**SUMMARY STATEMENT OF DEFICIENCIES**

**(X1) PROVIDER/SUPPLIER/CILA IDENTIFICATION NUMBER:**

435062

**STREET ADDRESS, CITY, STATE, ZIP CODE**

101 CHURCH STREET
ALCESTER, SD 57001

**NAME OF PROVIDER OR SUPPLIER**

ALCESTER CARE AND REHAB CENTER, INC

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**F 000 INITIAL COMMENTS**

Surveyor: 18560
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/20/19 through 9/22/19. Alcester Care and Rehab Center, Inc. was found not in compliance with the following requirements: F561, F555, F658, F686, F849, and F880.

**F 581 Self-Determination**

SS-D
CFR(s): 483.10(f)(1)-(3)(8)

§483.10(f) Self-determination.
The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.

§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not

**F 000 PROVIDER'S PLAN OF CORRECTION**

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:

**F 561 Resident 1's medical record was updated to reflect two baths per week on 9/2/2019. All other resident medical records were reviewed and revised to include, but not limited to, residents participating in choices and preferences with respect to bathing. Resident council was held on 9/6/19 and no concerns were brought up regarding bathing choices and preferences.**

DON and interdisciplinary team review and revised, as necessary, the policy and procedure for Resident Rights and respecting resident(s) individual choices and preferences for bathing.

Administrator or designee will provide education to all staff on Resident Rights, choices and preferences on 9/19/19.

Administrator or designee will audit the documentation respecting resident(s) individual choices and preference for bathing weekly for four weeks and monthly for two months.

**LABORATORY DIRECTOR FOR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Administrator
9/13/2019

**FORM CMS-2567(02-99) Previous Versions Deseated**

Facility ID: 0026

If continuation sheet Page 1 of 2
ALCESTER CARE AND REHAB CENTER, INC

F 561 Continued From page 1
interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:

Surveyor: 40771
Based on interview, record review, and policy review, the provider failed to ensure one of one
toined 1 had been able to participate in her choice of her own bathing schedule or preference. Findings include:

1. Review of resident 1's medical record revealed she had diagnoses of: peripheral vascular
disease; restless leg syndrome; and several pain in her right hip, ankle, joints, and lower back.

Observation and interview on 8/20/19 at 3:22
p.m. with resident 1 revealed:
* Her clothing was clean, coordinated, and in good condition.
* She was clean, hair was brushed and styled, fingernails clean and well manicured.
* She used to get a bath on both Mondays and Wednesdays, and that had changed to getting a
bath only on Mondays.
- She did not like only getting a bath one time a week.
- Since the change with the bathing schedule she would clean herself in the sink that was in her
room.
* She was notified with a paper note hanging in her room.
* No one had spoken with her and asked her preference of the day of the week nor if she was
okay with one day a week.
* She had told an aide she was going to miss her Wednesday bath and was told "Well there is not
anything we can do about it."
* It was changed to one day a week by the

Administrator or designee will present findings from these audits at the monthly
QAPI committee for review until the
QAPI committee advises to discontinue monitoring.
Continued From page 2

previous director of nursing (DON).

Review of resident 1's 8/21/19 care plan revealed she:

*Required assistance only with her bathing.
*Had clear speech and was able to make herself understood and could understand others.

Interview on 8/22/19 at 9:26 a.m. with the social services designee regarding the bath schedule revealed:

*The bath schedule had changed, because there were too many to do in one day.  
*She was unsure if it had been brought to resident council for resident input.  
*She was not involved in the bath schedule change.

Interview on 8/22/19 at 9:39 a.m. with the administrator regarding the changes to the bath schedule revealed:

*He had worked with the previous DON and made changes to the residents' bathing schedule.  
*They had added a bath aide that worked Monday through Friday.  
*They could promise the residents one bath a week.  
*He stated it was a matter of quality over quantity due to staffing concerns and workloads.  
*He confirmed it should have went to the resident council to make them aware of the change but would not have asked for resident input.  
*He was unaware of how residents were notified of their bath schedule changes.  
*He did not feel the notes were an appropriate way to communicate the change to the residents.

