above observations revealed:</p> <ul style="list-style-type: none"> *The DON's expectations would have been for the CNAs to have performed hand hygiene as soon as the soiled brief had been changed. *Both agreed the CNAs should have performed hand hygiene during the above events. *CNA D should have sanitized her hands before assisting residents in the dining room. <p>Review of the provider's 2015 Hand Hygiene policy revealed:</p> <ul style="list-style-type: none"> *"Hand hygiene must be performed after touching body fluids whether or not gloves are worn; immediately after gloves are removed, and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or environment. Specific examples include but are not limited to: *When hands are visibly soiled. 	F 441		

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

PRINTED: 08/02/2016
FORM APPROVED
OMB NO. 0938-0391

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F 441	Continued From page 18 *Before and after direct resident care. *Before and after entering isolation precaution settings. *Between contacts with different residents in high risk areas. *Before and after assisting a resident with meals. *Before and after touching food to be given to a resident. *Before and after assisting a resident with personal cares (peri-care). *Before and after assisting a resident with toileting. *After contact with a resident's body fluids." Review of the provider's undated Perineal Care policy revealed: *"2. Wash and dry your hands thoroughly. * 7. Put on gloves. *12. Remove gloves and discard into designated container. Wash and dry your hands thoroughly."	F 441			
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; accurately documented; readily accessible; and systematically organized. 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.	F 514	Resident #3, #5 and #8's medical records were reviewed for discrepancies and staff making errors was educated on fixing errors promptly. Resident #3 and #4's charts were reviewed for late entries and staff making late entries was educated on needing to have entries in within a 7 day window. All notes for all Residents' medical records will be monitored on a daily basis, notes from Saturday and Sunday reviewed on Monday, for accuracy and timeliness by DON and/or designee. Policy/procedures related to charting and documentation, along with registered dietician's job description were reviewed/ revised on 8-8-16. Agreement made with registered dietician to have all notes in residents medical record within 7 days. All staff educated on policy/procedure updates by 8-13-16.	*8/13/16 CS/SDO/PA	

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

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F 514	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and policy review, the provider failed to ensure: *An accurate medical record for 3 of 14 sampled residents (3, 5 and 8). *Medical notations were entered within an appropriate time frame for 2 of 14 sampled residents (3 and 4). Findings include:</p> <p>1. Interview and review of resident 5's medical record on 7/20/16 at 2:30 p.m. with the director of nursing (DON) revealed: *On 3/21/16 there was a notation involving the replacement of a urinary catheter. *On 3/22/16 there was a notation involving a change in hospice diagnosis. *The DON stated the resident had not had a urinary catheter or been placed on hospice. *She agreed those notations were regarding another resident not resident 5.</p> <p>2. Interview and review of resident 8's medical record on 7/20/16 at 2:30 p.m. with the DON revealed: *Both a DNR (do not resuscitate) and full code (do resuscitate) were documented on the physician's order summary sheet, the medication administration record, and the treatment record for July 2016. *She agreed that was an error and only one should have been identified as the current treatment.</p>	F 514	<p>Residents #3, #4, #5, #8, and 4 random residents will be audited weekly x1 month then monthly x3 months for accurate and complete notes made in medical record along with accurate advance directives. The DON and/or designee will audit IPN notes on a daily basis, notes from Saturday and Sunday reviewed on Monday, for accuracy and timeliness for 1 month and then monthly x3 months to ensure accuracy and timeliness of notes placed in medical record.</p> <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 3 months and then as deemed necessary by the QAPI committee.</p>		

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

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F 514	<p>Continued From page 20 Surveyor: 26180 3. Review of resident 3's medical record revealed: *5/4/16: "Resident continues with right arm in a splint." *5/5/16 at 2:50 a.m.: "Resident alert to person only up per usual routine staff anticipates all wants and needs 1/2 cast and ace wrap to right arm." *5/5/16 at 9:50 a.m.: "Resident continues with right arm in a splint." *5/6/16: "Resident up per usual routine no noted grimacing or s/s [signs and symptoms] or discomfort is able to move all extremities right arm remains in 1/2 cast."</p> <p>Interview on 7/18/16 at 1:45 p.m. with the director of nurses and review of resident 3's 5/25/16 physician's orders revealed: **"Splint on one more week then d/c [discontinue]." *She confirmed the resident had a splint on. *The medical record should have been documented accurately.</p> <p>4. Review of resident 3's medical record revealed there was not a dietary assessment completed by the consulting registered dietitian (RD) from July 2015 until the present.</p> <p>Interview on 7/18/16 at 11:25 a.m. and medical record review of resident 3 with the consulting RD revealed: *She knew she had assessed the resident in May. *She was unable to find that assessment in the medical record. *At 11:35 a.m. she left a note for this surveyor saying the assessment was now in the resident's</p>	F 514			

