

435102

B. WING

07/21/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

STURGIS REGIONAL SENIOR CARE

949 HARMON STREET
STURGIS, SD 57785(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETION
DATE

F 000

INITIAL COMMENTS

Surveyor: 23059

A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/19/16 through 7/21/16. Sturgis Regional Senior Care was found not in compliance with the following requirement(s): F240, F241, F250, F281, F309, F314, F325, F332, F441, and F490.

F 240
SS=E483.15 CARE AND ENVIRONMENT PROMOTES
QUALITY OF LIFE

A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

This REQUIREMENT is not met as evidenced by:

Surveyor: 18560

Based on observation, interview, and resident council minutes review, the provider failed to promote a dining experience that enhanced the residents' quality of life for two of two meal services observed. Findings include:

1. Interview on 7/19/16 at 8:30 a.m. with the certified dietary manager revealed meals were served in one dining room now. Previously two dining rooms had been used for the meal service. There would be a first seating and a second seating.

Interview on 7/19/16 at 2:40 p.m. with a random group of residents revealed concerns related to their dining room experience. Their concerns

F 000

Addendums noted with an asterisk per 8.11.16 telephone to facility interim DON.
VA/SD DOH

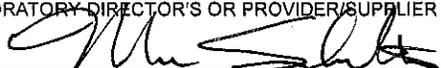
F 240

*
F240- Food Service and Nursing will work together to provide a team of leadership and caregivers that will allow residents to be served their meals in a timely and organized process. The leadership position would guide the flow of the dining room by directing caregivers according to the needs of the residents. Residents will be able to make menu selections prior to the meals, which will in turn allow food service to have more accurate count of items needed. Creation of the hostess, transporter, and servers to work in correlation of providing meals to residents to include delegation of tasks from hostess to staff for timely delivery of menu choices and service of meals. Hostess is responsible for seating of residents as entering dining area (prevention of confusion to residents on where to sit), menu delivery for resident choice meals, drink choices, throughout meal process. Delegates tasks to the interdisciplinary team to include servers (2) and transporter. Servers are responsible for delivery of menu to resident for meal choice then to dietary for delivery. Servers are responsible for the delivery of meal to residents, assist with set up and assistance with intake of meal to include sitting at eye level and communication with resident during meal intake. Transporter is responsible to assisting residents to and from meals as the direction of the hostess. Residents will be provided information on the dining experience changes to occur in the next resident council meeting to be held 8/18/16. VA/SD DOH

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

TITLE

(X6) DATE



Administrator

8-5-16

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F 240	<p>Continued From page 1 included: *There was only one dining room now and that was in the Massa Unit. *The old Berry dining room was used for activities. *Seating was based on first-come, first-served but had not always happened that way. *They no longer had assigned seats or name tags at the tables. *There was a lot of confusion when meals were served. *It took a lot of time to serve meals. *The second seating could go as late as 7:30 p.m. or 8:00 p.m. for evening meals. *It was not the restaurant style as had been promised. *They felt they had to hurry and eat. *Once one had finished eating it was difficult to get out of the dining room. *"It's the stupidest thing they've ever done."</p> <p>Review of the residents' council meeting notes related to the meal service revealed the following residents' comments: *On 3/17/16: -"Some prefer staying in their own room as it is too busy in the dining room." *On 4/21/16: -"Kitchen is too slow, four people at a table and one gets their meal and the others have to wait. New residents get the empty seat and get their meal first." -"We have to wait too long for the meal. A couple residents did not receive a meal. The kitchen is slow. We have to wait 45 minutes for a meal." -"We need a bigger space for meals and it needs to be organized." *On 5/19/16: -"Food is cold (room trays) in the morning, food</p>	F 240	<p>F0240 – The policy and procedure called the “Sturgis Food Services” will be updated and implemented by August 12, 2016. The policy will be educated on and will have an in-service by August 12, 2016. The meal service will be served in a timely manner and improved for the resident dining experience. Nursing will record resident food intake at each meal. Residents eating 50% or less of their meal will be offered a supplement. All Senior Care staff will be trained on expectations of the dining experience, change in menu selection process, hand hygiene and food handling in the dining room, proper cleaning and sanitizing of tables, proper recording of food intake percentages, dignity and respect by Aug 12, 2016. To ensure the facility is meeting needs and preferences of residents and family advocates, weekly surveys will be done by 10% of the resident and or their family members. The Concerns will be followed up with the dining experience committee and results reported to the QA/PI committee. Timelines of the meal service will be audited on the dining experience will be done on 25% of the meals by the DON, Food Service Operations Manager, and assigned nursing designee. Audits will then be reviewed by the dining experience committee and follow up done with results being reported to the QA/PI committee monthly. The dining experience committee will meet weekly until present issues are solved and will continue to meet no less than monthly through Aug of 2017.</p>	8/13/16

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F 240	<p>Continued From page 2</p> <p>temperature at lunch time okay.</p> <ul style="list-style-type: none"> -Food temperature in dining room at lunch time is mostly okay. -It is cold in the dining room in the morning. -Food is served late. -People who came in after others were served first. -Do not get what is circled on the menu. -Bread is served with no butter. -Do not get to sit with people who can converse with me. -Feel rushed to eat, like cattle being herded in and out. -It is too crowded in dining room. -Food should be more important than activities, time to relax, socialize. -Sometimes the meat is tough to eat. -Maybe we should see how they do it somewhere else." <p>Surveyor: 32355</p> <p>2. Observation on 7/19/16 from 11:30 a.m. through 12:57 p.m. at the Berry unit nurses' station revealed eight unidentified residents had been sitting in their wheelchairs (w/c) during that time.</p> <p>Interview on 7/19/16 at 12:50 p.m. with registered nurse (RN) D revealed:</p> <p>*She had confirmed:</p> <ul style="list-style-type: none"> -There was only one dining room for all the residents to eat in. -Those eight residents had been waiting to go eat dinner. -It was not uncommon for the residents to sit and wait to go eat their meal. -There was no system in place for who ate their meal first. <p>*She had stated:</p>	F 240	See page 2	

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F 240	<p>Continued From page 3</p> <p>- "There really is no rhyme or reason for the meal service."</p> <p>- "Basically it's first-come, first-served."</p> <p>- "Usually some of the residents are still down eating their lunch at 1:45 p.m."</p> <p>Observation on 7/19/16 from 5:30 p.m. through 7:00 p.m. of resident 2 revealed:</p> <p>*He had been sitting in his w/c at the Berry unit nurses' station.</p> <p>*He had not been:</p> <p>- Taken to the dining room to eat his supper until 6:45 p.m.</p> <p>- Served his supper until 7:00 p.m.</p> <p>Surveyor: 29162</p> <p>3. Interview on 7/19/16 at 5:25 p.m. and again at 6:15 p.m. during the evening meal in the Massa dining room with resident 24's husband revealed he stated:</p> <p>***"This is terrible. Not one person is happy. It's a jungle."</p> <p>***"We have got to get out of here, so someone else can eat."</p> <p>Surveyor: 23059</p> <p>4. Observation on 7/19/16 at 11:40 a.m. revealed there were several residents seated in the Massa unit dining room. Continued observation at that time revealed:</p> <p>*The posted start of meal time was 11:45 a.m.</p> <p>*Some residents were completing menus for what they wanted for lunch. Drinks were being served at that time.</p> <p>*Meal service began at 11:58 a.m. with the first resident served.</p> <p>*The table where men were primarily seated was</p>	F 240	See page 2	

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F 240	<p>Continued From page 4</p> <p>served first. Residents were not served on a first-come, first-served basis.</p> <p>*Interview with a random resident at the above time revealed "It doesn't matter when you come in. You will get served when they are ready." She stated she had been seated in the dining room since 11:30 a.m. before many other residents had come in.</p> <p>*As residents completed eating their meal they left their place at the table. That place setting was removed, and the dirty dishes were taken to an area outside the door of the dining room.</p> <p>*At 12:20 p.m. there were five residents seated in recliners or wheelchairs outside the dining room by the nurses station. An aide came out at that time and said "Who can come in? We have an open spot." No residents were escorted in at that time.</p> <p>*At 12:25 p.m. a full table was empty in the dining room and was being cleaned off. Residents were not seated at that table until 12:30 p.m.</p> <p>5. Observation of the evening meal service beginning at 5:30 p.m. on 7/19/16 revealed:</p> <p>*Multiple residents were seated at tables in the dining room. Menus were being completed and drinks were being served.</p> <p>*The posted start time of the meal was 5:30 p.m.</p> <p>*Meal service began at 5:45 p.m.</p> <p>*The men's table was served first as it had been at the noon meal observation.</p> <p>*One man at that table had not received his meal at the same time as his tablemates. He was still waiting to be served at 6:07 p.m.</p> <p>*At that same time the above resident was told they were out of pot pies and were waiting for more. He was given a bowl of soup to eat while he was waiting.</p> <p>*Eight residents were seated in wheelchairs or</p>	F 240	See page 2	

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F 240	<p>Continued From page 5</p> <p>recliners outside of the dining room door waiting for an opening, so they could be served.</p> <p>Interview on 7/19/16 at 6:15 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *They had changed to one dining room service, so they could have a sense of community. *The meal service was supposed to be restaurant style. Residents were to have been served on a first-come, first-served basis. *The meal services were designed so the majority of residents needing assistance were seated at the later service. *It normally did not take that long to serve and have people get done eating. *She agreed the service observed was a bit chaotic. She stated "It is not always like this. Last night we had the second service seated and served by 6:10 p.m." *She acknowledged that the area immediately outside of the dining room with dirty dishes and garbage piled up was not a homelike atmosphere. <p>6. Observation on 7/19/16 beginning at 6:10 p.m. of resident 8 revealed at:</p> <ul style="list-style-type: none"> *6:10 p.m. he was outside of the dining room seated in his wheelchair. He was sipping on a cup that was empty. *6:30 p.m. he had been wheeled into the dining room and seated at a table. He continued to sip on the empty cup. *6:40 p.m. he was served his supper. He made no attempt to eat on his own. No one stopped to provide him assistance or cue him to eat. *6:50 p.m. the DON was seated across the table assisting another resident with her meal. She made no attempt to cue resident 8 or obtain assistance for him to eat. 	F 240	See page 2	

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F 240	<p>Continued From page 6</p> <p>*7:05 p.m. the DON requested an aide come to assist resident 8 with his meal. The aide stood beside him and began feeding him. She had not offered to warm up the food.</p> <p>*7:10 p.m. the aide was cued by the DON to be seated next to resident 8. She continued to feed him the unwarmed food.</p> <p>Throughout the above time there were three aides in the dining room area plus other staff members passing trays of food to residents. At multiple times there were several staff lined up at the counter waiting for a tray of food to serve to a resident. Only one aide was observed assisting a resident to eat.</p> <p>Interview on 7/20/16 at 11:45 a.m. with the DON revealed the service at the previous evening's meal had not gone well. She stated residents normally did not wait long to be seated. She confirmed resident 8 had not received assistance in a timely manner. She stated she was not aware he had been seated for twenty-five minutes before he received assistance. She stated that was too long for him to wait. She also confirmed she should have advised the aide to offer to heat his meal before serving it to him.</p>	F 240	See page 2	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p>	F 241	See next page	

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F 241	<p>Continued From page 7</p> <p>Based on observation, interview, pamphlet review, and policy review, the provider failed to ensure dignity of residents was maintained for four of six randomly observed residents (2, 11, 17, and 18) who were unshaven. Findings include:</p> <p>1. Random observations on 7/19/16 from 8:50 a.m. through 5:45 p.m. and on 7/20/16 from 9:15 a.m. through 4:45 p.m. of residents 2, 11, 17, and 18 on the Berry unit revealed rough, black, white, and gray facial hair on their lips, chins, cheeks, and necks. During those time periods their facial hair had not been removed or shaved.</p> <p>Interview on 7/19/16 at 8:50 a.m. with resident 17 revealed:</p> <ul style="list-style-type: none"> *He was not aware he had more than a days worth of facial hair on his cheeks and neck. *He had recently shaved his chin and lip. *He stated "The staff help me sometimes to shave but most of the time I do it myself." *He tried to shave every day. <p>Interview on 7/20/16 at 9:07 a.m. with certified nursing assistant (CNA) J revealed:</p> <ul style="list-style-type: none"> *Both men and women would have been shaved on their bath day. *They would have shaved the residents if they needed it but not daily. *There had been only one resident who preferred to have his wife shave him. *No other residents had refused to be shaved. *The residents had been expected to have their own razors. *There were no extra razors in the facility for the staff to use when a resident did not have one. <p>Interview on 7/20/16 at 10:20 a.m. with registered</p>	F 241	<p style="text-align: center;">*</p> <p>F241- Policy on Shaving the Residents has been updated to determine when residents will be shaved. All residents needing shaved specifically residents # 2, 11, 17, and 18 also to include female residents in need of shaving will be completed at the preference of each resident to be documented in resident care plan. Each resident will be assessed for his/her preference for frequency of shaving. For residents who are unable to communicate preferences, family members will be involved in preference of frequency. Education will be completed at a mandatory education session on Policy on Shaving Residents and Policy on Practices Related to Resident Dignity. All CNA, CNA M, LPN, and RNs will receive the mandatory training and will receive and review these policies. The mandatory training and policy reviews will be completed by August 12, 2016. Random monitoring of 5 residents will be completed by the DON or designee daily for a one week, then weekly for 4 weeks, then monthly thereafter until 8/1/2017. Electric razors will be purchased as needed to assure that the Policy on Shaving Residents will be followed. DON or designee will report the results to the QAPI at their monthly meetings.</p> <p style="text-align: center;">W/SD DON</p>	8/13/16