Review of resident 1's medical record revealed she had been receiving two baths a week up to
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| F 561 | Continued From page 3  
6/20/19. Beginning on 7/1/19 she received one bath a week.  
Review of the provider's 10/5/16 Resident Rights  
- General policy revealed residents:  
  * Had the right to participate in their own care planning and treatment.  
  * Had the right to receive adequate and appropriate care.  
  * Were to be treated with consideration, respect, and dignity.  
  * Had the right to make independent choices. | F 561 | Unable to update Resident 191's medical record to include documentation and interventions to prevent further skin breakdown on his baseline care plan when he was discharged on 8/25/19.  
Residents 193's medical record was updated to include the focus areas for necessary care and services, and the signature to identify who initiated the baseline care plan. Unable to update Resident 193's medical record to account that he or his representative received a summary of his baseline care plan when he discharged on 9/8/2019.  
Resident 36's medical record was updated to indicate the Total Plan of Patient Care form is signed and completed.  
Resident 36 and 40's medical record will be updated to include the summary of the baseline care plan had been received by the resident or respective representative. | 10/11/2019 |
| F 655 | Baseline Care Plan  
SS=E  
CFR(s): 483.21(a)(1)-(3)  
§483.21 Comprehensive Person-Centered Care Planning  
§483.21(a) Baseline Care Plans  
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-  
(i) Be developed within 48 hours of a resident's admission.  
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-  
(A) Initial goals based on admission orders.  
(B) Physician orders.  
(C) Dietary orders.  
(D) Therapy services.  
(E) Social services.  
(F) PASARR recommendation, if applicable.  
§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline | F 655 | | |

Form CMS-2567(02-99) Previous Versions Obsolete  
Event ID: QK0311  
Facility ID: 0026  
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F 655
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care plan if the comprehensive care plan-
(i) is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:
Surveyor: 32355
Based on record review, interview, and policy review, the provider failed to complete baseline care plans and provide summaries to the resident and/or their representatives for four of four sampled residents (36, 40, 191, and 193). Findings include:

1. Review of resident 191's medical record revealed:
   "He had been admitted on 8/15/19.
   "His diagnoses included: sepsis, infection and inflammatory reaction due to indwelling urethral catheter, paraplegia, and a stage 2 pressure ulcer on his right heel.
   "He had good memory recall and was capable of making his needs known.
   "He had required staff support to ensure all of his...

All other resident's medical records will be updated to include, but not limited to documentation and interventions to prevent skin breakdown, focus areas for necessary care and services, signatures for the initial and completed baseline care plan, and documentation that the summary had been given to the resident or respective representative.

DON and interdisciplinary team review and revised, as necessary, the policy and procedure for Baseline Care Plans.

DON or designee will provide education to the MDS Coordinator and all other staff responsible for the baseline care plans.

DON or designee will audit all new admission for completed baseline care plans weekly for 4 weeks and monthly for two months.

DON or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.
**ALCESTER CARE AND REHAB CENTER, INC**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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- Those mobility needs had been met.
- His baseline care plan had been implemented on 8/15/19.
- That care plan had been developed and signed by the social service designee (SSD) and the Minimum Data Set (MDS) assessment coordinator.
- There was a focus area for "Skin care needs."
- That focus area identified a stage 2 pressure ulcer on his right heel.
- The interventions for that focus area referred the staff to see the treatment assessment record.
- There was no documentation to support:
  - How often he should have been turned or repositioned.
  - What pressure relieving devices he required to ensure no further skin breakdown had occurred.
  - He or his representative had received a summary of his baseline care plan.

