

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

ORIGINAL

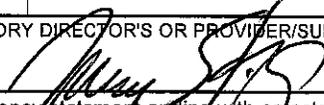
PRINTED: 08/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/25/16 through 7/27/16. White River Health Care Center was found not in compliance with the following requirements: F279, F281, F323, F371, F431, and F441.	F 000	*Addendums noted with an asterisk per 8/29/16 per email with facility DON. KW/SDDOT/jel	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	F279 483.20(d), 483.20(k) (1) DEVELOP COMPREHENSIVE CARE PLANS SS=D 1. Resident #9 had a plan of care implemented on 7-13-16, it was updated 7-27-16 and 8-9-16. All residents being admitted and assessed at the White River Health Care Center Facility will be at risk for developing a comprehensive care plan. One on one discussion with MDS coordinator, charge nurses, Director of nursing was held on 7-27-16 the concern was corrected. MDS coordinator verbalizes that the care plan would be developed within seven days of the completion of the resident's comprehensive assessment. A working care plan would be utilized and the assessments of residents were ongoing and care plans were revised as information about the resident and the condition changed defined by F279 483.10(b) (4) on the development of comprehensive care plans.	*8/15/16 KW/SDDOT/jel

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Admin</i>	(X6) DATE <i>Aug 19 2016</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	<p>Continued From page 1 under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on record review, interview, and policy review, the provider failed to complete an initial care plan within fourteen days of admission for one of one sampled resident (9). Findings include:</p> <p>1. Review of resident 9's medical record revealed: *He had been discharged on 5/8/16 and readmitted on 6/29/16. *No care plan had been implemented at the time of his readmission. *He did not have an interim care plan that had been developed since his admission. *Only the admission date had been changed on the previous care plan. -That care plan was not revised and updated.</p> <p>Interview on 7/26/16 at 11:10 a.m. with the director of nursing and the Minimum Data Set (MDS) coordinator regarding resident 9 revealed: *They confirmed he did not have a care plan. *It would be their normal procedure to start a care plan at the time a resident had been admitted by the MDS coordinator.</p> <p>Review of the provider's September 2010 Comprehensive Care Plan policy revealed: *The care plan would be developed within seven days of the completion of the resident's comprehensive assessment. *The assessments of residents were ongoing and care plans were revised as information about the</p>	F 279	<p>The Social Service Designee, Director of Nursing, MDS Coordinator/Case Manager, Dietary Manager and Medical Records have reviewed and clarified the policy for Comprehensive Care Plan in the facility.</p> <p>The Director of Nursing held a meeting on August 19th, 2016 on the policy for Comprehensive Care Plans in the facility at the all staff in service.</p> <p>The MDS Coordinator will review every care plan when the residents MDS assessment is scheduled to ensure that the Comprehensive Care Plan is being implemented as defined by F279 483.10(b) (4) on the development of comprehensive care plans.</p> <p>The MDS Coordinator and Director of nursing or designee will audit every new admit for an active comprehensive care plan every times 4 weeks, then every month times 3.</p> <p>The MDS Coordinator or designee will audit four resident's charts weekly times three month or until all the residents charts have been evaluated along with all new resident's charts on admit. Then audit four different resident charts monthly times three months to ensure that the Comprehensive Care Plan is being implemented as defined by F279 483.10(b) (4) on the development of comprehensive care plans. Results of this audit will be reported by the MDS coordinator to the QA/PI monthly with further follow up as recommended by the committee.</p> <p><i>* [Redacted] KW/SDD/H/EL</i></p>		

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F 279	Continued From page 2	F 279			
F 281 SS=E	<p>resident and the resident's condition changed.</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: 32332</p> <p>Surveyor: 26632 Based on observation, record review, interview, and policy review, the provider failed to ensure professional nursing standards were followed for: *Two insulin pens were not primed before use by one of two sampled licensed practical nurses (LPN) (A) for one of two observed residents (6). *Two of three LPNs (B and D) recorded medications in the medication administration records (MAR) before being administered. *One of one random resident (13) who had been sent with medications did not have a physician's order to send those medications. *Policy had not been followed for two of two sampled residents (2 and 14) with falls with a head injury. *One of one LPN (B) who had documented a skin assessment for one of one resident (2) that had not been completed. Findings included:</p> <p>1. Observation on 7/26/16 at 8:40 a.m. revealed LPN A took out two insulin pens for resident 6. She put on new needles and dialed the insulin pens to the ordered doses. She did not prime</p>	F 281	<p>F281 483.20(K) (3) (I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS SS=E</p> <p>One on one education on the appropriate insulin pen priming was reviewed with licensed practical nurse (A) on 7-29-16. LPN (A) verbalizes an understanding of the importance of priming insulin s prior to administration as defined by F281 483.20(k) (3) (I) for services provided to meet the professional standard.</p> <p>One on one education with LPN (B and D) was held on 7-27-16 on recording medications in the medication administration records (MAR) for resident (1) (15) (16). LPN (B and D) verbalizes an understanding of the recording of medications in the medication administration records (MAR) as defined by F281 483.20(k) (3) (I) for services provided to meet the professional standard.</p> <p>One on one education was provided to LPN (B) on sending resident (13) with medication without a physician's order to send those medications. LPN (B) verbalized on 7-27-16 that she should have not sent the resident with medication without a physician's order to send those medications realizing this was out of her scope of practice as defined by F281 483.20(k) (3) (I) for services provided to meet the professional standard.</p> <p>One on one education was held with the nursing staff on sampled residents with falls with head injury. That LPN on 7-27-16 verbalized understanding that she had not followed the policy had not been followed for two sampled residents (2 and 14) as defined by F281 483.20(k) (3) (I) for services provided to meet the professional standard.</p>	*9/15/16 KW/SDC/HJL	