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F 241	<p>Continued From page 8 nurse (RN) D revealed: *She had been the charge nurse on Berry unit that day. *The CNAs had been responsible for shaving the residents. *The residents should have been shaved as needed and on their bath day. *She agreed several of the male residents needed to be shaved. *She was not aware of who was responsible to ensure the CNAs had shaved the residents when needed.</p> <p>Interview on 7/20/16 at 3:50 p.m. with the director of nursing revealed she would have expected the residents to have been shaved every day and on their bath days. The staff should have been observant of the residents and their shaving needs. Both the men and women should have had their own razors. The facility currently did not have any extra razors for those residents who did not have one or if one was not working properly. She stated "We only have Shopko in town and they currently do not have any in stock."</p> <p>Review of the provider's 6/4/13 Dignity policy revealed: *"[facility name] will promote care for all residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." *"Staff must carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth." *"Grooming residents as they wish to be groomed."</p> <p>Review of the provider's undated Resident Rights admission pamphlet revealed:</p>	F 241	See page 8	

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F 241	Continued From page 9 **"The facility must care for you in a manner that enhances your quality of life." **"The facility will treat you with dignity and respect in full recognition of your individuality."	F 241	See page 8	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on record review, interview, job description review, and policy review, the provider failed to ensure medically related social services were provided for one of four sampled residents (1) with depression. Findings include: 1. Review of resident 1's Minimum Data Set (MDS) assessments for mood revealed: *On 12/24/15 the admission MDS resident mood interview noted: -"Thoughts that you would be better off dead, or of hurting yourself in some way" he had responded yes, and the frequency had been two to six days (several days). *On 6/16/16 the quarterly MDS resident mood interview noted: -"Thoughts that you would be better off dead, or of hurting yourself in some way" he had responded yes, and the frequency had been twelve to fourteen days (nearly every day).	F 250	F0250: Policy for Social Services at Sturgis Regional Senior Care will be updated to reflect a change in process as it relates those residents experiencing medically related Social Services issues. Policy will outline the process to appropriate personnel to ensure resident safety and well-being. Communication will be done via resident charting in Point Click Care as well as other outlets. This policy and procedure will in serviced to the entire Social Services department and presented to the Medical Director. Radom monitoring of 5 residents charts will be completed by the Social Services Manager or designee daily for a one week, then weekly for 4 weeks, then monthly thereafter until 8/1/2017. * Comments made by resident #11 and all residents with similar statements are documented in quarterly assessments in a progress note, documenting BIMS score and PHQ-9 score and if any Social Services concerns are identified and what action is taken. Comments made by residents on the PHQ-9, Question #9, in which a resident states they have "thoughts of being better off dead or of hurting self in some way" will be reported to the charge nurse, physician and family will be notified of resident's condition, resident will be discussed weekly in our interdisciplinary meeting, and in our Care Conference meeting (which include our interdisciplinary team and family and/or resident). This protocol is outlined in our LTC Social Service Caregivers Policy. Education provided to social services and nursing department regarding this protocol. DON or their designee will review the auditing process and RD will report results to the QAPI at their monthly meetings. VA/SD DOH	8/13/16

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Interview on 7/20/16 at 4:10 p.m. with the social worker and the social services coordinator revealed:

- *When a resident's MDS mood interview noted "better off dead" comments they informed the charge nurse.
- *The charge nurse would have then informed the resident's physician.
- *If a nurse or certified nurse aide had told them about a resident's negative comments they would then go and visit with the resident.
- *They usually completed quarterly social service notes.
- *They had recently started doing monthly social service notes.
- Those notes had not been documented in residents' charts.
- *Regarding resident 1:
 - He had been seen by a psychiatrist on 3/17/16.
 - No other social service notes had been documented.

Review of a 6/20/16 behavior note by registered nurse D regarding resident 1 revealed "During the mood screen. When resident ask if he had thoughts that you would be better off dead, or of hurting yourself in some way. Resident state "yes shoot myself."

Review of the provider's social worker job description revealed:

- *As a member of the interdisciplinary care team, the social worker was responsible for ensuring the resident's social and emotional needs were met as established in the resident's Bill of Rights.
- *The social worker would evaluate the daily activities of the department, act as a resource for the social service designee to address and solve resident and/or family needs, issues, or concerns.

F 250

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F 250	Continued From page 11	F 250	See page 10	
F 281 SS=G	<p>Review of the provider's undated Social Services policy and procedure revealed "It is the policy of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental, or psycho-social well-being of each resident."</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 A. Based on observation, interview, record review, policy review, job description review, and pamphlet review, the provider failed to ensure nutritional interventions were in place by one of one registered dietician (RD): *For 1 of 1 sampled resident (4) who had been admitted with a stage I pressure ulcer to her coccyx. *For 1 of 1 sampled resident (4) who developed two unstageable pressure ulcers while under the care of the facility. *For 9 of 13 sampled residents (1, 3, 4, 5, 7, 8, 10, 12, and 13) who had significant weight loss. Findings include:</p> <p>1. Observation on 7/19/16 at 8:20 a.m. of resident 4 revealed: *She had been laying in bed sleeping. *She had pressure relieving devices: -In her bed. -On both of her feet.</p>	F 281	<p>F0281 - The following updates have been made to those residents listed below as it relates to nutritional assessments and weight loss issues:</p> <p>Resident 1: reviewed weight, meal, I&O, skin assessment records; a fax was sent to the physician with weight change information and the recommendation for scheduled nutritional supplements; diet order changed by physician on 08/02/2016 to NDD1; Regional Nutrition Risk Assessment 1 completed.</p> <p>Resident 2: reviewed weight, meal, I&O, skin assessment records; weight fluctuations over the past 180 days; a fax was sent to the physician with weight change information and current scheduled nutritional supplement; Regional Nutrition Risk Assessment 1 completed.</p> <p>Resident 3: reviewed weight, meal, I&O reports, Nutrition Report for the week ending 07/31/2016, Summary by Resident for the week ending 07/31/2016, a fax was sent to the physician with the weight change information, Regional Nutrition Risk Assessment 1 completed.</p> <p>Resident 4: reviewed weight, meal, I&O, skin assessment records; a fax was sent to the physician with weight change information and the recommendation for scheduled nutritional supplements; recommendation approved by physician; Regional Nutritional Risk Assessment 1 completed.</p>	

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Continued From page 12

- In her wheelchair.
- *She appeared to be very thin and weak.
- *Her bones were easily noticed through her skin.

Interview on 7/19/16 at 9:10 a.m. with licensed practical nurse (LPN) C regarding resident 4 revealed:

- *She had good memory recall.
- *She had a history of unstageable pressure ulcers to both of her feet. Those pressure ulcers had been acquired during her stay in the facility.
- *She currently had an unstageable pressure ulcer to her right heel.
- *She had a poor appetite and would occasionally refuse meals.
- *The LPN had been unsure if the resident had been monitored for weight loss.

Review of resident 4's medical record revealed:

- *An admission date of 12/14/15.
- *She was admitted with a right lower leg fracture sustained from a fall and a pressure ulcer to her coccyx.
- *She had a history of gastroesophageal reflux disease, depression, anxiety, and pressure ulcers.
- *She had a stage I pressure ulcer to her coccyx upon admission.
- *She had received facility acquired unstageable pressure ulcers to both her left and right heels.
- *Her admission weight had been 100.6 pounds (lb).
- *A significant weight loss within six months of admission. Her weight had decreased to 89 lb. That weight loss had been 11% since admission.
- *She had been ordered a regular diet with thin consistency liquids.
- *She was to have been weighed weekly.
- *She had incomplete nutritional risk assessments

F 281

Resident 5: reviewed weight, meal, I&O, skin assessment records; a fax was sent to the physician with weight change information and the recommendation for scheduled nutritional supplements; recommendation approved by physician; Regional Nutrition Risk Assessment 1 completed.

Resident 7: reviewed weight, meal, I&O reports, Nutrition Report for week ending 07/16/2016, Trigger Summary by Resident Report for week ending 07/16/2016; Weight Change Note under the Prog Note tab completed.

Resident 8: reviewed weight, meal, I&O reports, glucometer checks, Nutrition Report for the week ending 06/29/2016, Trigger Summary by Resident Report for the week ending 06/29/2016; a fax was sent to the physician with the weight change information and the recommendation for scheduled nutritional supplement, Regional Nutrition Risk Assessment 1 completed.

Resident 10: reviewed weight, meal, I&O reports, glucometer checks, Nutrition Report for the week ending 07/31/2016, Trigger Summary by Resident Report for the week ending 07/31/2016, a fax was sent to the physician with the weight change information and the recommendation for scheduled nutritional supplement, Regional Nutrition Risk Assessment 1 completed.

Resident 12: reviewed weight, meal, I&O reports, Nutrition Report for the week ending 07/21/2016, Trigger Summary by Resident Report for the week ending 07/21/2016, a fax was sent to the physician with the weight change information (Hospice resident, order for no artificial hydration or nutrition), Regional Nutrition Risk Assessment 1 completed.

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F 281	<p>Continued From page 13 documented on 12/23/15, 1/6/16, 1/16/16, 2/10/16, and 6/16/16 .</p> <p>-There were no risk factors, goals, or interventions recorded for her weight loss, skin breakdown, and poor nutritional intake.</p> <p>Observation and interview on 7/19/16 at 11:30 a.m. with certified nursing assistant E regarding resident 4 revealed:</p> <p>*She had prepared to assist the resident to get out of her bed.</p> <p>*She had stated: "She does not always get up for every meal. If she was up for breakfast she probably will refuse to eat lunch."</p> <p>*The staff were to have offered the resident a glass of Ensure when she had refused a meal.</p> <p>*The resident frequently refused to drink the Ensure.</p> <p>Review of resident 4's Minimum Data Set (MDS) assessments revealed:</p> <p>*A 12/21/15 admission MDS assessment revealed:</p> <p>-A weight of 100 lb.</p> <p>-A stage I pressure ulcer to her coccyx.</p> <p>*A 6/6/16 quarterly MDS assessment revealed:</p> <p>-A weight of 89 lb.</p> <p>-Weight loss of 5% or more in last month or loss of 10% or more in the last six months indicated</p> <p>"Yes, not on physician-prescribed weight-loss regimen."</p> <p>-She had one unstageable pressure ulcer.</p> <p>Review of resident 4's physician's orders revealed:</p> <p>*On 12/28/15:</p> <p>- "No weight changes; no nutritional concerns."</p> <p>- "Skin: wound care issues."</p> <p>*On 2/19/16:</p>	F 281	<p>Resident 13: reviewed weight, meal, I&O report, Nutrition Report for the week ending 07/31/2016, Trigger Summary by Resident Report for the week ending 07/31/2016, a fax was sent to the physician with the weight change information, Regional Nutrition Risk Assessment completed.</p> <p style="text-align: center;">*</p> <p>Resident #4 -Education provided to nursing to include LPN's and RN's on wound care documentation to include daily pressure documentation and weekly PUSH scores for residents with current pressure ulcers. CRA's and Medication aids education provided on recognition of alteration in skin integrity to include notification of nursing with any skin concerns noted with daily cares and repositioning needs for decreasing risk for pressure ulcer formation. All nursing staff to include LPN's and RN's educated on recognition of pressure ulcers to include physician notification, staging, and documentation daily. Repositioning schedule initiated to reposition resident #4 every two hours. Paper format to be provided for CRA documentation and nursing to evaluate at the end of his/her shift.</p> <p>Nutritional assessments will be completed by: reviewing weight, meal, I&O, and skin assessment, and other PCC records, as appropriate; interviewing resident/family members/caregivers; and, completing Nutritional Risk Assessment form and/or Dietary Progress Note, and Care Plans; with identified nutritional risks, goals, and interventions being implemented and/or re-evaluated, as warranted. The RD will complete a Nutritional Assessment of all residents by 31 Aug 2016. All CNA, CNA M, LPN, RNs, and RD will receive the mandatory training and will receive and review these policies. The mandatory training and policy reviews will be completed by August 12, 2016. The RD or designee will monitor weight changes using the Trigger Summary Report. Weight changes of 3# in 1 week, 5% in 30 days, and 10% in 180 days, will be monitored weekly for 1 month; then monthly thereafter - with findings being reported by the RD to the monthly LTC QAPI committee. VA/SD DOH</p>	