2. Review of resident 193's medical record revealed:
- He had been admitted on 8/6/19.
- His baseline care plan had:
  - Been implemented on 8/6/19.
  - No signatures to identify who initiated the care plan.
  - No documentation to support he or his representative had received a summary of his baseline care plan.
- The following focus areas had no documentation for the staff to follow to ensure he had received the necessary care and services he required from them:
  - Resident's discharge goals.
  - Resident's daily routine/preferences.
  - Resident's ethnic/cultural preferences.
F 655 Continued From page 6
- Resident's goals on admission.
- Cognitive status.
- Safety.
- Dietary orders.
- Meal location preference.
- Dentures/teeth.
- Activities of daily living.
- Shaving, hair care, nail care, and required
equipment/devices.
- Bowel/bladder needs.
- Skin care needs.
- Communication, vision, and hearing.
- Behavior concerns.
- Social service needs.

Surveyor: 18550
3. Review of resident 40's medical record
revealed:
* She had been admitted on 8/5/19.
* Her baseline care plan had been implemented
on 8/6/19.
* Her baseline care plan had been developed and
signed by the SSD and the MDS coordinator.
* There was no documentation she or her
representative had received a summary of her
baseline care plan.

4. Review of resident 36's medical record
revealed:
* He had been admitted on 7/30/19.
* His Total Plan of Patient Care form had not
indicated when it had been completed.
* The form had not been signed.
* There was no documentation he or his
representative had received a summary of his
baseline care plan.

5. Interview on 8/21/19 at 9:19 a.m. with the MDS
coordinator confirmed the above residents and/or
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<td>F 655</td>
<td>Continued From page 7 their representatives had not received a summary of their baseline care plans within the required time frame. Interview on 8/22/19 at 10:20 a.m. with the interim director of nursing regarding the baseline care plans revealed: *The MDS assessment coordinator had been responsible to ensure they had been completed, signed, and reviewed with the resident. *She confirmed the staff would have used that information to ensure proper care and services for those residents had occurred. Review of the provider's 11/8/18 Care Plan Policy and Procedure revealed: *General instructions: -&quot;Upon admission, resident will be assessed by the Charge Nurse and a baseline care plan will be developed with information gathered from the resident and resident's family within 48 hours of their admission.&quot; -&quot;MDS Coordinator or designee will add Tasks to PointclickCare Point of Care charting to be completed by CNA [certified nursing assistant] staff each shift for at least the first 7 days of admission.&quot; Services Provided Meet Professional Standards CFR(s): 483.24(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32355</td>
<td>F 655</td>
<td>Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for Medication Administration to support a process for staff to follow when a medication is not available for administration.</td>
<td>10/11/2019</td>
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<td>SS=D</td>
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<td>F 658</td>
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F 658  Continued From page 8

Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the following for one of one sampled resident (25):

*Physician's orders were followed for acute and chronic diastolic congestive heart failure and fluid overload.
*A procedure and process was in place to ensure medications (med) had been ordered and delivered in a timely manner for his meds that came from the Veterans Affair (VA) pharmacy.
*The physician, resident, and resident's representative had been notified when high risk meds had not been available for administration.

Findings include:

1. Observation and interview on 8/20/19 at 10:09 a.m. of resident 25 revealed:
*He had been:
- Lying on his bed with his feet elevated on pillows.
- Receiving oxygen continuously at 2 liters per minute through a nasal cannula.
*Both of his feet were swollen and wrapped with Kerlix gauze.
*That Kerlix had extended up his calves and below his knees.
*He:
- Was alert, oriented, and capable of making his needs known.
- Became very short-of-breath when visiting with him.
*He stated:
- "My legs have sores on them from blisters that open up."
- "They change my dressings once a day or more if needed."
- "They drain a lot some days."
*He denied any pain or discomfort at that time.

DON or designee will provide education to all licensed staff responsible for Medication Administration and the process to follow when a medication is not available for administration. Job descriptions for staff responsible for Medication Administration will be updated to include a process to follow when medication is not available for administration.

Resident 25 received all medications on 8/23/19. All other resident medical records will be reviewed to ensure medication is distributed accurately and safely to residents within the required time frame.

DON or designee will perform audits on medication administration to ensure meds are distributed accurately and timely for 5 residents weekly for 4 weeks and monthly for two months.