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F 281	<p>Continued From page 3</p> <p>either of the insulin pens prior to dialing the ordered doses. Those insulin pens were Novolog and Lantus.</p> <p>Interview on 7/26/16 at 4:00 p.m. with LPN A revealed she was not aware she should have primed the insulin pens before she dialed the ordered dose.</p> <p>Interview on 7/27/16 at 9:00 a.m. with the director of nursing (DON) confirmed insulin pens had to be primed before dialing the ordered dose. She had previously provided education to all the nurses. She stated LPN A was a traveling nurse and had not been provided that education.</p> <p>Review of the provider's undated Using an Insulin Pen policy revealed to "Prime the pen by performing a test dose."</p> <p>2a. Observation on 7/26/16 from 10:35 a.m. through 11:10 a.m. revealed LPN B prepared medications for residents 1 and 15. She signed the electronic MAR before residents 1 and 15 had received their medications.</p> <p>Interview on 7/26/16 at 3:30 p.m. with LPN B revealed she had always charted the medications before she had given them. She was not aware she should have given the medications and then charted.</p> <p>b. Observation on 7/27/16 at 7:45 a.m. revealed LPN D prepared resident 16's medications. She signed the electronic MAR before resident 16 had received her medications. Interview at that time revealed she was aware she should have waited to chart the medications until after the resident had taken them.</p>	F 281	<p>One on one education was held with LPN (B) who had documented a skin assessment for resident (2) that had not been completed. LPN (B) was interviewed on 7-27-16 and she denied, then C.N.A.'s(C,H,L) were interviewed per her request they confirmed no bath was given, LPN(B) confirmed that the documentation of a skin assessment for resident (2) had not been completed as defined by F281 483.20(k) (3) (I) for services provided to meet the professional standard.</p> <p>All residents receiving services at the White River Health Care Center Facility will be at risk for services being provided need to meet a professional standard as defined by F281 483.20(k) (3) (I).</p> <p>The DON reviewed professional standards to administer insulin with appropriate insulin pen priming, administering medications with documenting signature following actual medication administration-not prior, administering medications after ensuring physician acknowledgement/order for medications to accompany resident when out of home, providing assessment and care for resident(s) following a fall –neuro checks and completing a skin assessment with appropriate documentation with the nursing staff. This was done 7-27-16(K.K., D.B., M.H., R.R., O.T., N.B., 7-28-16 G.W., B. G., B.B., 7-29-16 V.D., 8-2-16 B.B., and 8-18-16 I.B. AND M.A.)(UAP 7-27-16 J.H., 8-18-16 P.B.)</p> <p>Post one on one education with LPN (B) by the DON and MDS coordinator she has not been back to work since 8-4-16, she is no longer an employee of the Whiter River Health Care Center by de-hiring herself.</p>

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F 281	<p>Continued From page 4</p> <p>c. Interview on 7/26/16 at 9:00 a.m. with the DON confirmed LPNs B and D should have given the medications and then charted on the MAR.</p> <p>Review of the provider's December 2001 Administering Medications policy revealed "The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones."</p> <p>3. Observation on 7/26/16 at 11:40 revealed LPN B prepared resident 13's noon and 6:00 p.m. medications and placed them in a pill minder container. She gave that pill container to resident 13's daughter. She told the daughter at that time "I called the Dr. for an order to send her medications with but he hasn't called back." She then charted those medications as having been given.</p> <p>Review of resident 13's medical record on 7/27/16 revealed no physician's order had been obtained to send her medications with her when out on pass. A 7/26/16 10:25 a.m. nursing note by LPN B revealed "Call Dr. regarding resident. Awaiting call from Dr. to let us know if she can take her medications with her for the noon and evening. Resident (family) are on their way to take her."</p> <p>Interview on 7/27/16 at 8:30 a.m. with LPN B revealed she was aware she had given resident 13's daughter the medications without a physician's order to send them with her.</p> <p>Interview on 7/27/16 at 9:15 a.m. with the DON confirmed LPN B should have waited for a</p>	F 281	<p>The Director of Nursing, MDS Coordinator/Case Manager and Medical Records have reviewed and clarified the policy for nursing professional standards to administer insulin with appropriate insulin pen priming, administering medications with documenting signature following actual medication administration-not prior, administering medications after ensuring physician acknowledgement/order for medications to accompany resident when out of home, providing assessment and care for resident(s) following a fall -neuro checks and completing a skin assessment with appropriate documentation as defined by F281 483.20(k) (3) (l) for services provided to meet the professional standard .</p> <p>The Director of Nursing held a meeting on August 19th, 2016 (Directed In service) on the policy or procedure for nursing professional standards to administer insulin with appropriate insulin pen priming, administering medications with documenting signature following actual medication administration-not prior, administering medications after ensuring physician acknowledgement/order for medications to accompany resident when out of home, providing assessment and care for resident(s) following a fall and completing a skin assessment – appropriate documentation as defined by F281 483.20(k) (3) (l) for services provided to meet the professional standard.</p>	

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F 281	<p>Continued From page 5 physician's order to send resident 13's medications with her.</p> <p>Review of the provider's April 2007 Dispensing Medications to Residents on Leave/Pass policy revealed no procedure for obtaining a physician's order to send medications with a resident on pass.</p> <p>Surveyor: 35237 4. Review of resident 2's medical record revealed: *She had the following diagnoses: cerebrovascular accident, dementia, seizure disorder, and depression. *Her 4/29/16 Morse Fall Risk Assessment score was 55 indicating she was at high risk for falling.</p> <p>Review of resident 2's incident reports revealed: *On 7/16/16 at 8:05 p.m. she had an unwitnessed fall out of her wheelchair onto the floor on her left side. -She had received a large hematoma to the left side of her forehead. -The neurological (neuro) assessment sheet stated they should have: --Completed checks every fifteen minutes times two, every thirty minutes times two, every hour times one, once more in four hours, then continued every shift for three days after a suspected head injury. -Included: eye status, motor response, verbal response, respirations, pulse, temperature, and blood pressure. -The neuro assessment sheet showed the checks had only been completed on 7/16/16 at the following times: --8:20 p.m. --8:35 p.m.</p>	F 281	<p>Continue education with nursing will include a 5-10 minute tutorial with flex pen administration and initial skin assessment and documentation for LTC residents due by 8-24-16.</p> <p>The DON or designee will audit two nurses once a week for 4 weeks or until all nurses have been audited, then a nurse monthly times three and as needed to ensure compliance with nursing professional standards in regards to administer insulin with appropriate insulin pen priming, administering medications with documenting signature following actual medication administration-not prior, administering medications after ensuring physician acknowledgement/order for medications to accompany resident when out of home, providing assessment and care for resident(s) following a fall -neuro checks and completing a skin assessment with appropriate documentation to meet F281 483.20(k) (3) (I) for services provided to meet the professional standard. Results of this audit will be reported by the DON or designee to the QA/PI monthly with further follow up as recommended by the committee.</p> <p>* [Redacted] K W / 15000H / EL</p>	