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F 281	<p>Continued From page 14</p> <p>-"Supplements offered but refuses; weight loss." No documentation to support any further nutritional recommendations.</p> <p>-"Skin: wound care issues, pressure area of coccyx stage 2, not open and pink; pressure area of left heel greatly improved, right heel suspected deep tissue wound." *On 3/18/16 the physician's documentation and assessment regarding weight loss had been the same as 2/19/16. The pressure ulcers had been reviewed with no changes. *On 5/23/16: -"Problems not reviewed [last reviewed 3/18/16] abnormal weight loss." -The pressure ulcers had been reviewed with no further changes recommended. *On 7/11/16: -She had been seen by the physician for a sixty day review. -Weight: "No weight changes; no nutritional concerns." -No documentation to support the physician had been aware of the resident's 11% weight loss within six months. -"Skin: wound care issues [right heel]." *No documentation to support the RD had made any recommendations to the physicians for nutritional support during and in-between the above visits.</p> <p>Review of resident 4's 12/15/15 initial admit care plan revealed no documentation to support the RD had made any nutritional recommendations for weight gain and wound healing.</p> <p>Review of resident 4's current care plan revealed: *A focus area: -"I have potential/actual impairment to skin integrity r/t [related to] edema, fragile skin.</p>	F 281	<p>A policy titled Resident Nutritional Assessment will be created by RD. This policy will outline expectations for the nutritional assessments and the proper communication of those.</p> <p>Monitoring for completion of assessments (including completed risk/goal/intervention/provider notification, as appropriate) will be monitored weekly for a month; then, monthly thereafter, for one year. This will be done with all residents weekly for one month, 10 random residents monthly for one year ending 8/1/2017. Results will be reported by the RD or designee to the LTC QAPI committee.</p> <p>The policy for Identify Residents at Risk for Developing Pressure Ulcers was updated and reflects the frequency that residents will be assessed and how each pressure ulcer will be staged. This includes the identification of risk, prevention, treatment, monitoring, infection control, quality management, care plans, and MDS documentation will ensure correct coding. Education will be completed at a mandatory education session on the policy for Identify Residents at Risk for Developing Pressure Ulcers. All CNAs, LPNs, MDS, RD, and RNs will receive the mandatory training and will receive and review these policies. LPNs, and RNs, will complete additional eLearning training on Pressure Ulcer Staging. Radom monitoring of 5 sample records for residents with at risk for developing pressure ulcer or has pressure ulcer present will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QAPI at their monthly meetings.</p>	8/13/16

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F 281	<p>Continued From page 15</p> <p>-The focus area had not been initiated until 7/1/16.</p> <p>*Goal for the above focus area:</p> <p>"I will be free from pressure related skin breakdown with current interventions through the next review date."</p> <p>-The goal had not been initiated until 7/1/16.</p> <p>*Interventions for the above focus area:</p> <p>"Encourage good nutrition and hydration in order to promote healthier skin."</p> <p>-No documentation to support what "good nutrition" the staff were to have provided for the resident.</p> <p>*She had required assistance from the staff to ensure all of her activities of daily living needs had been met. That had included offering her nutritional supplements when she refused to eat a meal. The focus area and intervention had been initiated on 12/22/15. No documentation to support the RD or staff had reviewed that intervention for appropriateness between 12/22/15 and 7/20/16.</p> <p>*A focus area:</p> <p>-I have the potential for a nutritional problem of under nutrition r/t limited meal intake."</p> <p>-The focus area had not been initiated until 6/16/16 after the resident had experienced a 11% weight loss.</p> <p>Review of the provider's nutrition at risk meetings documentation from 2/2/16 through 6/7/16 regarding resident 4 revealed:</p> <p>*She had:</p> <p>-Been identified as nutritionally at risk.</p> <p>-Been reviewed for meal intake, fluid intake, snack intake, therapy concerns, medical concerns, and skin issues on 2/2/16 and 4/5/16.</p> <p>-Not been reviewed during the months of March, May, and June.</p>	F 281	<p>Education will be completed at a mandatory education session on the Policy on Medication Administration. All CNA M, LPNs, and RNs will receive the mandatory training and will receive and review these policies. The mandatory training and policy reviews will be completed by August 12, 2016. Radom monitoring of 5 residents medication administrations will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QAPI at their monthly meetings.</p>	

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-Not been reviewed for weight changes or additional concerns during any of those monthly meetings.

*No documentation to support the RD had any further recommendations or concerns regarding the results of her nutritional intake, weight loss, and current skin issues.

Interview on 7/20/16 at 5:50 p.m. with the director of nursing revealed:

*She was aware of resident 4's weight loss and skin concerns.

*She confirmed resident 4's weight loss and skin concerns had not been addressed as to risk factors, goals, or interventions.

*She confirmed:

-The above observations, interviews, and medical record review.

-Resident 4's weight loss and skin breakdown was a continual issue for her and should have been addressed upon admission and ongoing.

*She had been informed several times the RD was behind with her nutritional assessments and documentation.

*She was aware the RD had:

-Failed to complete her nutritional assessments.

-Not initiated a nutritional care plan on resident 4 until 6/16/16.

-Not made recommendations to the physician and staff regarding the resident's weight loss and skin breakdown concerns.

Interview on 7/21/16 at 8:00 a.m. with the administrator revealed:

*He had not been aware resident 4 had identified as nutritionally at risk for weight loss and skin breakdown.

*He would have expected:

-Any resident who was admitted under a

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compromised state to have been appropriately assessed by the RD in a timely manner.

- The nutritional assessments to have been fully completed.
- Resident 4 to have been reviewed monthly at the nutrition at risk committee meetings.
- Recommendations made to the physicians from the RD as deemed appropriate.

Interview on 7/21/16 at 9:15 a.m. with the RD revealed:

*She confirmed resident 4 was nutritionally at risk for weight loss and skin breakdown.

*She stated resident 4 was discussed at the weekly nutritional risk committee meetings and care conferences.

*She had been behind in completing her nutritional risk assessments.

*She confirmed none of the nutritional risk assessments had contained documentation to support risk factors, goals, and interventions for resident 4.

*She confirmed:

- The above medical record review.

- She completed section K of the MDS.

- She completed the nutritional section for the care plans.

- She had not made any recommendations to the physicians or staff as to how to address her weight loss and skin concerns.

*She stated: "I guess I dropped the ball on her. She just fell through the hoops."

*She had no comment to offer when asked what her expectations of an RD were.

Review of the provider's 2/24/2000

Comprehensive Care Plan policy revealed:

**A comprehensive care plan is developed for each resident that includes measurable

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F 281	<p>Continued From page 18</p> <p>objectives and timetables to meet the resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment (MDS)."</p> <p>*The RD had been considered a part of the interdisciplinary care plan team.</p> <p>***Each resident's care plan has been designed to:</p> <ul style="list-style-type: none"> -Identify problem areas. -Incorporate risk factors associated with identified problems. -Reflect treatment goals in measurable outcomes. -Identify the professional services responsible for each element of care." <p>***The resident's comprehensive care plan is developed within seven days of the completion of the resident's comprehensive assessment (MDS)."</p> <p>***It is the responsibility of all staff involved in the resident's care to review and update the care plan on an ongoing basis. A complete care plan review will be performed at least quarterly."</p> <p>Review of the provider's 1/8/11 Skin Care Protocol policy revealed:</p> <p>***To define treatment and monitoring methods used for pressure ulcers."</p> <p>***To provide education, in-service, continuous quality management and care plan guidelines for prevention and treatment of pressure ulcers to residents, staff, and family."</p> <p>***Prevention of Pressure Ulcers:</p> <ul style="list-style-type: none"> -A Nutritional assessment is completed when a resident is identified at risk for skin breakdown. The assessment will be completed by the dietary manager or the facility dietician." -Weights will be monitored for weight loss/gain. The weights will be monitored monthly for residents that are high risk on the nutritional 	F 281		

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F 281	<p>Continued From page 19 assessment and for a score of 18 or less on the Braden scale and for residents with actual pressure ulcers present." -"Review of current dietary plan and any recommendations for appropriate changes in meal plan and/or supplement." -"Reassess, reevaluate, and revise interventions when progress is not noted."</p> <p>Review of the provider's undated and unsigned Clinical Dietitian Job Description revealed: *"Responsible for providing high quality nutritional care to LTC [long term care] residents." *"Assess, plans, coordinates and provides safe and appropriate nutritional care assigned. This includes teaching and consulting." *"Completes nutritional assessment/Minimum Data Set /Care Plans for Senior Care Resident on admission, quarterly, and as necessary with a change in condition." *"Actively initiates evidence-based interventions with interdisciplinary collaborations to promote optimal patient care and outcomes."</p> <p>Review of the provider's undated Welcome pamphlet given to the residents and family upon admission revealed "Facility Services: Attention to changing medical or psychosocial needs such as weight loss."</p> <p>2. Record review, observation, and interview throughout the survey revealed residents 1, 2, 5, 7, 8, 10, 12, and 13 had significant weight losses. There were no RD assessments to identify risk factors, goals, or interventions for those residents. Refer to F325, findings 1, 2, 3, 4, and 5.</p> <p>Surveyor: 29162</p>	F 281		

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F 281	<p>Continued From page 20</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure two of two unlicensed assistive personnel (UAP) (N and O) and one of one licensed practical nurse (LPN) (B) accounted for narcotic medications administered to three random residents at the time of administration. Findings include:</p> <p>1. Observation on 7/19/16 at 12:05 p.m. of UAP N after she had administered Tramadol 50 milligrams (mg) to resident 21 revealed she did not sign for the medication in the narcotic accountability register.</p> <p>2. Observation on 7/19/16 at 12:15 p.m. of UAP O after she had administered hydrocodone/APAP 5/325 mg to resident 22 revealed she did not sign for the medication in the narcotic accountability register.</p> <p>3. Observation on 7/20/16 at 11:30 a.m. of LPN B revealed after she had administered Norco 5/325 mg resident 23 revealed she did not sign for the medication in the narcotic accountability register.</p> <p>4. Interview on 7/20/16 at 11:00 a.m. with UAPs N and O revealed: *They did not sign the narcotic accountability register for any narcotics they administered until after the midday medication pass. *The narcotic registers were kept at the nurses' desk. *They signed for all narcotics they had administered during their shift at one time.</p> <p>Interview on 7/20/16 at 4:40 p.m. with the director of nursing revealed her expectation had been for narcotics to have been signed out at the time of administration.</p>	F 281	<p>* Education will be completed at a mandatory education session on the Policy on Medication Administration. All CNA M, LPNs, and RNs will receive the mandatory training and will receive and review these policies. The mandatory training and policy reviews will be completed by August 12, 2016. Random monitoring of 5 residents medication administrations will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QAPI at their monthly meetings. All medication aids received training of proper administration and immediate documentation of narcotic medication. VA/ SD DON</p>	

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F 281	Continued From page 21 Review of the provider's last revised 11/22/05 Controlled Substance Administration & Control policy revealed the signature of the nurse administering the narcotic medications was to have been recorded on the control sheet. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Telewise, St. Louis, Mo., 2013, page 566, revealed: **"The nurse is responsible for following legal provisions when administering controlled substances such as opioids, which are carefully controlled through federal and state guidelines." **"Hospitals and other health care agencies have policies for the proper storage and distribution of narcotics." **"Use a special inventory record each time a narcotic is dispensed. Use the record to document the patient's name, date, time of medication administration, name of medication, dose, and signature of nurse dispensing the medication."	F 281		
F 309 SS=G	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: 32355	F 309	* Residents have been assessed in the facility for any existing pressure ulcers present. All residents will continue to be assessed weekly for any skin concerns and documented by nursing during bathing. All LPN's and RN's have received education on identifying any skin breakdown and risk factors of altered skin integrity. Any resident identified with a pressure ulcer will receive daily pressure/stasis monitoring and documentation by the charge nurse. Residents identified with pressure/stasis ulcers will be assessed weekly by the Nursing supervisor and documentation of weekly PUSH score will be completed with weekly skin documentation for progression/decline of wound status. Once new pressure ulcer is identified, nursing will initiate the dietician referral form. VA/SD DOH	