DON or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.
Review of resident 25's medical record revealed:
* He had been admitted on 5/13/19.
* His diagnoses included: acute and chronic diastolic congestive heart failure, fluid overload, atrial fibrillation, high blood pressure, chronic obstructive pulmonary disease, and atherosclerotic heart disease.
* He had good memory recall and was able to make his needs known to the staff.
* He required staff support to ensure all of his daily activities were met.
* His health was declining, and the physician had recommended support services from Hospice.
- He and his wife declined those services and had requested comfort care and support from the staff.
* He was in fluid overload and required a high dose of Lasix to help with fluid retention.
* To ensure his electrolytes remained in balance from that high dose of Lasix, the physician had ordered him to have potassium chloride (KCl) 40 milliequivalents (meq) three times a day (tid).
* He had a history of complaints of chest pain.
* He was a veteran and received his meds from the VA pharmacy.
* He was dependent upon the staff to ensure those meds were ordered from the VA and available for administration.
* There was no documentation to support a potassium level or basic metabolic panel (BMP) had been checked during his stay at the facility.
* On 8/1/19 the pharmacist had requested the physician to order a BMP to be completed on the next laboratory (lab) test day.
- The lab tests were not scheduled to be completed until the end of the month.

Observation on 8/21/19 at 8:30 a.m. of registered
**F 658 Continued From page 10**

- She had prepared to administer him his morning meds.
- Those meds had included:
  - Lasix 120 milligrams (mg) orally (po) daily.
  - Celexa 20 mg po daily.
  - Potassium chloride 40 meq po qid.

"She:
- Had no KCL available to give him.
- Stated: "His meds come from the VA, and it's not here yet."

Review of resident 25's medication administration record from 8/1/19 through 8/21/19 revealed he had not received ten doses of his prescribed KCL from 8/18/19 at 12:00 noon through 8/21/19 at 12:00 noon.

Review of resident 25's nurses' progress notes from 8/18/19 through 8/21/19 revealed:
- He was not able to receive his KCL on those dates as it was unavailable for administration.
- There was no documentation to support:
  - The physician had been notified with the concern of no KCL available for administration and to give further direction.
  - The resident or his representative had not been notified the KCL was not available for administration.
  - The resident or his representative were given the opportunity to allow the staff to seek other courses of action to ensure he was able to get his KCL.

Interview on 8/22/19 at 4:00 p.m. with the interim director of nursing (DON) and licensed practical nurse (LPN) D regarding resident 25 revealed:
- "LPN D:
  - Had been aware the resident's KCL was not..."
**NAME OF PROVIDER OR SUPPLIER**
ALCESTER CARE AND REHAB CENTER, INC