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F 281	<p>Continued From page 6</p> <p>--8:50 p.m. --9:05 p.m. --9:20 p.m. --10:20 p.m.</p> <p>*Those neuro checks had not been completed according to their guidelines. *On 7/20/16 at 6:20 p.m. she had an unwitnessed fall from her wheelchair onto the floor on her right side. -She had gotten a large hematoma to her right forehead. -The neuro assessment sheet showed the checks had only been completed on 7/20/16 at the following times: --6:45 p.m. --7:00 p.m. --7:15 p.m. --7:30 p.m. --8:00 p.m. --12:00 a.m. on 7/21/16. *Those neuro checks had not been completed according to their guidelines.</p> <p>Review of resident 2's progress notes related to the above falls revealed: *On 7/17/16 at 7:04 a.m. "This resident had an incident at 2005 [8:05 p.m.]...Resident had fallen out of her wheelchair onto the floor laying on her left side and she did receive a hematoma to left side of her forehead..." *On 7/18/16 at 3:00 a.m. it stated "res f/u fall no new injuries noted..." *On 7/18/16 at 12:51 p.m. it stated "resident s/p fall. Observed bruise on forehead. Resident said she felt no pain." *On 7/19/16 at 3:04 a.m. "res f/u fall no new injuries noted..." *On 7/19/16 at 6:18 p.m. "Resident is on S/P fall and behavior charting..."</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>*There was no mention of her neurological status at the time of her fall on 7/16/16 or following that fall.</p> <p>*Her bruising to the left side of her forehead was not documented consistently following the fall.</p> <p>*On 7/21/16 at 7:53 a.m. "At 1820 [6:20 p.m.] CNA [name] notified this nurse that resident was on the floor found her laying on her right side and received a huge hematoma to the right side of her forehead of where she must have hit her head on the bathroom door, when she fell out of her wheelchair..."</p> <p>*On 7/21/16 at 2:31 p.m. "resident is on f/u fall charting, bruise fading on her right forehead. Always leaning to the right acts like she is trying to pick up something off the floor."</p> <p>*On 7/22/16 at 1:46 p.m. "...Resident had a fall earlier in the week and had some bruising across forehead which looked to be fading some..."</p> <p>*On 7/22/16 at 5:52 a.m. "resident is on f/u fall with no complaints being voiced..."</p> <p>*On 7/22/16 at 3:31 p.m. "resident is f/u fall charting. leaning to the right all the time, even after straightening her up. Confused most of the time, talking out loud like she is talking to some children."</p> <p>*On 7/23/15 at 3:56 p.m. "...She is s/p fall with no noted injuries or c/o discomfort..."</p> <p>*On 7/24/16 at 7:07 a.m. "...noted bruising to forehead and right corner of her eye...had a fall time two."</p> <p>*There was no mention of her neurological status at the time of her fall on 7/21/16 or following that fall.</p> <p>*Her bruising to the right side of her forehead was not documented consistently following that fall.</p> <p>Observation on 7/25/16 at 6:20 p.m. of resident 2 revealed she was in the dining room eating</p>	F 281		

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F 281	<p>Continued From page 8 supper with a large bruise to the right side of her face and eye.</p> <p>Interview on 7/27/16 at 9:15 a.m. with the DON regarding resident 2's above falls and neuro checks revealed: *There was no specific neuro check policy. -They used the guidelines on the neuro assessment sheet. *The neuro checks for each shift should have been documented in the progress notes of her medical record. *Neuro checks for the resident had not been completed according to their guidelines.</p> <p>Interview on 7/27/16 at 10:30 a.m. with medical records staff/LPN G regarding neuro checks revealed: *They were completed on the neuro assessment sheet and in the progress notes. *The neuro assessment sheet was filed in the medical records office and not in the resident's medical record. *She agreed neuro checks should have been completed according to their guidelines and documented in the resident's medical record.</p> <p>Interview on 7/27/16 at 10:55 a.m. with LPN B regarding resident falls with head injury revealed: *Neuro checks should have been done at the time of the fall and following the fall according to the neuro sheet. *The first neuro checks were written on the sheet and the every shift check should have been documented in the progress notes. *She was unsure if the neuro check sheet became part of the resident's medical record.</p> <p>Review of the provider's revised April 2013 Fall -</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>Clinical Protocol policy revealed: *The nurse should have assessed and documented the resident's neurological status. **The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved."</p> <p>Surveyor: 32332</p> <p>5. Review of a random incident report for resident 14 revealed licensed practical nurse (LPN) M had documented: *On 6/8/16 at 6:30 p.m. he had fallen from his wheelchair "landing on his face/stomach." *He had a cut above his right eyebrow. **"Neuro checks will be done every 15 minutes x 1 hour every 30 minutes x 1 hour every hour x 2 then every 4 hours. Then every shift for 72 hours."</p> <p>Review of resident 14's medical record revealed neuro checks had been performed: *On 6/8/16 at: -6:30 p.m. -6:45 p.m. -7:00 p.m. -7:15 p.m. -7:45 p.m. -8:15 p.m. -9:15 p.m. -10:15 p.m. *On 6/9/16 at 2:10 a.m.</p> <p>Interview on 7/27/16 at 3:15 p.m. with the MDS coordinator and the director of nursing revealed: *Neuro checks were to have been monitored for all residents with known or suspected head injuries.</p>	F 281		

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F 281	<p>Continued From page 10</p> <p>*She was unable to locate any further neuro check records for resident 14</p> <p>*Her expectation was the neuro checks would have been completed following the recommendations on the provider's neuro check flowsheet.</p> <p>6. Observation and interview on 7/26/16 at 11:00 a.m. with certified nursing assistants (CNA) H and L revealed:</p> <p>*They had tried to give resident 2 a shower and she had refused.</p> <p>*CNA L stated she would let the evening staff know, so they could try to do her shower that evening.</p> <p>Review of resident 2's 7/26/16 at 11:03 a.m. progress note by LPN B stated "shower and skin assessment done."</p> <p>Interview on 7/27/16 at 2:45 p.m. with the DON and Minimum Data Set (MDS) coordinator revealed:</p> <p>*They confirmed resident 2 had not received a shower on 7/26/16.</p> <p>*The progress note by LPN B was not correct.</p> <p>*The nurse should not have documented something that was not done.</p> <p>Review of the provider's revised April 2008 Charting and Documentation policy revealed:</p> <p>*"All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record."</p> <p>*"Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy."</p>	F 281		