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F 309	<p>Continued From page 22</p> <p>Based on observation, interview, record review, policy review, job description review, and pamphlet review, the provider failed to assess, develop, and implement interventions for:</p> <p>*One of one sampled resident (4) who had been admitted with a stage I pressure ulcer to her coccyx.</p> <p>*One of one sampled resident (4) who developed two unstageable pressure ulcers while under the care of the facility.</p> <p>*One of one sampled resident (4) who experienced a significant weight loss within six months of her stay in the facility.</p> <p>Findings include:</p> <p>1a. Observation on 7/19/16 at 8:20 a.m. of resident 4 revealed:</p> <p>*She had been laying in bed sleeping.</p> <p>*She had pressure relieving devices:</p> <p>-In her bed.</p> <p>-On both of her feet.</p> <p>-In her wheelchair.</p> <p>*She appeared to be very thin and weak.</p> <p>*Her bones were easily noticed through her skin.</p> <p>*Her back had been curved causing her head to bend forward and to the right.</p> <p>Review of resident 4's medical record revealed:</p> <p>*An admission date of 12/14/15.</p> <p>*She was admitted with:</p> <p>-A right tibia fracture sustained from a fall.</p> <p>-An immobilizer on her right leg/knee upon admission.</p> <p>-A stage I pressure ulcer to her coccyx.</p> <p>-A weakened and compromised health condition.</p> <p>*She had a history of gastroesophageal reflux disease, depression, anxiety, chronic obstructive pulmonary disease, and pressure ulcers.</p> <p>*She had received two facility acquired</p>	F 309	<p>F0309 –</p> <p>The policy titled Identify Residents at Risk for Developing Pressure Ulcers was updated and reflects the frequency that residents will be assessed, how each will be staged, identification of risk, prevention, treatment, monitoring, infection control, and how quality management, care plans updated, documentation, and MDS will ensure correct coding. Education will be completed at a mandatory education session on the Policy Identify Residents at Risk for Developing Pressure Ulcers. All CNAs, CNA, LPNs, MDS, RD, and RNs will receive the mandatory training and will receive and review these polices. LPNs, and RNs, will complete addition eLearning training on Pressure Ulcer Staging. The mandatory training and policy reviews will be completed by August 12, 2016. Radom monitoring of 5 sample records for residents with at risk for developing pressure ulcer or has pressure ulcer present, will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QAPI at their monthly meetings. Weight Change Protocol was updated and identifies responsibilities of the CNAs, LPNs, RNs, and RD. Education will be completed at a mandatory education session on the Policy on Weight Change Protocol. All CNA, LPNs, RNs and RD will receive the mandatory training and will receive and review these policies. The mandatory training and policy reviews will be completed by August 12, 2016. Radom monitoring of 5 residents with at risk for weight loss or has weight loss present, will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017.</p>	

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F 309	<p>Continued From page 23</p> <p>unstageable pressure ulcers to both her left and right heels.</p> <p>-Those pressure ulcers had been acquired within thirty days of her stay in the facility.</p> <p>*She had been dependent upon the staff to assist her with all of her mobility and activities of daily living (ADL)</p> <p>*On 12/14/15, 3/12/16, and 6/6/16 her Braden pressure ulcer risk assessment scores ranged from 12 to 13. Those scores had indicated she was at high risk for developing pressure ulcers.</p> <p>b. Continued review of resident 4's medical record revealed:</p> <p>*Her admission weight had been 100.6 pounds (lb).</p> <p>*She had a significant weight loss within six months of admission. Her weight had decreased to 89 lb by the 6/6/16 Minimum Data Set (MDS) quarterly assessment. That weight loss had been calculated to 11%.</p> <p>*She had been ordered a regular diet with thin consistency liquids.</p> <p>*She was to have been weighed weekly.</p> <p>*She had incomplete nutritional risk assessments documented on 12/23/15, 1/6/16, 1/16/16, 2/10/16, and 6/16/16 .</p> <p>-There were no risk factors, goals, or interventions recorded for her weight loss, skin breakdown, and poor nutritional intake.</p> <p>c. Interview on 7/19/16 at 9:10 a.m. with licensed practical nurse (LPN) C regarding resident 4 revealed:</p> <p>*She had good memory recall.</p> <p>*She had a history of unstageable pressure ulcers to both of her feet. Those pressure ulcers had been acquired during her stay in the facility.</p> <p>*She currently had an unstageable pressure ulcer</p>	F 309	<p>DON or designee will report the results to the QAPI at their monthly meetings.</p> <p>Resident 4: reviewed weight, meal, I&O, skin assessment records; a fax was sent to the physician with weight change information and the recommendation for scheduled nutritional supplements; recommendation approved by physician; Regional Nutritional Risk Assessment 1 completed.</p> <p>A policy titled Resident Nutritional Assessment will be created by RD. This policy will outline expectations for the nutritional assessments and the proper communication of those.</p> <p>Monitoring for completion of assessments (including completed risk/goal/intervention/provider notification, as appropriate) will be monitored weekly for a month; then, monthly thereafter, for one year. This will be done with all residents weekly for one month, 10 random residents monthly for one year ending 8/1/2017. Results will be reported by the RD or designee to the LTC QAPI committee.</p>	8/13/16

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F 309	Continued From page 24 to her right heel. *She had a poor appetite and would occasionally refuse meal services. The LPN had been unsure if the resident had been monitored for weight loss.	F 309		
F 314 SS=G	Refer to F281, finding 1. Refer to F314, finding 2. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, pamphlet review, job description review, and policy review, the provider failed to: *Reposition one of two sampled residents (2) with a history of pressure ulcers according to his care plan and individual needs. *Implement interventions to promote healing and prevent pressure ulcers from developing for one of one sampled resident (4) who had acquired two unstageable pressure ulcers while in the facility. Findings include:	F 314	F0314 - * Policy Identify Residents # 2 & 4, at Risk for Developing Pressure Ulcers was updated and reflects the frequency that residents will be assessed, how each will be staged, identification of risk, prevention, treatment, monitoring, infection control, and how quality management, care plans updated, documentation, and MDS will ensure correct coding. Education will be completed at a mandatory education session on the Policy Identify Residents at Risk for Developing Pressure Ulcers. All CNAs, CNA Ms, LPNs, MDS, RD, and RNs will receive the mandatory training and will receive and review these policies. LPNs, and RNs, will complete addition e-learning training on Pressure Ulcer Staging. Random monitoring of 5 sample records for residents with at risk for developing pressure ulcer or has pressure ulcer present, will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QA/PI at their monthly meetings. Residents # 2 & 4: Repositioning schedule implemented for reducing risk for further pressure related skin breakdown. Securing device provided for Resident # 2 with daily monitoring for changes in skin status on both resident # 2 and 4. All residents assessed for risk of pressure related skin breakdown with implementation of repositioning schedules for all residents identified at a higher risk for pressure related skin breakdown. VA/SD DOH	8/13/16

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1. Interview on 7/19/16 at 9:10 a.m. with licensed practical nurse (LPN) C regarding resident 2 revealed:

*He had:

- Required staff assistance with all activities of daily living (ADL) including transferring him in and out of his wheelchair (w/c).
- A urinary catheter to drain his bladder.
- A history of pressure ulcers to his penis from the urinary catheter tubing.

Review of resident 2's medical record revealed:

*An admission date of 7/25/14.

*Diagnoses of Alzheimer's disease, dementia, urinary retention, history of urinary tract infections, depression, and Parkinson disease.

*On 9/11/15, 12/10/15, 3/4/16, and 5/29/16 his Braden pressure ulcer risk assessment score ranged from 15 to 17. Those scores indicated he was at high risk for developing pressure ulcers.

*On 5/27/16 a stage I pressure ulcer had been assessed on his penis.

*He had required one to two staff members to assist him with all ADL.

-That had included transfers and bed mobility.

Observation and interview on 7/19/16 from 10:45 a.m. through 2:30 p.m. with certified nursing assistant (CNA) F regarding resident 2 revealed:

*He:

- Had a urinary catheter to drain his bladder.
- Was incontinent of bowel.
- Had received assistance with perineal care earlier in the morning before he got out of bed for the day.
- Would not require perineal care the rest of the day unless he had to have a bowel movement.

*She would let the surveyor know if and when she assisted him with perineal care.

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F 314	<p>Continued From page 26</p> <p>-Her shift ended at 2:30 p.m.</p> <p>*The CNA had not informed the surveyor of any perineal care for the resident during the above time frame.</p> <p>Random observations on 7/19/16 from 2:30 p.m. through 7:00 p.m. of resident 2 revealed he:</p> <p>*Had been sitting in his wheelchair on a pressure relieving cushion in the Berry unit activity room.</p> <p>*Did not leave the room.</p> <p>*Was assisted to the dining room for supper at 6:45 p.m. by an unidentified staff member.</p> <p>*Had been served his supper at 7:00 p.m.</p> <p>*Was not observed being repositioned in his w/c during the above time frame.</p> <p>Review of resident 2's current care plan revealed:</p> <p>*A focus of area: "I have potential impairment to skin integrity r/t [related to] bowel incontinence, decreased mobility, need for assistance with toileting and transfers.</p> <p>-Revision date of 6/9/16.</p> <p>*A focus area: "I am frequently incontinent of bowels r/t impaired mobility and dementia."</p> <p>-Interventions for the above focus area: "Check me every two hours and as required for incontinence."</p> <p>-Revision date of 3/19/16.</p> <p>Interview on 7/20/16 at 5:50 p.m. with the director of nursing (DON) and the Minimum Data Set (MDS) assessment nurse regarding resident 2 revealed:</p> <p>*They had confirmed:</p> <p>-The above medical review for the resident.</p> <p>-He had acquired a pressure ulcer from his catheter tubing.</p> <p>-He required staff assistance with all ADLs.</p> <p>*They would have expected the staff to have</p>	F 314		

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F 314	<p>Continued From page 27 repositioned him at a minimum of every two hours.</p> <p>2. Observation on 7/19/16 at 8:20 a.m. of resident 4 revealed: *She had been laying in bed sleeping. *She had pressure relieving devices: -In her bed. -On both of her feet. -In her wheelchair. *She appeared to be very thin and weak. *Her bones were easily noticed through her skin.</p> <p>Interview on 7/19/16 at 9:10 a.m. with licensed practical nurse (LPN) C regarding resident 4 revealed: *She had good memory recall. *She had a history of unstageable pressure ulcers to both of her feet. Those pressure ulcers had been acquired during her stay in the facility. *She currently had an unstageable pressure ulcer to her right heel. *She had a poor appetite and would occasionally refuse meal.</p> <p>Observation on 7/19/16 at 10:53 a.m. with LPN C regarding resident 4 revealed: *She had prepared to apply Betadine to her right heel. *The right heel had a hard, black, and thickened area attached to it. -That area measured approximately 2 centimeters (cm) by 2 cm.</p> <p>Review of resident 4's medical record revealed: *An admission date of 12/14/15. *She was admitted with a right tibia fracture sustained from a fall. *She had:</p>	F 314		

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F 314	<p>Continued From page 28</p> <ul style="list-style-type: none"> -A history of gastroesophageal reflux disease, depression, anxiety, chronic obstructive pulmonary disease, and pressure ulcers. -An immobilizer on her right leg/knee upon admission. -Acquired a stage I pressure ulcer to her coccyx during her stay at the hospital. -Acquired two facility acquired unstageable pressure ulcers to both of her heels within 30 days. -Been dependent upon staff to assist her with all her mobility and ADL needs. <p>*On 12/14/15, 3/12/16, and 6/6/16 her Braden pressure ulcer risk assessment score ranged from 12 to 13. Those scores had indicated she was at high risk for developing pressure ulcers.</p> <p>Review of resident 4's 12/14/15 physician's admission orders revealed:</p> <ul style="list-style-type: none"> *She had a right tibia fracture with a knee immobilizer in place for support and stability. *The therapy department was to have weaned her out of the immobilizer. **"Complete weekly skin assessment every Friday." *No documentation to support: <ul style="list-style-type: none"> -The staff should not perform skin checks underneath of the immobilizer. -A stage I pressure ulcer to her coccyx. -The resident was at high risk for pressure ulcers and required preventative interventions to ensure no further skin breakdown occurred. <p>Review of resident 4's physicians' orders revealed on:</p> <p>*12/28/15:</p> <ul style="list-style-type: none"> -She had been assessed by the physician. That physician confirmed she had a stage I pressure ulcer to her coccyx. 	F 314		

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F 314	<p>Continued From page 29</p> <ul style="list-style-type: none"> -No documentation to support the resident required any specialized treatment for the pressure ulcer to her coccyx. -No documentation to support the necessity for additional preventative skin break down interventions. *1/27/16 an order for "Low air loss mattress to assist with wound healing and pressure redistribution." -No documentation to support she had required the use of a specialized air mattress prior to 1/27/16. *1/29/16 an order for "Resident to have heel lift boots on bilaterally in bed and in w/c." -No documentation to support why she needed those heel lift boots. *4/15/16 an order to "Complete daily pressure assessment on right heel and document in assessments. May DC [discontinue] when healed." <p>Review of resident 4's Skin Integrity Assessment records from 12/14/15 through 7/8/16 revealed:</p> <ul style="list-style-type: none"> *On 12/14/15: <ul style="list-style-type: none"> -A stage I pressure ulcer had been identified on her coccyx. -No documentation to support her heels had been identified as an area of concern. *On 12/18/15 both heels had been identified as having dry skin attached to them. <ul style="list-style-type: none"> -That skin integrity change to both of her heels had occurred four days after admission. *On 12/31/15 her right heel had a 3.1 cm to 4.0 cm black area. <ul style="list-style-type: none"> -That area on her heel remained unhealed as of 7/20/16. *On 1/15/16 a 1.5 cm x 1.0 cm reddened area had been identified to her left heel. *On 1/29/16 that left heel area had increased in 	F 314		

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size to 2.0 cm by 1.8 cm. The area had been documented as deep purple/black in color.