**STREET ADDRESS, CITY, STATE, ZIP CODE**
101 CHURCH STREET
ALCESTER, SD 57001

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 658</td>
<td>Continued From page 11 available for administration.</td>
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<td>- Had written it down on her list to check on today but had not had the opportunity to do so yet.</td>
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<td>- <em>They confirmed:</em></td>
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<td>- The resident's health was declining, he had a history of chest pain, and he was in fluid overload.</td>
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<td>- The resident had not had his KCL available for administration for some time now.</td>
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<td>- The med was important for his system to ensure his electrolyte balance had remained stable.</td>
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<td>- The KCL was considered a high risk med and could have a negative affect on his heart should the potassium in his blood level become abnormal.</td>
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<td>- The KCL was an essential electrolyte and supplement he needed due to the dose of Lasix he had been taking.</td>
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<td><em>The interim DON:</em></td>
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<td>- Was not aware his KCL had not been available for administration.</td>
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<td>- Stated:</td>
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<td>-- &quot;It's the charge nurse's responsibility to make sure the meds are available.&quot;</td>
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<td>-- &quot;They should have followed-up with the VA, physician, and his representative when it was not available.&quot;</td>
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<td>- Confirmed he got his meds through the VA, and there was no other system in place to ensure he was able to get those meds when they were not available.</td>
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<td>- Called the VA pharmacy and confirmed they had received the request on 8/16/19 for that med.</td>
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<td>*The VA pharmacy had to have that med approved through the physician prior to dispensing it to the facility.</td>
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<td>*The VA physician had approved the med on 8/20/19.</td>
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<td>- That had been four days after the facility had sent in a request for that med.</td>
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| F 658 | Continued From page 12<br>"The VA pharmacy was in the process of dispensing and sending the med to the facility.<br>-That med was not due to arrive in the facility until 8/26/19.<br>*The interim DON agreed:<br>-They should have another process in place to ensure all meds were available for administration in a timely manner.<br>-The process above had created the potential for a negative outcome to have occurred.<br>Review of the provider's November 2011 Specific Medication Administration Procedures policy revealed no documentation to support a process for the staff to follow when a med was not available for administration.<br>Review of the provider's 10/30/15 Medication Aide job description revealed no documentation of a process for them to follow when a med was not available for administration.<br>Review of the provider's 10/26/17 Registered Nurse job description revealed:<br>"""Renders professional nursing care to residents and is accountable for demonstrating the ability to identify and utilize quality resident care."
""""Administers medications as prescribed by the resident's physician."
""""Distributes medications accurately and safely to residents within required time frame per physician order."
"No documentation to support a process for them to follow when a medication was not available for administration.<br>F 688 | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3) | F 688 | Resident 191's medical record was reviewed and revised to include proper interventions and<br>10/1/2019
F 688 Continued From page 13

§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident’s clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:

Surveyor: 32355
Based on observation, interview, record review, and policy review, the provider failed to identify the repositioning needs for one of one sampled resident (191) who was a paraplegic and had a history of acquiring pressure ulcers. Findings include:

1. Review of resident 191’s medical record revealed:
   * He had been admitted on 8/15/19.
   * His diagnoses included: sepsis, infection and inflammatory reaction due to indwelling urethral catheter, paraplegia, and a history of pressure ulcers.
   * He was dependent upon the staff to assist him with all activities of daily living.
   - That had included bed mobility, transfers, personal hygiene, toileting, set-up for meals, and documentation to promote the healing of high risk skin areas. All other residents that have high risk skin areas will have their medical records reviewed and revised to include proper interventions and documentation.

Administrator, DON, and interdisciplinary team will review and revise as necessary the policy and procedure for Skin Injury/Wound and Pressure Ulcer Prevention to support a process for repositioning a resident to ensure skin breakdown did not occur or worsen.

DON or designee will educate all staff responsible for repositioning, interventions and documentation to ensure skin breakdown does not occur or worsen.

DON or designee will perform audits on repositioning for 5 residents weekly for 4 weeks and monthly for two months.

DON or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.
**ALCESTER CARE AND REHAB CENTER, INC**

**F 688**  
Continued From page 14  
management of all his healthcare needs.  
*His memory recall was good, and he was capable of making his needs known.  
*He had been admitted with a stage 2 pressure ulcer on his right heel.  
*His 8/15/19 Braden Scale for Predicting Pressure Sores was a fifteen.  
-That number had placed him at risk for acquiring skin breakdown.

Random observations on 8/20/19 from 11:06 a.m. through 5:30 p.m. and on 8/21/19 from 7:45 a.m. through 3:10 p.m. of resident 191 revealed:

*He had been laying on his bed resting and was positioned partially on his left side.  
*His:

- Bottom and heels were resting directly on the mattress without any devices used to prevent pressure ulcers from occurring or worsening.
- Legs were bent and laying on top of each other.
- There were no devices used between his knees to prevent pressure from occurring.
- He:
  - Could make major and frequent movements of his arms and head independently.
  - Was not observed making frequent and major body movements independently from his waist down.
  - Was not observed out of his bed or in a different position.