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F 281	Continued From page 11 **"Information documented in the resident's clinical record is professional, confidential and may only be released in accordance with state law and facility policy."	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 37551 A. Based on observation, record review, interview, and policy review, the provider failed to ensure interventions were implemented to prevent falls for one of five sampled residents (2). Findings include: 1. Review of resident 2's medical record revealed: *She had the following diagnoses: cerebrovascular accident, dementia, seizure disorder and depression. *On 4/29/16 her Morse Fall Risk Assessment had a score of 55 indicating she was at a high risk of falling. *Her July 2016 treatment administration record indicated she should have had: -A fall alarm to her bed and wheel chair every day and night. -A non-skid mat to her wheelchair every day and	F 323	F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES SS=D One on one education with LPN filling out resident (2) incident report on following neuro assessment and intervention post falls per policy and plan of care. LPN verbalized understanding. One on one education with LPN (B) was done 7-27-16 for post fall assessment charting of resident and accurately following already implemented fall prevention interventions. LPN verbalized understanding. One on one education with CNA (H) on skid mat care plans for resident. CNA verbalized understanding. One on one education with LPN (G) was done 7-27-16 for post fall assessment charting of resident and accurately following already implemented fall prevention interventions. LPN verbalized understanding.	* 9/15/16 KWB/DOCHJEL

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F 323	<p>Continued From page 12 night to prevent her from sliding down.</p> <p>Review of resident 2's incident reports from 7/16/16 and 7/20/16 revealed: *On 7/16/16 at 8:05 p.m. she had fallen out of her wheelchair onto the floor on her left side. -She had received a large hematoma to the left side of her forehead. -The chair alarm was not sounding and was not on her wheelchair. *On 7/20/16 at 6:20 p.m. she had an unwitnessed fall. -She was found on floor laying on her right side with a "huge hematoma" to the right side of her forehead. *There were no interventions documented to implement for either of those above reports to prevent further falls or injury.</p> <p>Observations of resident 2 at the following times revealed on: *7/25/16 at 6:20 p.m. she was in the dining room eating supper. -She had a large bruise to the right side of her face and eye. *7/26/16 at 11:45 a.m. she was sitting in her wheelchair in her room and the call light was not within her reach. *7/26/16 at 12:00 noon she was sitting in her room without the non-skid mat in her wheelchair. *7/26/16 at 4:50 p.m. she was lying in her bed, and her wheelchair/bed alarm was not attached. -That alarm was found on her wheelchair. -There was no non-skid mat in her wheelchair. *7/27/16 at 9:20 a.m. she was sitting in her wheelchair without the non-skid mat in place.</p> <p>Interview on 7/27/16 at 10:30 a.m. with certified nursing assistant (CNA) H revealed she did not</p>	F 323	<p>*2 KWISDOLIS</p> <p>Resident's skid-proof mat and fall alarm was placed 7-27-16. 8-4-16 resident medication list sent for pharmacy review, 8-15-16 consulting pharmacist into review medication .8-8-12 order placed for anti thrust cushion, lap buddy and lateral support for possible intervention till wheel chair available. 8-10-16 Evolution mobility chair available for resident and placed. 8-12-16 resident states evolution chair too big and unable to adjust height, requested regular wheel chair back. Resident placed back in wheel chair with anti-cushion and lateral support, noted not to be proper fit for resident. 8-16-16 different wheel chair customized for resident with anti-thrust cushion, lateral support and resident comfortable. 8-19-16 Dr. Plumage into evaluate for other ideas for plan of care received post falls and review pharmacy consult just. Morse fall assessment done on 8-18-16.</p> <p>One on one education with maintenance supervisor for preventative maintenance program reviewed on 7-27-16 to follow up on safety clips from previous request. Maintenance supervisor verbalize understanding.</p> <p>Clips ordered from direct supply on 8-2-16 and 8-12-16, placed on lift on 8-12-16 and 8-18-16 and E-z stand taken out of service.</p> <p>All resident that mobility concerns are at risk. Post one on one education with LPN (B) by the DON and MDS coordinator she has not been back to work since 8-4-16, she is no longer an employee of the Whiter River Health Care Center by de-hiring herself</p> <p>The Director of Nursing, MDS Coordinator/Case Manager, Medical Records and Maintenance Supervisor for fall assessment and cause policy and the lift manuals for general maintenance have reviewed and clarified the policy and procedure as defined by F 323 483.25(h) FREE OF ACCIDENTHAZARDS/SUPERVISION/ of DEVICES.</p>	

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F 323	<p>Continued From page 13</p> <p>know anything about a non-skid mat for her wheelchair and had not seen one previously used.</p> <p>Interview on 7/27/16 at 11:00 a.m. with licensed practical nurse (LPN) G revealed resident 2 should have had a slip mat in her wheelchair to prevent sliding. That should be placed on top of her wheelchair cushion.</p> <p>Interview on 7/27/16 at 2:20 p.m. with the director of nursing and Minimum Data Set (MDS)/LPN coordinator regarding resident 2 revealed: *She should have had a non-skid mat and chair alarm on her wheelchair and her bed. *The nurse was responsible for checking to see that those were in place. *There was not an updated Morse Fall Risk Assessment completed, and that should have been done after a fall.</p> <p>Review of the provider's revised April 2013 Falls-Clinical Protocol policy for treatment and management of falls included: **"1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling." **"2. If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation."</p> <p>Review of the provider's revised December 2007 Falls and Fall Risk, Managing policy revealed "That if falling recurs despite initial interventions,</p>	F 323	<p>The Director of Nursing held a meeting on August 19th, 2016 to review the policy and procedure F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES.</p> <p>The medical records or designee will audit resident safety devices in place weekly times 4, and then every month times 3. Results of this audit will be reported by the maintenance supervisor or designee to the QA/PI monthly with further follow up as recommended by the committee.</p> <p>Maintenance supervisor or designee will audit all wheel chairs and assistive lifting devices in the facility every week times 4, then every month. Results of this audit will be reported by the maintenance supervisor or designee to the QA/PI monthly with further follow up as recommended by the committee.</p> <p>*  KW/SDAH/CL</p>	