*On 2/12/16 both the left and right heels had been documented as "Suspected deep tissue injury."

*From 2/14/16 through 4/8/16:

- The left heel showed progression towards healing with a decrease in size and improvement in color.
- There was no documentation on the left heel after 4/8/16 to support when the wound had healed.
- *From 4/8/16 through 7/15/16 the right heel remained unhealed and unstageable.
- *No documentation to support:
- The treatment, goals, and interventions put in place and utilized by the staff to ensure healing had occurred for all the areas of concern.
- When the stage I coccyx pressure ulcer had healed.

Review of resident 4's 12/15/15 initial care plan revealed:

- *Skin care had been identified as an area of concern.
- *She was to have received pressure ulcer care.
- Staff had been directed to "See TAR for orders."
- *She had a brace on her right lower extremity.
- *No documentation to support:
- What type of pressure ulcer care she was to have received.
- What interventions had been put in place for the staff to follow to ensure no further skin break down had occurred.
- The staff should have performed skin checks underneath of her right leg brace to ensure no skin break down occurred.
- How often she should have been repositioned.
- She required staff assistance with transfers, bed

F 314

435102

B. WING

07/21/2016

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F 314	<p>Continued From page 31 mobility, and repositioning. -She had been at high risk for skin break down.</p> <p>Review of resident 4's current care plan revealed on 12/22/15: *A Focus area: "I have a pressure ulcer to my right heel and am at high risk for pressure related skin breakdown r/t immobility." -That focus area had been revised on 3/19/16. *The interventions for the above focus area had not identified: -The use of a pressure relieving air mattress. -The use of pressure relieving foam boots to both of her feet. -Heel protectors and/or pillow to keep heels off the bed. -How often the staff should have checked the skin underneath the brace on her right leg. -What the facility policies/protocols for the prevention of skin breakdown were. -If the staff had reviewed and revised those interventions to ensure appropriateness since 12/22/15.</p> <p>Interview on 7/20/16 at 6:00 p.m. with the DON and MDS assessment coordinator regarding resident 4 revealed: *They confirmed: -The above medical record review. -She had been admitted in a weakened and compromised state. That condition had placed her at high risk for skin breakdown. -She had been admitted with a stage I pressure ulcer to her coccyx. -She had acquired the unstageable pressure ulcers to both of her heels while under the care of the facility. -There had been no documentation to support the staff had done skin checks underneath of her</p>	F 314		

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right leg brace.
-No pressure relieving devices had been put in place prior to the physician's orders in January 2016.
-The skin assessments should have identified interventions to ensure no further skin breakdown had occurred.
-The skin assessments should have identified when a wound was healed.
-The staff failed to be proactive with preventative interventions in a timely manner to ensure no further skin breakdown had occurred.
-The staff followed the care plan to ensure appropriate care had been provided.
-The care plan was not updated, reviewed, and revised to ensure she had received the necessary care and services she required.

F 314

Review of the provider's 1/8/11 Skin Care Protocol policy revealed:

***The goal is to identify residents at risk for developing pressure ulcers and to ensure that a treatment plan is in place for residents with pressure ulcers."

***The Braden Scale protocol will be used to implement the appropriate prevention devices for all risk areas."

***Bed and chair bound individuals with impaired ability to reposition will be assessed for additional factors increasing risk for pressure ulcers. These factors include immobility, incontinence, and inadequate nutritional intake."

***Reposition bed bound and chair bound residents at least every 2 hours."

***Utilize pressure reducing mattress or pressure reducing overlays (air or gel)."

***Heel protector's and/or pillows under legs/ankles to keep heels off of the bed."

***Observe skin daily especially bony

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F 314	Continued From page 33 prominence's."	F 314		
F 325 SS=E	<p>Refer to F281, finding 1. 483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, record review, and policy review, the provider failed to ensure 8 of 13 sampled residents (1, 3, 5, 7, 8, 10, 12, and 13), 1 of 1 resident with dialysis (13), and 1 of 3 residents with pressure ulcers (12) had received complete nutritional assessments and interventions to address their significant weight losses. Findings include:</p> <p>1. Observation on 7/19/16 at 10:55 a.m. revealed resident 5 was seated in a Broda wheelchair in his room. He was noticeably thin.</p> <p>Observation on 7/19/16 at 6:55 p.m. and on 7/20/16 at 8:30 a.m. revealed he had been eating alone in his room. Interview with him at both of</p>	F 325	<p>F0325 - Weight Change Protocol was updated and identifies responsibilities of the CNAs, LPNs, RNs, and RD. Education will be completed at a mandatory education session on the Policy on Weight Change Protocol. All CNA, LPNs, RNs and RD will receive the mandatory training and will receive and review these policies. The mandatory training and policy reviews will be completed by August 12, 2016. Radom monitoring of 5 residents with at risk for weight loss or has weight loss present, will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QAPI at their monthly meetings.</p> <p>The policy for Identify Residents at Risk for Developing Pressure Ulcers was updated and reflects the frequency that residents will be assessed and how each pressure ulcer will be staged. This includes the identification of risk, prevention, treatment, monitoring, infection control, quality management, care plans, and MDS documentation will ensure correct coding. Education will be completed at a mandatory education session on the policy for Identify Residents at Risk for Developing Pressure Ulcers. All CNAs, LPNs, MDS, RD, and RNs will receive the mandatory training and will receive and review these polices. LPNs, and RNs, will complete addition eLearning training on Pressure Ulcer Staging. Radom monitoring of 5 sample records for residents with at risk for developing pressure ulcer or has pressure ulcer</p>	8/13/16

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F 325	<p>Continued From page 34 those times revealed that was his preference. He stated he did not like to be around other people when he ate.</p> <p>Review of resident 5's Minimum Data Set (MDS) assessments revealed: *A 9/16/15 significant change MDS weight of 134 pounds (lb). *A 4/25/16 quarterly MDS weight of 109 lb. -Weight loss of 5 percent (%) or more in last month or loss of 10% or more in last six months indicated "yes, not on physician-prescribed weight-loss regimen."</p> <p>Review of resident 5's 10/20/15 through 7/16/16 weekly weight records revealed he had steadily been losing weight. He weighed 120.6 lb on 10/15/15 and 102 lb on 7/19/16. His initial weight at the time of his admission on 3/24/16 was 138 lb. He had shown either a 5% weight loss in one month or 10% weight loss in six months for all of his weights entered. That had been considered a significant weight loss.</p> <p>Review of resident 5's nutritional assessments revealed he had one completed by the registered dietitian (RD) on 11/10/15, 2/3/16, and 4/26/16. All of those assessments had acknowledged his significant weight loss. None of the assessments had listed risk factors, goals, or interventions for his weight loss.</p> <p>2. Review of resident 8's weight records revealed weights on: *9/17/15: 171 lb. *9/14/15: 156.8 lb, a significant weight loss of greater than 5% in one week. 8.4 lb. ough 11/23/15: weights fluctuated</p>	F 325	<p>present will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QAPI at their monthly meetings.</p> <p>Resident 5: reviewed weight, meal, I&O, skin assessment records; a fax was sent to the physician with weight change information and the recommendation for scheduled nutritional supplements; recommendation approved by physician; Regional Nutrition Risk Assessment 1 completed.</p> <p>Resident 8: reviewed weight, meal, I&O reports, glucometer checks, Nutrition Report for the week ending 06/29/2016, Trigger Summary by Resident Report for the week ending 06/29/2016; a fax was sent to the physician with the weight change information and the recommendation for scheduled nutritional supplement, Regional Nutrition Risk Assessment 1 completed.</p>	

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STREET ADDRESS, CITY, STATE, ZIP CODE

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F 325	<p>Continued From page 35 between 155.2 lb and 160 lb. *11/30/15: 217.6 lb. *12/15/15: 166.8 lb. No reweight had been done on the erroneous weight of 217.6 lb. *12/21/15 through 1/26/16: weights fluctuated between 168.2 lb and 153.8 lb, a significant loss of greater than 5% in one month. *2/9/16 through 7/19/16: weights fluctuated between 157.8 lb and 144.8 lb, a loss of nearly 10% which would have been considered a significant weight loss.</p> <p>Review of the notes provided by the RD on the nutritional trigger summary report revealed on: *11/9/15: -He had flagged as having 10% weight loss over six months. -He had eaten less than 50% of his meals that week. -Handwritten notes revealed "ST/OT [speech therapy/occupational therapy] screens. More leg. 3-5 p.m. very awake." *1/2/16: -He had flagged as having greater than 5% weight loss in thirty days and greater than 10% weight loss in six months. -Handwritten notes revealed he would be having a speech evaluation. There was no date as to when that evaluation would occur. *2/9/16: He was not mentioned on the report. *3/8/16: -He had flagged for greater than 10% weight loss over six months. -Handwritten notes stated the speech evaluation had resulted in no diet changes. "His family wanted an upgrade." There was no clarification as to what that meant. *4/12/16: He again flagged for greater than 10% weight loss over six months.</p>	F 325	<p style="text-align: center;">*</p> <p>Residents have been assessed in the facility for any existing pressure ulcers present. All residents will continue to be assessed weekly for any skin concerns and documented by nursing during bathing. All LPN's and RN's have received education on identifying any skin breakdown and risk factors of altered skin integrity. Any resident identified with a pressure ulcer will receive daily pressure/stasis monitoring and documentation by the charge nurse. Residents identified with pressure/stasis ulcers will be assessed weekly by the Nursing supervisor and documentation of weekly PUSH score will be completed with weekly skin documentation for progression/decline of wound status. Once new pressure ulcer is identified, nursing will initiate the dietician referral form.</p> <p>Nutritional assessments will be completed by: reviewing weight, meal, I&O, and skin assessment, and other PCC records, as appropriate; interviewing resident/family members/caregivers; and, completing Nutritional Risk Assessment form and/or Dietary Progress Note, and Care Plans; with identified nutritional risks, goals, and interventions being implemented and/or re-evaluated, as warranted. The RD will complete a Nutritional Assessment of all residents by 31 Aug 2016. The RD or designee will monitor weight changes using the Trigger Summary Report. Weight changes of 3# in 1 week, 5% in 30 days, and 10% in 180 days, will be monitored weekly for 1 month; then monthly thereafter – with findings being reported by the RD to the monthly LTC QA/PI committee. VA / SD DDA</p>	

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F 325	<p>Continued From page 36</p> <ul style="list-style-type: none"> -There were no notes written on the form addressing that weight loss. *5/10/16: He was not listed on the nutritional support list. -He was documented as eating less than 60% of his meals. -He was identified as being at high risk nutritionally. -No interventions or goals were found on that report. *6/14/16 and 7/12/16: He was listed as having greater than 10% weight loss in six months. -He was documented as eating less than 60% of his meals. -He was identified as being at high risk nutritionally. -No interventions or goals were found on those reports. <p>Review of resident 8's nutritional assessments revealed none had been completed by the RD. There had been no documentation of risk factors, goals, or interventions.</p> <p>3. Interview on 7/20/16 at 11:20 a.m. with the RD revealed she stated she had been behind in completing her nutritional risk assessments. She confirmed none of the risk assessments completed had contained risk factors, goals, or interventions for resident 5. She confirmed resident 8 had been identified as being at risk, but no nutritional assessments had been completed on him. She stated she discussed the residents at weekly nutritional risk meetings and at care conferences. She confirmed she had no documentation on those meetings as to what was discussed for resident 5. She stated she had not made any recommendations to the staff or physician as to how to address residents 5 and</p>	F 325		

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F 325	<p>Continued From page 37 8's weight loss.</p> <p>Interview on 7/20/16 at 5:30 p.m. with the director of nursing (DON) revealed she was aware of resident 5 and 8's weight losses. She confirmed resident 5 liked to eat alone in his room. She also confirmed neither resident's weight loss had been addressed as to risk factors, goals, or interventions. She stated weight loss was a continual problem for both residents and should have been addressed.</p> <p>Surveyor: 18560 4. Review of resident 1's MDS assessments revealed: *A 12/24/15 annual MDS weight of 170 lb. *A 6/16/16 quarterly MDS weight of 154 lb. -Weight loss of five percent (%) or more in last month or loss of 10% or more in last six months indicated "yes, not on physician-prescribed weight-loss regimen."</p> <p>Review of resident 1's weight summary revealed: *On 6/20/16, 149.8 lb. *On 6/22/16, 148 lb. *On 6/27/16, 147.4 lb. *On 6/28/16, 149 lb. *On 7/6/16, 149 lb. *On 7/11/16, 146.2 lb. *On 7/18/16, 144.4 lb. That weight loss indicated a severe weight loss of greater than 10% in six months.</p> <p>Review of the RD's progress notes revealed: *A 1/5/16 Nutritional Risk Committee note with no comments related to meal time concerns, scheduled nutritional supplements, fluid intake, snack intake, therapy concerns, medical concerns, skin issues, or additional concerns.</p>	F 325	<p>Resident 1: reviewed weight, meal, I&O, skin assessment records; a fax was sent to the physician with weight change information and the recommendation for scheduled nutritional supplements; diet order changed by physician on 08/02/2016 to NDD1; Regional Nutrition Risk Assessment 1 completed.</p>	

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F 325

Continued From page 38

-Recommendations noted those in attendance, committee aware of weight changes, and continue to monitor.