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

PRINTED: 08/02/2016
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2016
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
(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 514	<p>Continued From page 21 medical record. -A review of that medical record at that time revealed a Late Entry 7/18/16 at 11:33 a.m. a dietary assessment completed by the RD on 5/25/16.</p> <p>Interview on 7/19/16 at 4:30 p.m. with the certified dietary manager revealed: *The RD came to the facility every Monday for their Nutrition at Risk meeting. *Whenever there was a resident that had nutritional concerns she notified the RD. *When the RD was in the building she gathered all the information on a resident that she needed to do her nutritional assessment. *The assessments were done remotely, away from the facility. *The RD was always available when she was contacted but was not available in the facility for a lot of time because of her other commitments. *The RD's practice was always to complete her documentation, but it was always available to staff at a later time when the RD had the time to put the assessment in the electronic record. *Almost all of her assessments were entered as a Late Entry.</p> <p>Surveyor: 29354 4. Review of resident 4's medical record revealed: *She had diagnoses of diabetes, congestive heart disease, and stage three kidney disease.</p>	F 514		

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

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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
(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 514	<p>Continued From page 22</p> <p>*She had a weight gain of 10.5% in three months. *She received a concentrated carbohydrate diet. *Documentation by the registered dietitian (RD) dated: -7/19/16 with "Late Entry For 6/10/16 8:00." -3/7/16 with "Late Entry For 3/2/15 15:14 (3:14 p.m.).</p> <p>Review of the provider's 7/8/15 Charting and Documentation policy revealed: **"All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. -Documentation Criteria: --6. Documentation of procedures and treatments shall include care-specific details."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, pp.348 and 352, revealed: *P.348: -"Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve clinical data, maintain continuity of care, track patient (resident) outcomes, and reflect current standards of nursing practice. -Information in the patient record provides a detailed account of the level of quality of care delivered to patients." *P. 352: -"Timely entries are essential in a patient's ongoing care. -Delays in documentation lead to unsafe patient care."</p> <p>Review of the provider's 10/23/13 Role of the Consulting Dietitian job description revealed "Our facility's Dietitian is responsible for, but not</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
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F 514	Continued From page 23 necessarily limited to assessing nutritional needs of residents."	F 514			

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

ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105	
(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: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/20/16. Southridge Health Care Center 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

TITLE

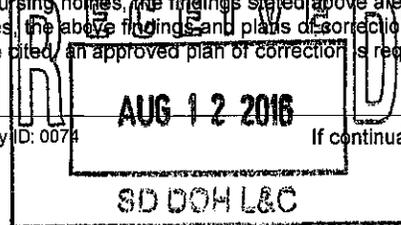
(X6) DATE

[Handwritten Signature]

[Handwritten Title: CTO]

[Handwritten Date: 8-11-2016]

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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SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10682	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3900S NORTON AVENUE SIOUX FALLS, SD 57105
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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: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/18/16 through 7/20/16. Southridge Health Care Center was found not in compliance with the following requirement: S315.	S 000	*Addendums noted with an asterisk per 8/18/16 per telephone with facility administrator, director of nursing, and assistant administrator. CS/SDDOH/EL	
S 315	44:73:08:04 Storage and Labeling of Medication and Drugs All drugs or medications shall be stored in a well illuminated, locked storage area that is well ventilated, maintained at a temperature appropriate for drug storage, and inaccessible to residents, or visitors at all times. Medications suitable for storage at room temperature shall be maintained between 59 and 86 degrees Fahrenheit (15 and 30 degrees centigrade). Medications that require refrigeration shall be maintained between 36 and 46 degrees Fahrenheit (2 and 8 degrees centigrade). Poisons and medications prescribed for external use shall be stored separately from internal medications, locked and made inaccessible to residents. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to maintain medications at the required range: *In one of three observed medication rooms (center). *In three of three (center, east, and Warren) observed refrigerators for the storage of medications. Findings include:	S 315	In center medication room 2 refrigerators have been removed and a thermometer placed to monitor the room temp on a daily basis as to keep temperature between 56-86 degrees F. A thermometer has been placed in all medication rooms and is monitored on a daily basis to ensure all medications are stored at proper room temperatures, between 56-86 degrees F. New temperature monitoring logs have been placed for all refrigerators (medication, food, therapy, resident) to be monitored on a daily basis and for accurate temperature range (between 36-46 degrees F.) Refrigerator and Medication room policy/procedure reviewed/ revised on 7-21-16 and all staff will be educated on updated policy by 8-13-16. DON and/or designee will audit refrigerator temperature monitoring and medication room temperature monitoring weekly x1 month then monthly x3 months. DON and/or designee will audit refrigerator temperature monitoring and medication room temperature monitoring weekly x1 month then monthly x3 months for each medication room and refrigerator.	*8/13/16 CS/SDDOH/EL