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F 323	<p>Continued From page 14</p> <p>staff should implement additional or different interventions, or indicate why the current approach remains revelant."</p> <p>Surveyor: 35237</p> <p>B. Based on observation, interview, manufacturer's instruction review, and policy review, the provider failed to ensure three of five randomly observed mechanical lifts (two Invacare Reliant 450 lifts and one EZ stand lift) had safety tabs in place per manufacturer's guidelines. Findings include:</p> <p>1. Random observations on 7/25/16 at 6:00 p.m., on 7/26/16 at 9:50 a.m., and on 7/27/16 at 7:45 a.m. revealed:</p> <ul style="list-style-type: none"> *One Invacare Reliant 450 lift had no safety tabs on the sling attachment area. *Another Invacare Reliant 450 lift had four of the six safety tabs missing. *An EZ stand lift had no safety tabs on the harness attachment area. <p>Interview on 7/26/16 at 9:25 a.m. with the maintenance supervisor revealed he:</p> <ul style="list-style-type: none"> *Had not been aware the above mechanical lifts had been missing some of their safety tabs. *Did not have the mechanical lifts on a preventative maintenance program to ensure they were in proper working condition. *Would have replaced the safety tabs when the director of nursing (DON) told him to. <p>Interview on 7/26/16 at 3:30 p.m. with the DON regarding the above observation revealed:</p> <ul style="list-style-type: none"> *She confirmed if the safety tabs were missing it could have been a risk to the residents who used those mechanical lifts. *The safety tabs should have been replaced as 	F 323		

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F 323	<p>Continued From page 15 needed by maintenance. *She thought maintenance had the mechanical lifts on a preventative maintenance schedule.</p> <p>Review of the provider's revised October 2009 Safe Lifting and Movement of Residents policy revealed "Maintenance staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order."</p> <p>Review of the provider's copy of the revised 3/11/09 EZ Way Smart Stand Operator's Instructions Manual revealed: *Recommendations were suggested to inspect the mechanical lifts every month. **"Any detected deficiency must be rectified before the stand is put back into service." ***"Safety tabs need to be checked to make sure they are installed correctly, not missing or torn."</p> <p>A copy of the Invacare mechanical lift instruction manual was requested from the DON on 7/26/16 and on 7/27/16 and was not received by the end of survey.</p> <p>Review of the 2013 copy of the Invacare Reliant 450 lift user manual from www.invacare.com (accessed on 7/28/16) revealed: **"After the first year of use, the hooks of the hanger bar and the mounting brackets of the boom should be inspected every three months to determine the extent of wear. If these parts become worn, replacement must be made." ***"Regular maintenance of patient lifts and accessories is necessary to assure proper operation."</p>	F 323		
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 16 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, food temperature documentation review, manufacturer's instructions, and policy review, the provider failed to document the food temperatures for 15 of 78 meals in July 2016 and had not used a food thermometer to measure the proper food temperatures for the last three months. Findings include: 1. Observation on 7/26/16 during the breakfast and lunch meals revealed cook F used a non-contact infrared thermometer to check all food temperatures. Interview on 7/26/16 at 4:15 p.m. with the dietary manager revealed: *She was unaware the thermometer the staff were using took a surface temperature and not an internal temperature of the food. *The kitchen had used that above thermometer for about three months. *She was aware of staff who had not taken the temperatures of the food and had not	F 371	F371 483.35(I) FOOD PROCURE STORE/PREPARE/Section, Inc. on 6/RVE - SANITARY SS=F One on one education with cook (F) was held on 7-26-16 on non-contact infrared thermometer which is for surface temperature and the need to use a probe thermometer to obtain internal temperature for food safety. Cook (F) verbalizes understanding. Dietary manager reviewed with all cook the use of a probe thermometer on 7-26-16 and 7-27-16, all staff verbalized understanding on use of probe thermometer. All food being prepared at the White River Health Care Center Facility will need procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare distribute and serve food under sanitary conditions as F371. One on one education was held with all dietary staff on 7-26-16 and 7-27-16 by the dietary manager on the policy and procedure for daily food temperature logs recording. The dietary manager or designee will audit thermometer use and temperature logs daily times one week then weekly times one month to meet F371 store/prepare/serve-sanitary regulations. Results of this audit will be reported by Dietary manager or designee to the QA/PI monthly with further follow up as recommended by the committee. *  KW/SDOAH/EL	*9/15/16 KW/SDOAH/EL	

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F 371	Continued From page 17 documented for their shift. -She usually had looked at that documentation at the end of the month. -Temperatures and documentation were incomplete for previous months also. Review of the food temperature documentation revealed fifteen of seventy-eight meals were not documented for July. Review of the manufacturer's instructions for the non-contact infrared thermometer revealed it took the surface temperature of the food and not an internal temperature. Review of the provider's 2013 Food Temperature policy revealed: *All hot food items must be cooked to the appropriate internal temperature. *The temperatures of the food items would be taken and recorded for each meal.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431			