*The last weight change note had been dated 9/8/15.

5. Review of resident 3's MDS assessments revealed:

*A 11/23/15 admission MDS weight of 124 lb.

*A 5/13/16 quarterly MDS weight of 143 lb.

-Weight gain of 5% or more in last month or gain of 10% or more in last six months indicated "yes, not on physician-prescribed weight-gain regimen."

Review of the RD's progress notes revealed she had last documented on resident 3 on 11/24/15.

Interview on 7/21/16 at 8:30 a.m. with the RD revealed she:

*Collected the data to complete the nutrition section of the MDS assessments.

*Confirmed she was behind in her charting in residents' medical records.

Surveyor: 26632

6. Review of resident 12's medical record revealed:

*She was receiving hospice services since 3/18/16.

*She had an unstageable coccyx (tailbone) pressure sore.

*She had diagnoses that included dementia and Alzheimer's late onset.

*Had a 10.6% weight loss from 3/9/16 to 7/20/16.

*Had an 11.1% weight loss from 10/7/15 to 3/2/16.

*Had an incomplete nutritional risk assessment documented on 7/7/16.

F 325

Resident 3: reviewed weight, meal, I&O reports, Nutrition Report for the week ending 07/31/2016, Summary by Resident for the week ending 07/31/2016, a fax was sent to the physician with the weight change information, Regional Nutrition Risk Assessment 1 completed.

Resident 12: reviewed weight, meal, I&O reports, Nutrition Report for the week ending 07/21/2016, Trigger Summary by Resident Report for the week ending 07/21/2016, a fax was sent to the physician with the weight change information (Hospice resident, order for no artificial hydration or nutrition), Regional Nutrition Risk Assessment 1 completed.

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F 325	<p>Continued From page 39</p> <p>*The weight on that assessment was the weight from 3/30/16 and was 102.4 pounds. *Her weight on 7/6/16 was 95.6 pounds. *There were no goals or interventions recorded for her weight losses.</p> <p>7. Review of resident 13's medical record revealed: *She underwent dialysis three times a week. *Her weight on 1/14/16 was 145.8 pounds. *Her weight on 7/20/16 was 126 pounds. *She had a 13% weight loss in six months. *Had an incomplete nutritional risk assessment documented on 7/5/16. *There were no goals or interventions recorded for her weight loss.</p> <p>Surveyor: 29162</p> <p>8. Review of resident 7's medical record revealed: *She had: -A 10% weight loss from 10/30/15 to 4/22/16. -A 5% weight loss from 7/8/16 to 7/15/16. -An incomplete nutritional risk assessment on 7/1/16. -No other nutritional risk assessments were found. *The Nutritional Risk Committee meeting notes from 5/17/16, 5/10/16, 4/26/16, 4/19/16, and 4/12/16 indicated she had been having decreased intake and weight loss. *There had been no dietary progress notes or assessments found regarding the resident's nutrition status related to the Nutritional Risk Committee.</p> <p>9. Review of resident 10's medical record revealed: *She had:</p>	F 325	<p>Resident 13: reviewed weight, meal, I&O report, Nutrition Report for the week ending 07/31/2016, Trigger Summary by Resident Report for the week ending 07/31/2016, a fax was sent to the physician with the weight change information, Regional Nutrition Risk Assessment completed.</p> <p>Resident 7: reviewed weight, meal, I&O reports, Nutrition Report for week ending 07/16/2016, Trigger Summary by Resident Report for week ending 07/16/2016; Weight Change Note under the Prog Note tab completed.</p>	

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F 325 Continued From page 40

- A 10% weight loss from 2/16/16 to 7/19/16.
- A dietary progress note identified as a late entry on 3/3/16. That note was blank.
- A quarterly dietary progress note on 5/18/16.
- No other dietary progress notes had been found.
- *Nutritional Risk Committee notes on 3/8/16, 4/25/16, 5/3/16, 5/10/16, 5/17/16, 6/14/16, 6/21/16, and 7/12/16 indicated the resident had weight loss.
- There had been only one time on 5/10/16 when additional documentation regarding the resident's weight loss had been noted. That information had been hand written on the nutrition report beside the resident's name.

Surveyor 23059

10. Review of the provider's September 2015 Nutritional Risk policy revealed:

***The interdisciplinary team will meet, at a minimum, twice monthly; alternating units to be reviewed per meeting."

***The team would strive to reduce/resolve the nutritional risk issues through appropriate interventions in accordance with advance directives, individual goals, and prognosis.

Review of the provider's 9/16/15 Weight Change Protocol policy revealed:

***Residents with unintended/undesired significant weight change will be addressed accordingly."

***Dietitian's responsibilities:

- Reviews the 'Unintended Weight Change Assessment Form' in a timely manner.
- Determine if the weight change is significant or severe.
- Conduct further inquiries as needed.
- Document recommendations/findings.
- Notify appropriate services for further review as needed.

F 325

Resident 10: reviewed weight, meal, I&O reports, glucometer checks, Nutrition Report for the week ending 07/31/2016, Trigger Summary by Resident Report for the week ending 07/31/2016, a fax was sent to the physician with the weight change information and the recommendation for scheduled nutritional supplement, Regional Nutrition Risk Assessment 1 completed.

A policy titled Resident Nutritional Assessment will be created by RD. This policy will outline expectations for the nutritional assessments and the proper communication of those.

Monitoring for completion of assessments (including completed risk/goal/intervention/provider notification, as appropriate) will be monitored weekly for a month; then, monthly thereafter, for one year. This will be done with all residents weekly for one month, 10 random residents monthly for one year ending 8/1/2017. Results will be reported by the RD or designee to the LTC QAPI committee.

8/13/16

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F 325	Continued From page 41 -Reviews 'Weights and Vitals Exceptions Report' on a monthly basis and compares with received referral forms."	F 325		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure 2 of 27 medications were administered according to physicians' orders for one randomly observed resident (5) for an error rate of 7.4 percent. Findings include: 1. Observation on 7/19/16 at 11:10 a.m. of licensed practical nurse (LPN) A while she gave a nebulizer treatment to resident 5 revealed she: *Added DuoNeb liquid medication directly into a liquid that had already been in the nebulizer cup. *Put the equipment beside the nebulizer machine and left the room after the treatment. *Did not empty the excess liquid from the nebulizer medication cup. *Had not cleaned any of the nebulizer inhalation equipment. 2. Observation on 7/20/16 at 9:25 a.m. of LPN B while she gave a nebulizer treatment to resident 5 revealed she: *Added DuoNeb liquid medication directly into a liquid that had already been in the nebulizer cup.	F 332	* Policy Aerosolized Medication administration updated and reflects the expected process after treatment or for cleaning the equipment. Education will be completed at a mandatory education session on the Policy Aerosolized Medication administration. All LPNs and RNs will receive the mandatory training and will receive and review the policy. The mandatory training and policy review will be completed 8/12/2016. All LPN's and RN's education provided on correct administration of inhalation medication to include cleansing of mask for future administrations. Observation of medication administration completed with resident's # five and all residents with current orders for this administration for accuracy. <i>12/5/2016</i> Random monitoring of 5 residents medication administrations will be completed by the DON or designee weekly for a one week, then bi-weekly for 4 weeks, then monthly thereafter until 8/1/2017. DON or designee will report the results to the QAPI at their monthly meetings.	8/13/16

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*Put the equipment beside the nebulizer machine
and left the room after the treatment.*Did not empty the excess liquid from the
nebulizer medication cup.*Had not cleaned any of the nebulizer inhalation
equipment.

3. Interview on 7/20/16 at 4:40 p.m. with the
director of nursing revealed she expected the
nebulizer equipment to be removed from the
machine, rinsed with water, and placed on a
clean paper towel beside the machine to dry. She
agreed the DuoNeb medication should not have
been added to the liquid that had already been in
the cup.

Review of the provider's last revised 9/29/15
Nebulizer Treatments policy revealed no mention
of the expected process after the treatment or for
cleaning the equipment.

F 332

F 441
SS=F483.65 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

F 441

F0441

Infection control will provide education
regarding hand hygiene which includes wound
care, glucometer usage, personal cares for all
residents to LPNs and RNs. Education will be
completed through a mandatory on-line
education session that requires employee to
demonstrate understanding by taking a test. DON
or designee will report the results to the QAPI at
their monthly meetings.

8/13/16

435102

B. WING

07/21/2016

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F 441

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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 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.

F 441

This REQUIREMENT is not met as evidenced by:

Surveyor: 29162

Surveyor: 32355

Based on observation, interview, manufacturer's instruction review, and policy review, the provider failed to:

*Maintain sanitary conditions while performing personal care for two of three observed residents (6 and 10).

*Perform wound care in a sanitary manner for

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F 441	<p>Continued From page 44</p> <p>three of three observed residents (4, 10, and 21).</p> <p>*Follow manufacturer's instructions for cleaning and disinfecting for one of one observed whirlpool tub (Berry unit).</p> <p>*Follow manufacturer's instructions for cleaning and disinfecting for one of one observed shower unit/chair (Berry unit).</p> <p>*Maintain three of five randomly observed residents' (13, 19, and 20) oxygen concentrators in a sanitary manner.</p> <p>*Properly store resident's personal care products in six of ten randomly observed resident bathrooms (26, 27, 28, 29, 31, and 32).</p> <p>*Ensure two of two soiled utility rooms (Berry and Massa units) were maintained in a sanitary manner.</p> <p>*Ensure two of two EZ Way stand aides (Berry and Massa units) were clean.</p> <p>*Ensure two of three randomly observed residents' (4 and 21) floor mats were clean.</p> <p>Findings include:</p> <p>1. Observation on 7/19/16 of certified nurse aides (CNA) E and F while they provided care for resident 6 revealed:</p> <p>*They prepared to assist the resident with toileting.</p> <p>*They both sanitized their hands and put gloves on.</p> <p>*While CNA E had her gloves on she:</p> <p>-Assisted the resident to stand-up by the toilet.</p> <p>-Pulled the resident's slacks down and removed her soiled brief.</p> <p>-Assisted the resident to sit on the toilet.</p> <p>-Touched the handles on the resident's wheelchair (w/c) to move it out of the way.</p> <p>-Sprayed several dry wipes with perineal cleaner.</p> <p>-Provided perineal care for the resident.</p> <p>-Cleaned a large amount of bowel movement off</p>	F 441	<p>* Education regarding proper glove use will be provided to all staff. The hand hygiene policy will be reviewed with staff and in accordance with procedure involved. Education will be provided by 8/11/2016 to CNA E, F regarding resident 6, to K & L regarding resident 10. Education was also provided to CNAs, bath aides, RNs, and LPNs. Education will be completed at a mandatory education session that requires the employee to demonstrate understanding by taking a written post-test. DON or designee will report the results to the QAPI at their monthly meetings. Monitoring will include the personal cares and proper glove use when caring for residents, including residents 6 & 10. Monitoring of 5 occurrences will be completed by DON or designee daily for one week; then weekly for 4 weeks; then monthly thereafter until 8/1/2017 to assure compliance. DON or designee will report the results to the QA/PI at their monthly meetings. VA / SD DDH</p>	8/13/16

435102

B. WING

07/21/2016

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on the floor.

- The resident had a history of urinary tract infections.
- Touched the floor with her gloved hands.
- Provided perineal care with the same dirty gloves on. When she provided perineal care she cleaned the resident's perineal area without specific direction and from the back to the front.
- Continued to wear those same soiled gloves when she adjusted the bed.
- Applied NutraShield ointment to an area on the resident's buttocks with the same soiled gloves on.
- Removed her gloves and did not wash her hands.

*CNA K carried the dirty linen from this observation against her clean uniform down the hallway.

Interview on 7/19/16 at the above time with CNA L revealed the soiled linen should have been put in a bag when carried in the hallway.

Interview on 7/19/16 at the above time with CNA K revealed carrying the dirty linen against her uniform had been her usual practice.

Review of the provider's Personal Hygiene Care for the Female Resident policy effective date of 1/1/10 revealed:

- *Soiled lined was to have been kept from touching staff clothing.
- *Perineal care for females was to have been completed in front to back cleansing motions.
- *For resident's with an indwelling catheter "gently wash the juncture of the tubing from the urethra down the catheter about 3 inches."