*The nurse will be responsible for daily monitoring.
CS/SDDOH/EL

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

Bruce Gray

STATE FORM

8899

BY (M)

TITLE

(X6) DATE

RECEIVED
AUG 12 2016
SD DOH L&C

8-11-2016

If continuation sheet 1 of 4

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10682	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3900S NORTON AVENUE SIOUX FALLS, SD 57105
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S 315	<p>Continued From page 1</p> <p>1. Observation on 7/20/16 at 11:00 a.m. of the center wing medication room with registered nurse G revealed:</p> <ul style="list-style-type: none"> *The temperature was 89 degrees Fahrenheit (F) in the room, according to the thermometer on the wall. *There was a tackle box filled with emergency medications on an upper shelf of a cupboard. *Other medications were stored on the counter in containers. *The air vent in the ceiling was checked and observed to be in working order pulling air out of the room. <p>Interview with the director of nursing during observation of the center wing medication room on 7/20/16 at 2:45 p.m. revealed:</p> <ul style="list-style-type: none"> *The temperature in the cupboard on the shelf with the emergency medication container was 88.7 degrees F. based on the surveyor's digital thermometer. *Moving the digital thermometer out of the cupboard and into the room caused the temperature on the digital thermometer to rise to 89.5 degrees F. *She stated the maintenance director had checked the temperature once today between 11:00 a.m. and 2:45 p.m. and had gotten 87.2 degree F. *She agreed the center medication room was above the 86 degrees F. upper range limit for the storage of medication. <p>Review of the center wing medication refrigerator temperature logs from 1/1/16 to 7/19/16 revealed:</p> <ul style="list-style-type: none"> *Throughout the documentation the log form was not being accurately filled in to identify the required temperature range, location of the refrigerator, month, and year. *During the seven months reviewed: 	S 315	<p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 3 months and then as deemed necessary by the QAPI committee.</p>	

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NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3900S NORTON AVENUE SIOUX FALLS, SD 57105
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S 315	<p>Continued From page 2</p> <p>-Seventeen of the two hundred and one days had not been filled in. -One of the two hundred and one days the temperature had been above the 36 to 46 degree F. temperature range. -Twelve of the two hundred and one days had been below the 36 to 46 degree F. temperature range.</p> <p>2. Review of the Warren wing medication refrigerator temperature logs from 1/1/16 to 7/19/16 revealed: *Throughout the documentation the log form was not being accurately filled in to identify the required temperature range, location of the refrigerator, month, and year. *During the seven months reviewed: -Eighteen of the two hundred and one days had not been filled in. -Two of the two hundred and one days the temperature had been above the 36 to 46 degree F. temperature range. -Three of the two hundred and one days had been below the 36 to 46 degree F. temperature range.</p> <p>3. Review of the east wing medication refrigerator temperature logs from 1/1/16 to 7/19/16 revealed: *Throughout the documentation the log form was not being accurately filled in to identify the location of the refrigerator and the year. *During the seven months reviewed twenty-two of the two hundred and one days had not been filled in.</p> <p>4. Interview and temperature record reviews on 7/20/16 at 2:30 p.m. with the DON revealed she agreed the: *Temperature was not being consistently</p>	S 315		

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S 315	<p>Continued From page 3</p> <p>maintained within the 36 to 46 degrees F. range in the medication refrigerators.</p> <p>*Temperature was not being consistently documented on the medication refrigerator log forms.</p> <p>*Log form was not being accurately filled in to identify the required temperature range, location of the refrigerator, month, and year.</p> <p>Review of the undated Refrigerator Cleaning policy revealed:</p> <p>*Refrigerators were to be kept between 36 to 46 degrees F.</p> <p>*If out of range they were to readjust the thermostat and check in one hour.</p> <p>*If refrigerator continued out of range they were to move the contents to another refrigerator and notify maintenance.</p> <p>*Which refrigerators that referred to was not identified.</p> <p>*How often the refrigerator temperatures were to be documented was not identified.</p> <p>A policy regarding the medication room temperature was requested from the DON on 7/20/16 at 1:30 p.m. No policy was received before the end of the survey.</p>	S 315		