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F 431	<p>Continued From page 18 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and policy review, the provider failed to ensure: *One of two medication carts (East) was kept secured by two of two licensed practical nurses (LPN) (B and D). *Keys to one of two medications carts (East) were not given to a certified nursing assistant (C) by one of one LPN (B) to retrieve a pair of scissors. *Medications had not been left on top of one of two medication carts (East) by one of one LPN (B). Findings include: 1. Observation on 7/25/16 from 5:30 p.m. through 6:00 p.m. of the East medication cart revealed it was sitting next to the nurses station. The</p>	F 431	<p>F 431 483.60(b). (d), (e) DRUG RECORDS, LABELS/STORE DRUGS & BIOLOGICALS SS=E=</p> <p>All residents admitted to the White River Health Care Center Facility at risk.</p> <p>One on one education with LPN (B) was held on 7-27-16 that all medications have to be securely locked in accordance with State and Federal laws. The facility must store all drugs and biological in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. She was reminded that certified nursing assistants (C) are not authorized personnel. LPN (B) verbalizes understanding.</p> <p>One on one education with certified nursing assistant (C) was held on 7-27-16 that all medications have to be securely locked in accordance with State and Federal laws. The facility must store all drugs and biological in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. LPN (B) should not have given her the keys to get scissors out of the medication cart. CNA(C) verbalizes understanding.</p> <p>One on one education was held with LPN (B) & (D) 7-27-16 that medication cart was not kept secure and that the cart has to be locked if not attendee or in visible site. LPN (B) & (D) verbalize understanding of not leaving medication cart, store room door, and biologic's for unauthorized personal to gain access.</p> <p>One on one education was held on 7-26-16 with LPN (B) that she cannot leave medications on top of the medication cart. LPN (B) verbalizes understanding.</p> <p>Post one on one education with LPN (B) by the DON and MDS coordinator she has not been back to work since 8-4-16, she is no longer an employee of the Whiter River Health Care Center by de-hiring herself</p>	*9/15/16 KM/SDD/HJEL	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	<p>Continued From page 19</p> <p>medication cart was unlocked. LPN B was sitting at the nurses station charting. Another surveyor went up to the medication cart and opened drawers. LPN B did not respond to the cart having been opened.</p> <p>2. Observation on 7/26/16 from 11:27 a.m. through 11:45 a.m. revealed LPN B was passing medications to residents in the East hall. She would leave the medication cart unlocked while she went into residents' rooms to give them medications. During those times LPN B was in residents' rooms unlicensed staff and residents were in the hall near the unlocked cart.</p> <p>3. Observation on 7/26/16 at 3:15 p.m. during a dressing change for resident 5 revealed LPN B gave the medication cart keys to CNA C to retrieve a pair of scissors. The East medication cart was in the hallway, and CNA C had stated she had left the keys under a binder when she re-entered resident 5's room.</p> <p>4. Observation on 7/27/16 at 7:45 a.m. revealed LPN D had the East medication cart parked by the main dining room. She took medications to resident 16 and left the cart unlocked. She was unable to view the medication cart during that time. During that time unlicensed staff and residents went by the unlocked medication cart.</p> <p>5. Observation on 7/26/16 at 3:30 p.m. of the East medication cart revealed two insulin pens wrapped in a tissue on top of the cart. The cart was unattended. Interview at that time with LPN B revealed the insulin pens were for resident 12. LPN B stated "Because her blood sugar was 83 after lunch I was holding the insulin until after bingo and her snack." She agreed she should not</p>	F 431	<p>All residents residing at the White River Health Care Center Facility have the potential risk for F431 483.60(b), (d), (e) drug records, label/store drugs & biologics.</p> <p>The Director of Nursing, MDS Coordinator/Case Manager, and Medical Records have reviewed and clarified the policy for drug records, label/store drugs and biologics as defined by F431 483.60(b)(d)(e).</p> <p>The Director of Nursing will held a Directed In service meeting on August 19th, 2016 on the policy for policy for drug records, label/store drugs and biologics to maintain security of medication carts as defined by F431 483.60(b)(d)(e).</p> <p>The DON or designee will audit that during administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide and no medication are kept on top of the cart, weekly times 4, then monthly times 3, then as need to meet the policy for drug records, label/store drugs and biologics as defined by F431 483.60(b) (d) (e). Results of this audit will be reported by Director of nursing or designee to the QA/PI monthly with further follow up as recommended by the committee.</p> <p>* [REDACTED] KW/SOP/H/JS</p>		

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F 431	Continued From page 20 have left the insulin pens unsecured. 6. Interview on 7/27/16 at 9:30 a.m. with the director of nursing revealed: *The medication cart should have been locked when not in view. *Medications should not have been left on top of the medication cart when it was not monitored. *LPN B should not have given CNA C the keys to the medication cart. Only authorized staff should have access to the medication carts. Review of the provider's December 2012 Administering Medications policy revealed: *"During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide." *"No medications are kept on top of the cart."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS SS=D One on one education was held on 7-27-16 with LPN (B) proper technique on dressing changes and hand washing procedure. LPN (B) verbalized understanding. On 7-27-16 Ez-stand and Hoyer journey was cleaned by MDS coordinator. 8-19-16 Ez -stand taken out of service. Post one on one education with LPN (B) by the DON and MDS coordinator she has not been back to work since 8-4-16, she is no longer an employee of the Whiter River Health Care Center by de-hiring herself All residents and surface areas residing at the White River Health Care Center Facility are at risk.	*9/15/16 KIMSPROTJE

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F 441	<p>Continued From page 21</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, observation, interview, and policy review, the provider failed to ensure: *One of one licensed practical nurse (LPN) (B) used proper technique when doing one of two dressing changes for one of two sampled residents (5). *Two of five mechanical lifts (EZ stand lift and Hoyer Journey stand lift) had been kept in a sanitary manner. Findings include:</p> <p>1. Observation on 7/26/16 from 3:15 p.m. through 3:30 p.m. revealed LPN B: *Took the dressing supplies into resident 5's room.</p>	F 441	<p>The Director of Nursing, MDS Coordinator/Case Manager, and housekeepers have reviewed and clarified policy and procedure for dressing changes, glove use, hand washing/sanitizing, when and who will clean reusable items are cleaned and disinfected between residents and ensure the environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces are appropriately cleaned in the building for infection prevention and control as defined by F441 483.65 infection control, prevent spread and linens.</p> <p>The Director of Nursing held a Directed In service meeting on August 19th, 2016 the cleaning reusable equipment and environmental surfaces, dressing changes, glove use and hand washing/hand hygiene policy for general for infection prevention and control as defined by F441 483.65 infection control, prevent spread and linens.</p> <p>The DON or designee will audit the cleaning of lift equipment, dressing changes, glove use and hand washing/hand hygiene every week times 4, then every month times 3 and then as needed. Results of this audit will be reported by Director of nursing or designee to the QA/PI monthly with further follow up as recommended by the committee.</p> <p>*  Kulsouh/EL</p>	

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F 441	<p>Continued From page 22</p> <ul style="list-style-type: none"> *She put down a barrier on the overbed table and placed the dressing supplies on the barrier. *She removed the soiled dressing from resident 5's left outer thigh. *Removed her gloves. She had one pair of gloves on over another pair. *Cleansed the wound with Saf-Clens AF and gauze. *Reached into her pocket and retrieved the medication cart keys for certified nursing assistant (CNA) C to bring her a pair of scissors. *Took the scissors from CNA C and without sanitizing the scissors cut a small part of foam dressing and an abdominal dressing in half. *Placed both of those dressings over the wound and taped them in place. *Then checked resident 5's buttocks for any open areas. *Removed her gloves and without sanitizing her hands put on new gloves. *Removed the soiled lower left leg dressing. *Again used the scissors to cut dressings. *Removed her gloves and without sanitizing her hands put on new gloves. *Cleansed the wound with Saf-Clens AF and gauze. *Placed a new dressing over the wound and taped the area. *Gathered all the supplies left on the barrier and took them to the medication cart. *She placed the barrier on top of the medication cart and put away the supplies. *Removed her gloves and did not sanitize her hands. <p>Review of resident 5's medical record revealed she had an active diagnosis of methicillin resistant staphylococcus aureus (infection resistant to many antibiotics) to the left thigh</p>	F 441			