Surveyor: 32355

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F 441	<p>Continued From page 47</p> <p>3. Observation on 7/19/16 at 10:53 a.m. with licensed practical nurse (LPN) C while she provided wound care for resident 4 revealed:</p> <p>*She gathered supplies to provide wound care for the resident. Those supplies had consisted of a medication cup containing Betadine and several 2 inch by 2 inch gauze wipes. The 2 by 2 gauze wipes had not been covered and were placed directly on the resident's bedside table.</p> <p>*She washed her hands and turned the water faucet off without a barrier protection prior to putting on clean gloves.</p> <p>*While LPN C had her gloves on she:</p> <ul style="list-style-type: none"> -Adjusted the bed by using the hand control. -Removed the resident's pressure relieving boot off of her right foot. The bottom of the boot had been covered with black/gray colored debris. -Removed the resident's sock. -Gathered the 2 by 2 gauze wipes and soaked them with the Betadine. -Cleansed the resident's unstageable pressure ulcer to her right heel with those 2 by 2 wipes. -Put the resident's sock and pressure relieving boot back on her right foot. <p>*She removed her gloves and washed her hands.</p> <p>Interview on 7/19/16 at 5:57 p.m. with the DON confirmed the:</p> <ul style="list-style-type: none"> *Process above had not been performed in a sanitary manner. *The water faucet should have been turned off with a paper towel. *Gauze wipes should have been placed on a clean surface or clean barrier prior to use. *The resident had the potential for cross-contamination of bacterial germs to her wound with the care provided above. <p>Surveyor: 29162</p>	F 441	<p>* Education regarding proper wound care technique will be provided to all staff. Education will be provided to LPN C regarding resident 4 on proper wound care technique, hand hygiene, and moving from a dirty field to a clean field by 8/11/2016. Education will also be provided to all CNAs, RNs, and LPNs by 8/11/2016. Education will include proper supplies, proper glove usage, and placement of supplies in the residents' room during wound care, and transporting of supplies to and from the residents room. Education will be completed at a mandatory education session that will require the caregiver to complete an Infection Control written post-test. Monitoring will include proper wound care technique, proper hand hygiene, and correctly moving from a dirty field to a clean field including resident 4. Monitoring of 5 occurrences will be completed by the DON or designee daily for one week, then weekly for 4 weeks, then monthly thereafter until 8/1/2017 to ensure compliance. DON or designee will report the results to the QA/PI at their monthly meetings. <i>VA/SB DOH</i></p>	8/13/16

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F 441	<p>Continued From page 48</p> <p>3. Observation on 7/20/16 at 8:20 a.m. of LPN B while she provided a treatment for resident 10 revealed she washed her hands and put on gloves. She then:</p> <ul style="list-style-type: none"> *Repositioned the resident and adjusted the blankets. *Placed a tube of ointment, wound cleanser, and gauze pads directly onto the resident's bottom sheet. Those items had been in her pocket. *While wearing the same gloves used the wound cleanser to clean the resident's wound. *Put some of the ointment directly onto her soiled gloved finger and applied it to the wound. <p>4. Observation on 7/20/16 at 9:15 a.m. of LPN B while she completed a treatment for resident 21 revealed she:</p> <ul style="list-style-type: none"> *Entered the room, washed her hands, and put on gloves. *Assisted the resident to lay down, took off his shoes, removed a Lidoderm five percent medication patch from his left hip, and applied a new one. *Laid the wound cleanser and two ointment boxes that contained medication directly on his bedspread. *Loosened his adult brief and completed the treatment to his left hip. *Removed her gloves and put on clean gloves. She did not wash her hands between glove changes. *Removed his socks. *Applied an ointment to his toes using the products she had laid on his bed. *Put all of the products that had been on his bed into her pockets. *Removed her gloves and washed her hands. *Placed all of the ointments and wound cleanser from her pockets into the medication cart. 	F 441		

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F 441	<p>Continued From page 49</p> <p>5. Interview on 7/20/16 at 4:40 p.m. with the director of nurses revealed:</p> <ul style="list-style-type: none"> *CNAs K and L had not worn, used, and changed gloves correctly. *Perineal care for resident 10 had been done incorrectly. *Moving a catheter drainage bag with feet was not good practice. *CNA K should have washed her hands when she removed her gloves. *Soiled linen was to be bagged when taken from a resident's room to the dirty utility room. *Treatment supplies should have been placed on a clean area or on a clean barrier. *Ointment should not have been put directly onto a soiled gloved finger. *Hand washing should have been done between glove changes. <p>Review of the provider's 3/29/11 Clean Dressing Change policy revealed:</p> <ul style="list-style-type: none"> **Create a clean field using a towel or drape on top of the stand at bedside or on bed." **Assemble and ready the supplies on clean field." *Handwashing was to have been completed after removing soiled gloves and before putting on clean gloves. <p>Review of the provider's last revised March 2014 Hand Hygiene policy revealed hands were to have been washed:</p> <ul style="list-style-type: none"> *After removing soiled gloves. **After contact with inanimate objects including medical equipment, in the immediate vicinity of the patient/resident." **When moving from a contaminated body site to a clean body site during patient/resident care." 	F 441		

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F 441	<p>Continued From page 50</p> <p>Surveyor: 32355</p> <p>6. Observation and interview on 7/19/16 at 11:10 a.m. with CNA P cleaning the whirlpool tub in the Berry Unit tub room revealed:</p> <p>*Without the use of gloves she:</p> <ul style="list-style-type: none"> -Closed the drain and turned the disinfectant MasterCare/cleansing knob on and sprayed down the entire tub and chair. -Used a scrub brush to scrub down all the surfaces of the tub and chair. -Left the disinfectant in the tub "About five minutes." <p>*She did not:</p> <ul style="list-style-type: none"> -Ensure the air jets were covered with the disinfectant. -Turn on the air jets to ensure proper cleaning of them had occurred. <p>*After five minutes she had:</p> <ul style="list-style-type: none"> -Drained the tub of the disinfectant. -Rinsed the disinfectant off all of the surfaces. <p>Interview on 7/19/16 at the time of the above observation with CNA P revealed:</p> <ul style="list-style-type: none"> *That had been her usual process for cleaning and disinfecting the whirlpool tub and chair. *After all the residents had received their baths for the day she would have: <ul style="list-style-type: none"> -Performed the same process as above. -Filled the tub half full of water after she had completed her scrubbing process. -Turned the air jets on to ensure they had been clean. That had been the only time she would have turned on the air jets to ensure proper cleaning. *She had not realized the chemical she used had required exact parts-per-million (PPM) concentration when mixed with water. *She agreed: 	F 441	<p style="text-align: center;">*</p> <p>The tub sanitizing policy has been updated and in accordance with the manufacturer's recommendations. Education will be provided to CNA P, and to all CNAs, LPNs, RNs and bath aides on the proper process for tub sanitizing, correct wet time, correct chemicals for tub sanitizing and shower disinfection and policy revisions by 8/11/2016. Education will be completed at a mandatory education session by 8/11/2016. Monitoring of 5 occurrences will be completed by the DON or designee daily for one week, then weekly for 4 weeks, then monthly thereafter until 8/1/2017 to ensure compliance. DON or designee will report the results to the QA/PI at their monthly meetings. WA/SDDOH</p>	8/13/16

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- The PPM concentration would not have been accurate after she filled the tub half full with water.
- She did not know how to check for proper PPM. The tub had been programmed to do that for them. She had relied upon that process.
- The air jets should have been turned on and cleaned between each resident's bath to ensure cleanliness.

Review of the provider's undated instructions for MasterCare bath air system disinfectant revealed all surfaces should have remained wet with the chemical for ten minutes.

Review of the provider's 1/26/10 Operating Instructions for the MasterCare Integrity Bathtub revealed no process on how to clean the air jets.

Review of the provider's 9/5/10 tub Sanitizing policy revealed:

- *"Flush the jets, either by running jets or using sanitizing wand."
- *"Allow water and sanitizing solution to sit for 10 minutes or proper 'set time' according to disinfectant manufacturer's recommendations."

7. Observation and interview on 7/19/16 at 11:20 a.m. with CNA P cleaning the shower stall and shower chair in the Berry Unit tub room revealed:

- *She retrieved a spray bottle half full of a solution from underneath the whirlpool tub. That spray bottle had not been dated. The name on the bottle was Tough Guy.
- *There had been no:
 - Identification as to what kind of cleaner the Tough Guy was.
 - Directions for proper use of that chemical on the bottle.

F 441

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B. WING

07/21/2016

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F 441	<p>Continued From page 52</p> <p>*She sprayed the shower stall and shower chair with that chemical.</p> <p>*With a scrub brush she had scrubbed all the surfaces.</p> <p>*She stated the chemical would sit on the shower stand and chair for "3 minutes."</p> <p>*After the 3 minute wait she rinsed the stall and chair.</p> <p>Interview on 7/19/16 at 2:30 p.m. with the maintenance director revealed:</p> <p>*He had not been responsible for the proper chemical used to clean the whirlpool tubs and showers.</p> <p>*The nursing department had been responsible to ensure:</p> <ul style="list-style-type: none"> -The proper chemicals were used. -All the staff had been educated on the proper cleaning process for the whirlpool tubs and showers. <p>*He confirmed the label on the spray bottle had been Tough Guy.</p> <p>*He had not been aware of any chemicals used in the facility named Tough Guy.</p> <p>Interview on 7/19/16 at 3:00 p.m. with the environmental services supervisor revealed:</p> <p>*She was the supervisor for the housekeeping department.</p> <p>*She was not responsible to ensure the nursing department had been using the proper chemicals to clean the whirlpool tubs and showers.</p> <p>*She confirmed the above interview with the maintenance director regarding the chemical Tough Guy.</p> <p>Interview on 7/20/16 at 8:15 a.m. with the maintenance director and the environmental services supervisor revealed:</p>	F 441		

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F 441	<p>Continued From page 53</p> <ul style="list-style-type: none"> *They had retrieved the spray bottle labeled Tough Guy. *The spray bottle had been changed to reflect: <ul style="list-style-type: none"> -A date of 7/19/16 written on it. -It contained the chemical Oxifer in it. The name had been hand written on the bottle. No directions for proper use of the Oxifer were found on the spray bottle. *They had no explanation as to why those areas of identification had not been on the spray bottle the day before. *They agreed those areas of identification should have been on the spray bottle before use. *The chemical Oxifer had been a disinfectant and required all surfaces to remain wet for five minutes. <p>Interview on 7/20/16 at 11:00 a.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> *There were no recent audits completed to ensure the staff had been cleaning the whirlpool tub and shower unit/chair correctly. *The nursing and housekeeping departments had been been responsible to ensure the proper chemicals had been used for the cleaning and disinfecting of the whirlpool tub and shower. *She confirmed the spray bottle had not been properly labeled. <ul style="list-style-type: none"> -That spray bottle should have had the chemical name, date, and proper instructions for use. *The staff were not to have used a bottle unless it had been properly labeled. <p>Review of the provider's undated Bathing, Showering the Resident policy revealed:</p> <ul style="list-style-type: none"> *The policy had been: <ul style="list-style-type: none"> -Typed onto a blank sheet of paper. -Taped to the wall for viewing above the whirlpool tub. 	F 441		

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"If the shower is not clean, clean it with a disinfectant solution."
"Allow the disinfectant to stand on surface for 10 minutes."

Interview on 7/20/16 at 6:03 p.m. with the DON revealed:

- *The staff had been set-up to fail with the cleaning of the whirlpool tub and shower.
- *The facility had been changing their chemicals frequently, and none of them had the same instructions and recommendations for use.
- *She stated "We are all responsible to ensure the proper chemicals had been used on the whirlpool and shower unit."
- *The instructions hanging in the bathing room were incorrect, old, and should have been removed.