Interview on 8/20/19 at 11:15 a.m. with certified nursing assistants (CNA) B and E regarding resident 191 revealed:

*They would have assisted him with personal care in the morning.
*He preferred to stay in his room and would have requested any type of assistance on his own.
The surveyor requested to watch any and all
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:** 435062

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**(X3) DATE SURVEY COMPLETED:** 08/22/2019

**NAME OF PROVIDER OR SUPPLIER:**
ALCESTER CARE AND REHAB CENTER, INC

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
101 CHURCH STREET
ALCESTER, SC  57001

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<tr>
<th>(X4) ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 688</td>
<td>Continued From page 15 personal care when that occurred. “CNA B stated “He can turn himself in bed, so we really don't do that much unless he asks.” Interview on 8/20/19 at 1:35 p.m. with CNA C regarding resident 191 revealed the same interview and answers as with CNAs B and E. Review of resident 191's 8/15/19 baseline care plan revealed: *His baseline care plan had been implemented on 8/15/19. *That care plan had been developed and signed by the social service designee and the Minimum Data Set (MDS) assessment coordinator. *There was a focus area for &quot;Skin care needs.&quot; *That focus area identified a stage 2 pressure ulcer on his right heel. *The interventions for that focus area referred the staff to see the treatment assessment record. *There was no documentation to support: --How often he should have been turned or repositioned. --What pressure relieving devices he required to ensure no further skin breakdown had occurred. *He required: -Two staff members to assist him with bed mobility, transfers, and toileting. -The use of a total body mechanic lift for transfers. Review of resident 191's nurses' progress notes from 8/15/19 through 8/20/19 revealed: *The documentation supported he had a stage 2 pressure ulcer on his right heel. *No documentation to support: -He had refused assistance with repositioning or pressure relieving devices. -How much assistance from the staff he had</td>
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<td>Interview on 8/22/19 at 9:50 a.m. with the interim director of nursing regarding resident 191 revealed she:</td>
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<td>*Had not been aware of the positioning concerns for him that had been observed above.</td>
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<td>*Confirmed:</td>
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<td>- He had a stage 2 pressure ulcer on his right heel.</td>
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<td>- The staff should have repositioned and used devices for him to ensure pressure relief from high risk areas would not have occurred for him while laying in the bed.</td>
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<td>- The baseline care plan had been the MDS assessment coordinator’s responsibility to ensure it was updated and reflected the services and assistance he required from the staff.</td>
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<td>- Interventions had not been followed nor implemented to promote the healing of that wound and continued pressure relief for those high risk areas.</td>
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<td>Review of the provider’s 8/22/18 Skin Injury/Wound policy revealed:</td>
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<td>*Purpose:</td>
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<td>- &quot;To identify, monitor and treat skin injuries/wounds and promote early healing.&quot;</td>
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<td>- &quot;To prevent further skin destruction and infection.&quot;</td>
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<td>Review of the provider’s 2006 Positioning the Resident policy revealed no documentation to support a process for repositioning a resident to ensure skin breakdown did not occur or worsen.</td>
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<td>F 849</td>
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<td>Hospice Services</td>
<td>F 849</td>
<td>Hospice notes from the CNA, RN, and SS were included for Resident 33's</td>
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<td>SS=D</td>
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<td>CRR(s): 483.70(a)(1)-(4)</td>
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Continued From page 17

§483.70(o) Hospice services.
§483.70(o)(1) A long-term care (LTC) facility may do either of the following:

(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.

(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:

(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.

(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:

(A) The services the hospice will provide.

(B) The hospice’s responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.

(C) The services the LTC facility will continue to provide based on each resident’s plan of care.

(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and medical record. All other residents receiving hospice services will have their medical records reviewed and updated by the DON or designee to include notes from the hospice CNA, RN, and SS.

Administrator, DON, and interdisciplinary team in collaboration with hospice services representatives will review and revise the Services Agreement policy and procedure to effectively establish open and ongoing communication between the facility and hospice provider.

Administrator and hospice agency will provide education to all staff about their roles and responsibilities for residents on hospice.

DON or designee will perform audits on all residents receiving hospice services to ensure effective communication and collaboration between both parties weekly for 4 weeks and monthly for two months.