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F 441	<p>Continued From page 23</p> <p>wound. She also had osteomyelitis (infection in the bone) in the wound.</p> <p>Interview on 7/27/16 at 8:30 a.m. with LPN B revealed she agreed the dressing change had not been completed to prevent contamination. She agreed she had not sanitized her hands with glove changes. She was not aware she should not have doubled-gloved as an infection control measure.</p> <p>Interview on 7/27/16 at 9:15 a.m. with the director of nursing (DON) revealed LPN B had not completed the dressing change per their policy. She agreed double-gloving was not a proper infection control measure.</p> <p>Review of the provider's August 2014 Handwashing/Hand Hygiene policy revealed to use an alcohol-based hand rub before and after gloves were used.</p> <p>Surveyor: 35237</p> <p>2. Random observations on 7/25/16 at 6:00 p.m., on 7/26/16 at 8:50 a.m., and on 7/27/16 at 7:45 a.m. of the following mechanical lifts stored in unoccupied areas of the resident's rooms revealed:</p> <p>*Room 201 had an EZ stand lift with a large amount of dirt and food-like substances on the foot base.</p> <p>*Room 209 had a Hoyer Journey stand lift with a large amount food-like substances on the foot base.</p> <p>Interview on 7/26/16 at 2:40 p.m. with CNA L regarding cleaning the mechanical lifts revealed: *Night staff cleaned them during their shift.</p>	F 441			

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F 441	<p>Continued From page 24</p> <p>*CNAs should also have cleaned them any time they were dirty.</p> <p>Interview on 7/26/16 at 3:15 p.m. with housekeeper N revealed housekeeping staff sometimes cleaned the mechanical lifts, and CNAs also cleaned them as needed.</p> <p>Interview on 7/26/16 at 3:30 p.m. with housekeeper O regarding the mechanical lifts revealed: *Nursing staff were supposed to clean them. *He was aware they had been dirty at times, especially on the foot bases.</p> <p>Interview on 7/26/16 at 3:30 p.m. with the Minimum Data Set nurse and the DON revealed: *Nursing staff should have cleaned the lifts whenever they were dirty. *Lift cleaning was also scheduled for night shift staff to do.</p> <p>Review of the provider's revised December 2007 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed: *"d. Reusable items are cleaned and disinfected between residents (e.g., stethoscopes, durable medical equipment)." *"Ensure that environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces are appropriately cleaned."</p>	F 441		

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/27/16. White River Health Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K062 and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 8/25/16 per telephone with facility interim administrator. LF/SPDOHJEL	
K 062 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the fire sprinkler system was maintained in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Excessive corrosion was found on two sprinkler heads in the dishwasher room. Findings include: 1. Observation at 11:20 a.m. on 7/27/16 revealed a dishwasher room in the kitchen. The fire sprinkler heads in that room had excessive corrosion on the entire surface of the sprinkler head including the orifice plug. The excessive corrosion on those heads was caused due to the high humidity	K 062	K062 NFPA 101 LIFE SAFETY CODE STANDARDS SS=B Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19, 7, 6,4,12 NFPA 13, NFPA 25, 9, 7, 5 The fire sprinkler heads have excessive corrosion on the entire surface of the sprinkler head including the orifice plug in the dishwasher room in the kitchen area. Noted last inspection by Rapid Fire Protection, Inc. 8-12-16 maintenance Supervisor contacted Rapid Fire Protection, Inc. message left for follow up on findings. 8-18-16 the Director of Nursing contacted Rapid Fire Protection, Inc. Report was faxed to Rapid Fire Protection, Inc., return call pending with appointment to change our sprinkler head including the orifice plug in the dishwasher room in the kitchen area. Rapid Fire Protection, Inc was into check on system on 8-19-16. They will come and replace sprinkler head as soon as schedule allows, estimated time is 2 weeks.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

[Signature]

[Signature]

Aug 19, 2016

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

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K 062	Continued From page 1 environment in that room. Excessive corrosion of the sprinkler head and orifice plug has the potential to affect the functionality of the sprinkler discharge in a fire situation. Interview with the facility manager at the time of the above observation confirmed that condition. He indicated he was not aware of the sprinkler heads in question. He believed the fire sprinkler inspection company was checking sprinkler heads for proper maintenance. This deficiency has the potential to affect one of five smoke compartments.	K 062	The Maintenance supervisor or designee will monitor sprinkler heads every week time's 4, then every month times 3 and then as needed with Fire Sprinkler Inspection Report every quarter. Results of this audit will be reported by Maintenance supervisor or designee to the QA/PI monthly with further follow up as recommended by the committee.	*8/24/16 LF/SDDO/H/EL
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the electrical system was maintained in conformance with NFPA 70 National Electrical Code in one randomly observed location (multitap in use at electrical receptacle behind lounge area entertainment center). Findings include: 1. Observation at 1:30 p.m. on 7/27/16 in the central lounge area revealed an electrical receptacle behind the entertainment center. That duplex receptacle was used to power multiple electrical appliances for the entertainment center via a multitap adapter. Per NFPA 70 multitap adapters are not permitted. A United Laboratories (U.L.) listed power strip with surge protection would be a permissible means of supplying power	K 147	K147 NFPA101 LIFESAFETY CODE STANDARD SS=C Electric wiring and equipment shall be in accordance with National Electrical Code. 9-1, 2.(NFPA 99) 18.9.1, 19.9.1 The central lounge area revealed an electrical receptacle behind the entertainment center, that duplex receptacle was used to power multiple electrical appliance for entertainment center. Multi tap adapter was discontinued and new electrical trip was placed on 8-9-16. Electrician was contacted 8-18-16, states he will have new outlet wired and placed by 8-24-16. The Maintenance supervisor or designee will monitor outlets every week times 4, then every month times 3 and then as needed. Results of this audit will be reported by Maintenance supervisor or designee to the QA/PI monthly with further follow up as recommended by the committee.	*8/24/16 LF/SDDO/H/EL

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K 147	Continued From page 2 to the lounge area entertainment center. Interview with the facility manager and emergency permit holder during the exit interview at 2:30 p.m. on 7/27/16 revealed they were not aware of the above condition. This deficiency has the potential to affect one of five smoke compartments.	K 147			