8. Random observations on 7/19/16 from 8:15 a.m. through 4:20 p.m. throughout the facility revealed:

*The residents' oxygen concentrators 13, 19, and

F 441

*
A policy and procedure has been written regarding the care and cleaning of oxygen concentrators and their filters. The filters on residents 13, 19 & 20 were all cleaned and replaced. All other resident oxygen concentrators were checked for clean filters, and replaced appropriately. A log sheet has been developed for the oxygen supplier to notate the date, time, and which concentrators have been checked. Education regarding the policy and process for cleaning oxygen concentrator filters will be completed at a mandatory education session for CNAs, LPNs, and RNs by 8/11/2016. Monitoring of 5 occurrences will be completed by the DON or designee daily for one week, then weekly for 4 weeks, then monthly thereafter until 8/1/2017 to ensure compliance. DON or designee will report the results to the QA/PI at their monthly meetings. **VA/SD DON**

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concentrators filters had been

Interview on 7/20/16 at 6:05 p.m. with the DON revealed:

- *The provider had no policy and procedure in place for the staff to follow on the proper use of the oxygen concentrators and their filters.
- *The oxygen supplier had been in the facility this past month to check all the oxygen concentrators for proper functioning.
- They had no documentation to support when the oxygen supplier had been in-house to check the concentrators.
- *The night shift staff had been responsible for the

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F 441	<p>Continued From page 55 cleaning and placement of those oxygen filters every week on Wednesdays.</p> <p>9. Random observations on 7/19/16 from 8:10 a.m. through 9:10 a.m. of resident rooms 26, 27, 28, 29, 31, and 32 revealed:</p> <ul style="list-style-type: none"> *The rooms had been shared by two residents. *There had been one bathroom with a sink. *Above the sinks had been a medicine cabinet. *Inside of those medicine cabinets had been: <ul style="list-style-type: none"> -Three separate shelves. -On the shelves were residents' personal care supplies. Those supplies had been toothbrushes, toothpaste, denture cups, emesis basins, deodorant, lotions, mouth wash. *The resident's personal care items were not marked. *There was no identification indicating which items on the shelves belonged to which resident in the shared room. *By the sink had been a paper towel unit containing paper towels to use to dry hands after washing. -Those units had a shelf underneath of the paper towels. -On those shelves had been emesis basins containing toothbrushes and toothpaste, perineal cleanser, and denture cups. <p>Interview on 7/19/16 at 11:30 a.m. with CNA E revealed:</p> <ul style="list-style-type: none"> *She had not been aware all of the resident's personal care items had not been marked. *She had been aware of the various resident personal care items located underneath of the paper towels. She stated: "The residents put those there. It makes it easier for them to get those things." *She agreed the items had not been stored in a 	F 441	<p>* The infection control policy has been updated to indicate that all personal care items will be labeled with patient identifying information and stored in a clean location within the residents' bathroom or room. All resident personal belongings are being stored in the medicine cabinet. All resident personal care items and shelves are labeled with resident initials. All resident rooms were checked and labeled including resident rooms 26, 27, 28, 29, 31 & 32. Education regarding the process will be provided to all caregivers during a mandatory education session by 8/11/2016. Monitoring of 5 occurrences will be completed by the DON or designee daily for one week, then weekly for 4 weeks, then monthly thereafter until 8/1/2017 to ensure compliance. DON or designee will report the results to the QAPI at their monthly meetings.</p> <p style="text-align: right;">m/sd doh</p>	8/13/16

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sanitary manner.Interview on 7/20/16 at 6:08 p.m. with the DON
revealed:*All residents' personal care items should have
been labeled with their names or "W" for window
or "D" for door.*The expectation was to be able to identify which
supplies belonged to each resident.*She had not been aware that process had been
broken.*She agreed the above process had created the
potential for the transfer of bacteria from one
resident to another.*The provider had no policy and procedure for the
storage of residents' personal care products.10. Random observations on 7/19/16 from 9:00
a.m. through 4:00 p.m. of two soiled utility rooms
(Berry and Massa units) revealed:*Both of the rooms had cupboards with a sink
and countertop area.*On top of those cupboards and inside of those
sinks had been multiple resident-use equipment.-That equipment had been nebulizer machines,
k-pad heating units, pillows, incentive
spirometers, personal alarming monitors and
devices, and wash tubs/basins.*On the floors had been wheelchair pedals,
pressure relieving cushions for chairs, and
repositioning devices utilized in the resident's
beds for feet/ankles.*The Massa soiled utility room had several
buckets sitting on the floor. One of the buckets
had been full of water. Inside of that water was
plastic tubing and a dust pan.Interview on 7/19/16 at 2:30 p.m. with CNA F
regarding the soiled utility room on the Berry Unit

F 441

*
The Infection Control policy has been revised to include
equipment cleaning immediately after use. Policies titled
Resident Mat Cleaning, Procedure, and Resident Lift
Cleaning Procedure were written. All equipment located
in the soiled utility rooms has been cleaned as well mats
and resident lifts and moved into their proper clean
storage location. Education regarding the revised policies
and procedures will be provided to CNAs, LPNs, RNs,
and CNA F & H & LPN G during a mandatory education
session by 8/11/2016. Monitoring of 5 occurrences will
be completed by the DON or designee daily for one week,
then weekly for 4 weeks, then monthly thereafter until
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revealed:
*She had not been sure who was responsible to ensure all of the resident-use equipment had been cleaned.
*She stated: "The CNAs do not do any of that. All that stuff is usually not in here."
*She agreed the staff would have had to bring those various items into the soiled utility room.

Interview on 7/19/16 at 4:00 p.m. with CNA H regarding the soiled utility room on the Massa Unit revealed:
*She was not sure who had been responsible for the cleaning and upkeep of the resident-use equipment.
*She stated: "This room is usually not like this. I just worked last Thursday and none of these things were in here."
*She agreed the room and equipment had not been maintained in a sanitary manner to ensure cross-contamination of bacteria had not occurred.

Interview on 7/20/16 at 6:10 p.m. with the DON revealed all the staff were responsible for the cleaning and up-keep of the resident-use items in the soiled utility rooms. She stated: "You bring it in, you clean it." She had not been aware the soiled utility rooms were not maintained in a clean manner.

Review of the provider's March 2014 Exposure Control Plan policy revealed:
*Housekeeping:
-"All places of work, passageways, storerooms, and service rooms are to be maintained in a clean and sanitary condition."
-"All equipment and environmental and work surfaces shall be cleaned and decontaminated immediately or as soon as feasible."

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F 441	<p>Continued From page 58</p> <p>11. Random observation on 7/19/16 from 8:30 a.m. through 5:30 p.m. on the Berry and Massa units revealed:</p> <ul style="list-style-type: none"> *Two EZ Way Stand-aides. *The EZ Way Stand-aide bases were dirty with red debris. <p>7/19/16 at 5:30 p.m. with LPN G revealed:</p> <ul style="list-style-type: none"> *She confirmed the base of the EZ Way stand-aide on the Berry unit had been dirty. *She stated: "The staff were to have cleaned the lifts after each use." -That cleaning process had included the bases. <p>Interview on 7/20/16 at 6:10 p.m. with the DON confirmed the above interview with LPN G.</p> <p>Review of the provider's March 2014 Exposure Control Plan policy revealed "All equipment and environmental and work surfaces shall be cleaned and decontaminated immediately or as soon as feasible."</p> <p>12. Observation on 7/19/16 at 8:20 a.m. of resident 4 and 21's room revealed:</p> <ul style="list-style-type: none"> *Both of the residents had floor mats located on the side of their beds. *The floor mats surfaces were dirty with black/brown spots. *Those spots had been dried on the surfaces. <p>Some of those dried spots gave the appearance of a shoe print.</p> <p>Interview on 7/20/16 at 6:12 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She confirmed the floor mats had been used for those residents who had a history of falling out of 	F 441		

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F 441	<p>Continued From page 59 their bed. *The floor mats should have been: -Cleaned weekly on the resident's bath day. -Cleaned as needed when they were dirty. *There had been no policy and procedure in place for the cleaning of the floor mats. *She was not aware that process had not been followed by the staff.</p>	F 441		
F 490 SS=E	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, throughout the course of the survey from 7/19/16 through 7/21/16 revealed administration did not ensure one of one registered dietician completed her responsibilities to ensure all residents attained and/or maintained their highest practical physical, mental, and psychosocial well-being. Findings include:</p> <p>1. Interview and observation revealed the provider failed to promote a dining experience that enhanced the residents' quality of life.</p> <p>Refer to F240, findings 1, 2, 3, 4, 5, and 6.</p> <p>2. Record review, observation, interview, policy review, job description review, and pamphlet</p>	F 490	<p>* F490- The administrator will review monthly the consultant's report from the clinical nutrition supervisor at Regional Health and it will be reported at the QAPI committee monthly. The Administrator will review and go over the job description for the Registered Dietician to guarantee the dietician understands their job description, duties and responsibilities. The Sturgis Registered Dietician will be audited by the clinical nutrition supervisor from Regional Health with "the review of 5 residents at risk for nutritional issues --five a week for one month and then monthly thereafter until 8/1/2017". A monthly meeting will be held with the administrator and the registered dietician to ensure all resources are available to confirm each resident meets their highest practicable physical, mental and psychosocial well-being is maintained starting August 13th, 2016. Administration will share the reviewed audit results with the board members and discuss changes to occur. VA/SB DOH</p>	8/13/16

STURGIS REGIONAL SENIOR CARE

949 HARMON STREET

STURGIS, SD 57785

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F 490	<p>Continued From page 60</p> <p>review throughout the survey revealed revealed residents 1, 2, 4, 5, 7, 8, 10, 12, and 13 had significant weight losses. There were no RD assessments, interventions, and goals to identify risk factors for those residents.</p> <p>Refer to F281, findings 1 and 2. Refer to F309, findings 1a, b, and c. Refer to F325, findings 1, 2, 3, 4, and 5.</p> <p>3. Observation, record review, interview, and policy review revealed the provider failed to ensure resident 4 had no interventions, goals, assessments, and RD involvement to ensure healing and prevention of pressure ulcers from developing for resident 4.</p> <p>Refer to F314, finding 2.</p> <p>4. Review of the provider's undated and unsigned Chief Executive Officer job description revealed: *"Mission: "Our mission is to provide and support health care excellence in partnership with the communities we serve." *Vision: "Our vision is to be the premier regional health system providing health care excellence in the communities we serve." *Values: "Quality/High Standard of Performance, Integrity, Skilled, Caring People, Community Partnerships, Innovation, Lifelong learning, and Provide Value." *"The Administrator is assigned full management operational responsibility for the designated facility under Regional Health Network." *"The Administrator shall have all authority and responsibility necessary to operate the institution and in all of its activities and departments and carry out its objectives in the provision of health care, including the execution of policy formulated</p>	F 490		

STURGIS REGIONAL SENIOR CARE**949 HARMON STREET
STURGIS, SD 57785**

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F 490	Continued From page 61 by the Regional Health Network of Directors." *Accountability: "I will be accountable for the choices I make. -I choose to hold myself and others accountable to the Standards of Performance. -I choose to give my best to my work and my customers."	F 490		

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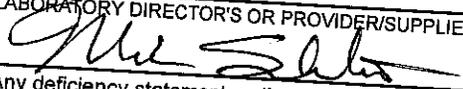
K 000

INITIAL COMMENTS

K 000

Surveyor: 20031
A recertification survey for compliance with the
Life Safety Code (LSC) (2000 existing health care
occupancy) was conducted on 7/20/16. Sturgis
Regional Senior Care (Building 1 - Massa) was
found in compliance with 42 CFR 483.70 (a)
requirements for Long Term Care Facilities.

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



TITLE

Administrator

(X6) DATE

8-5-16

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

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/20/16. Sturgis Regional Senior Care (Building 2 - Berry) 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

[Handwritten Signature]

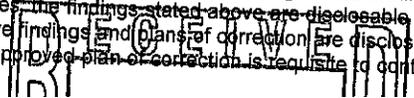
TITLE

Administrator

(X6) DATE

8-5-16

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



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(X5)
COMPLETION
DATE

K 000

INITIAL COMMENTS

K 000

Surveyor: 20031
A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/20/16. Sturgis Regional Senior Care (Building 3 - Administration) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

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



TITLE

Administrator

(X6) DATE

3-5-16

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 must be submitted to the program participation.

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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/19/16 through 7/21/16. Sturgis Regional Senior Care was found in compliance.</p>	S 000	<p>Addendums noted with an asterisk per 8.11.16 telephone to facility interim DON. YA/SDDOH</p>	
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/19/16 through 7/21/16. Sturgis Regional Senior Care was found not in compliance with the following requirement: S030.</p>	S 000		
S 030	<p>44:74:02:06 Required to Pay Costs of Training/Evaluation</p> <p>A nursing facility shall pay all costs of nurse aide training and competency evaluation or reimburse the nurse aide for the cost incurred in completing the program if the facility employs the aide within twelve months following completion of the training program. Reimbursement may be made during the first twelve months of employment by installments. A nursing facility is not required to pay the cost of training and competency evaluation of a training program, conducted by an online or non-nursing home based nurse aide training program, if the nurse aide leaves employment or is terminated before completing the facilities probationary period of employment. The nursing facilities probationary period for nurse aides shall be similar to other employees of the nursing home. A nursing facility shall not seek</p>	S 030	<p>* S030- The entire employment contract for CNA education will be discontinued effective 8/5/2016. All necessary personal will be notified of this discontinuation of contract to include all CNA's, human resources, and board members. YA/SD DOH</p>	8/05/16

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



TITLE

Administrative

(X6) DATE

8-5-16

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If continuation sheet 1 of 2

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S 030	<p>Continued From page 1</p> <p>restitution for those installments already paid to nurse aide prior to termination. The nurse aide shall not seek payment of training costs if costs have already been paid by another facility where previously employed.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18560 Based on employee file review and interview, the provider failed to ensure nurse aide training costs were provided for two of two newly hired nurse aide employees (Q and R). Findings include:</p> <ol style="list-style-type: none"> 1. Review of employees Q and R's personnel files revealed they had been hired as nurse aides on 2/23/16. Both files contained signed employment contracts for certified nurse aide (CNA) education. <p>Review of the employment contract revealed: *The employee received a loan and agreed to remain employed for at least eight months following completion of the course. *If the employee voluntarily left the loan had to be fully repaid.</p> <p>Interview on 7/20/16 at 9:00 a.m. with the human resources specialist revealed: *They had been using the employment contract for several years. *They had problems with nurse aide students not staying after their training had been completed.</p>	S 030		