ORIGINAL

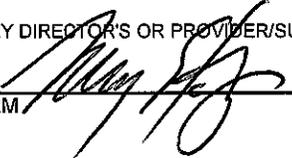
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SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/25/16 through 7/27/16. White River Health Care Center was found not in compliance with the following requirements: S206 and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	<p>*Addendums noted with an asterisk per 8/29/16 per email with facility DON. K/W/SDDOTT/EL</p> <p>S206 44:73:04:05 PERSONNEL TRAINING</p> <p>One on one notification of dietary aide (I), bookkeeper (J) and C.N.A. (L) that they need to do Relias learn training by 8-24-16, each was given their password.</p> <p>The Administrator, Business manager, Director of Nursing and Maintenance review personnel training to be compliant with S206 44: 73:04:05 Personal Training.</p> <p>8-19-16 will add users to Relias learn to meet the number of employees. *9/15/16 K/W/SDDOTT/EL</p> <p>The Business manager or designee will assign all new hire training to new employees and training as needed for mandatory training to meet the S206 44:73:04:05 for Personal Training.</p> <p>The Business manager or designee will audit new hire training every week times one week and then every month. Results of this audit will be reported by Maintenance supervisor or designee to the QA/PI monthly with further follow up as recommended by the committee.</p> <p>S301 44:73:07:16 Required Dietary In service Training</p> <p>One on one notification of dietary aide (I), bookkeeper (J) and C.N.A. (K, L) that they need to do Relias learn training by 8-24-16, each was given their password along with the directed dietary in service.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X6) DATE Aug 19, 2016
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SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
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S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to ensure 3 of 4 newly hired sampled employees (I, J, and L) had received an orientation program for 11 of 11 required annual topics. Findings include:</p> <p>1. Review of sampled employees I, J, and L's orientation records revealed: *The employees had been hired on the following dates: -Dietary aide I on 4/8/16. -Bookkeeper J on 5/16/16. -CNA L on 6/9/16. *No documentation of employee I, J, or L having received any training for the eleven required topics.</p> <p>Interview on 7/27/16 at 3:15 p.m. with the director of nursing and Minimum Data Set coordinator revealed: *The provider had begun using the computerized training in the past year after the last survey. *The department heads were responsible for ensuring the required training had been completed for their staff. *Employees I, J, and L had no documentation of having received any of the above training. *Their expectation was that all new employees would have been trained in all of the required topics upon having been hired and annually.</p> <p>Review of the provider's 2008 Orientation Program for Newly Hired Employees, Transfers, Volunteers policy revealed:</p>	S 206 *	    <p>KW/SD00H/EL</p>	
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SD Department of Health Vital Records

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S 206	<p>Continued From page 2</p> <p>*All newly hired personnel would attend a ten hour orientation program in their first five days of employment, to include:</p> <ul style="list-style-type: none"> -Unusual occurrences, such as accidents, wandering, or missing residents. -Disaster preparedness. -Accident prevention and emergency first-aid procedures. -Resident rights. <p>*A record of orientation should have been filed in each employee's personnel file.</p> <p>Review of the provider's 2009 Staff Development Program policy revealed mandatory in-service training classes had included:</p> <ul style="list-style-type: none"> *Infection control. *Resident rights. *Resident abuse. *A hazard communication plan. *Exposure to blood/body fluids control. *A hand-written addition of the name of the computerized learning program. <p>Review of provider's 2011 In-service Training, Nurse Aide policy revealed all nurse aide personnel would participate in regularly scheduled in-service training classes to have included:</p> <ul style="list-style-type: none"> *Providing care for residents with dementia. *Preventing resident abuse. 	S 206		
S 301	<p>44:73:07:16 Required Dietary Inservice Training</p> <p>The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover</p>	S 301		

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S 301	<p>Continued From page 3</p> <p>food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to ensure: *Eight of nine required in-service training sessions (food safety, handwashing, food handling and preparation techniques, food borne illnesses, sanitary requirements, serving and distribution procedures, leftover food handling policies, and time and temperature controls for food preparation and service) were provided to one of four sampled newly hired food-handling employees (K). *Nine of nine required in-service training sessions (food safety, handwashing, food handling and preparation techniques, food borne illnesses, sanitary requirements, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation, and service, and nutrition and hydration) were provided to two of three sampled newly hired food-handling employees (I and L). Findings include:</p> <p>1. Review of sampled employees I, K, and L's orientation records revealed: *The employees had been hired on the following dates: -Dietary aide I on 4/8/16. -Certified nursing assistant (CNA) K on 5/16/16. -CNA L on 6/9/16. *CNA K had received computerized training in nutrition in hydration, but none of the other required topics. *Employees I and L had not received training in</p>	S 301	<p>*Review of policy by the dietary manager and the registered dietitian has been revised to meet the training requirements for all dietary aides and all food handling employees as defined by S301 44:73:07:16 required dietary in-service training. The register dietitian held a meeting on August 19th, 2016 on S301 44:73:07:16 required dietary in-service training. The business manager or designee will assign all dietary aides and all food handling personnel training as needed by S301 44:73:07:16 required dietary in-service training. The business manager or designee will audit new dietary aides and all food handling personnel. (cont)</p>	*9/15/16 KMSDDOHH/EL
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S 301	Continued From page 4 any dietary in-service training. Interview on 7/27/16 at 3:15 p.m. with the director of nursing and Minimum Data Set coordinator revealed they had not known that non-dietary employees who handled food were required to receive the above training. Interview on 7/27/16 at 3:30 p.m. with the dietary manager revealed: *Dietary aide I had not received the above training, because he had been in school during the training session. *She was not aware all non-dietary employees who handled food were required to receive the above training. Review of the provider's 2008 Orientation Program for Newly Hired Employees, Transfers, Volunteers policy revealed: *All newly hired personnel would attend a ten hour orientation program in their first five days of employment. *The above dietary in-service training requirements had not been included as part of the training.	S 301 (cont)	Every week times one week and then every month 8309 44: 73:07:16 required dietary in service training. Results of this audit will be reported by maintenance supervisor or designee to the QAPI monthly with further follow-up as recommended by the committee. KW/SDDOH/EL	
S 000	Compliance/Noncompliance Statement Surveyor: 26632 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 7/25/16 through 7/27/16. White River Health Care Center was found in compliance.	S 000		