DON or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.
**F 849** Continued From page 18
meet 24 hours per day.

(E) A provision that the LTC facility immediately notifies the hospice about the following:
   (1) A significant change in the resident's physical, mental, social, or emotional status.
   (2) Clinical complications that suggest a need to alter the plan of care.
   (3) A need to transfer the resident from the facility for any condition.
   (4) The resident's death.

(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC
Continued From page 19

facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality
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| F 849 | Continued From page 20 of care for the patient and family.  
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.  
(iv) Obtaining the following information from the hospice:  
(A) The most recent hospice plan of care specific to each patient.  
(B) Hospice election form.  
(C) Physician certification and recertification of the terminal illness specific to each patient.  
(D) Names and contact information for hospice personnel involved in hospice care of each patient.  
(E) Instructions on how to access the hospice's 24-hour on-call system.  
(F) Hospice medication information specific to each patient.  
(G) Hospice physician and attending physician (if any) orders specific to each patient.  
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.  
§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.  
This REQUIREMENT is not met as evidenced by: | F 849 |
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<td>F 849</td>
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Surveyor: 18560
Based on record review, interview, and contract review, the provider failed to ensure communication between the provider and the hospice provider was complete and timely for one of two sampled residents (33) on hospice. Findings include:

1. Review of resident 33's medical record revealed:
   * She had been admitted to the facility on 1/12/19.
   * Her diagnoses included dementia with behavioral disturbance, other psychoactive substance use, anxiety, and epilepsy.
   * She had been admitted to hospice on 7/11/19.
   * Her hospice care list included:
     - Registered nurse (RN) visits one to two times weekly.
     - Certified nursing assistant (CNA) visits five times weekly.
     - Social service (SS) visits one time monthly and as needed.
     * There had been no documentation from the hospice RN, CNA, or SS.

Interview on 8/22/19 at 1:10 p.m. with the interim director of nursing and the hospice RN revealed:
* The hospice provider had recently started a new charting system.
* The charting would have been available from their office.
* Resident 33's hospice care plan had been in her chart.
* They both confirmed there were currently no notes from the hospice RN, hospice CNA, or hospice SS in resident 33's chart.
* They both agreed the hospice notes regarding resident 33's hospice care should have been current and in her chart.
**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>F849</td>
<td>Continued From page 22</td>
<td>F849</td>
<td>Administrator, DON, interdisciplinary team, and medical director reviewed and revised as necessary the policies and procedures for wound cleansings, glove use, Perineal care of a Male resident, and appropriate hand hygiene. CNA B will be re-educated about proper procedure for glove use, Perineal Care of a Male resident, and appropriate hand hygiene. All other staff responsible for these roles will also be re-educated. RN A and Interim DON will be re-educated about proper procedure for wound cleansings, glove use, and appropriate hand hygiene. All other staff responsible for these roles will also be re-educated. DON or designee will audit proper procedure for wound cleansings, glove use, perineal care of a resident, and appropriate hand hygiene weekly for 4 weeks and monthly for two months.</td>
<td>10/11/2019</td>
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**Infection Prevention & Control**

CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include,
## Continued From page 23

but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.
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<th>Page 24</th>
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This REQUIREMENT is not met as evidenced by:

- Surveyor: 32355
- Based on observation, interview, and policy
- review, the provider failed to ensure infection control practices and protocols were maintained during:
  - Personal care for one of three sampled residents (193) by one of two certified nursing assistants (CNA) (B).
  - Dressing changes for three of three sampled residents (25, 40, and 193) by one of one registered nurse (RN) (A) and one of one interim director of nursing (DON).
- Findings include:

1. Observation on 8/20/19 at 11:20 a.m. of CNAs B and E with resident 193 revealed:
   - The resident had been in his bathroom sitting on the toilet.
   - He had finished having a bowel movement (BM) and required assistance from the staff.
   - They had:
     - Prepared to provide personal care and assist him with transferring into his wheelchair (w/c).
     - Washed their hands and put on clean gloves.
   - With those clean gloves on CNA B:
     - Moved his wheeled walker closer to him and assisted him to stand-up.
     - Opened a package of wet wipes and took out several of them.
     - Used those wet wipes to clean his bottom first that had a large amount of BM on it.
     - After cleaning his bottom she took more wet wipes from the package.
   - With those soiled gloves still on CNA B:
     - Used the wet wipes to clean his front perineal area.
     - Opened a cupboard door and took out a tube of
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<td>F 880</td>
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<td>-Opened the tube and put some of the cream on her fingers and put some on his front perineal area.</td>
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<td>*They:</td>
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<td>-Removed their gloves, finished dressing him, and assisted him into the wc.</td>
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<td>-Washed their hands prior to leaving his room.</td>
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<td>2a. Observation and interview on 9/21/19 at 9:50 a.m. of R N A and the interim DON with resident 25 revealed:</td>
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<td>*He had poor circulation in his legs and was in fluid overload.</td>
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<td>*Both of his feet and legs were quite edematous and had been covered with Kerlex wraps and edema compression hose.</td>
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<td>*They had:</td>
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<td>-Prepared to complete wound care and dressing changes to both of his feet and legs.</td>
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<td>-Gathered several supplies that included:</td>
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<td>--Protective dressings.</td>
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<td>--Several packages of 4 x (by) 4 gauze.</td>
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<td>--Package of Kerlex.</td>
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<td>--Tape and a box with a tube of antibiotic ointment inside of it.</td>
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<td>*The interim DON:</td>
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<td>-Got a clean towel and put it on his bedside table.</td>
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<td>-Placed all of the above supplies on that towel.</td>
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<td>-Removed the dressings from both of his legs.</td>
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<td>*He had three opened wounds.</td>
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<td>-Two of the wounds were on his left foot and left shin.</td>
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<td>-There had been an opened wound on his right shin.</td>
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<td>*R N A sanitized her hands and put on clean gloves.</td>
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<td>*With those clean gloves on she:</td>
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<td>-Opened a package of 4x4 gauze and sprayed</td>
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- The wound cleanser was applied.
- She removed her gloves and without sanitizing her hands put on another pair of gloves.
- With those clean gloves she:
  - Opened a package of 4x4 gauze and sprayed the wound cleanser on it.
  - Used that gauze to clean the wound on his right shin.
  - Opened the box and removed the tube of antibiotic ointment.
  - Placed some of it on the opened protective dressings.
  - Covered the wounds with those dressings.
- They finished covering his wounds and dressings with the Kerlex and edema compression hose.
- They removed their gloves, sanitized their hands, gathered up the rest of the supplies, and left the room.

b. Observation on 8/21/19 at 10:25 a.m. with the interim DON and RN A with resident 193 revealed:
- They had prepared to complete dressing changes to the following areas:
  - Left great toe surgical and amputation site.
  - Left and right shins.
  - Right heel.
  - Sacral pressure ulcer.
- RN A:
  - Gathered multiple dressing supplies and entered his room.
  - Had not sanitized or washed her hands prior to or after entering his room.
  - Had several clean gloves inside of a pocket on her uniform top.
- There had also been other dressing supplies
### Statement of Deficiencies and Plan of Correction

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| F 880 |  | continued from page 27 and tape inside her pocket. - put on a pair of those gloves and laid down a protective barrier on his bedside stand. - placed all of the supplies on top of the protective barrier. - removed his socks and the dressings from both of his feet and legs. * there was an opened blister on his right shin. - with those same gloves on she touched and assessed that wound. * she removed her gloves and without sanitizing or washing her hands put on a pair of gloves from her pocket. - she finished dressing the wound on his right shin. * she removed her gloves and without sanitizing or washing her hands put on a pair of gloves from her pocket.  * with those gloves on she: - opened a package of 4x4 gauze, sprayed wound cleanser on it, and cleaned both wounds on his left foot and shin with the same gauze - applied protective dressings and covered the wounds. * she removed her gloves, sanitized her hands, and put a pair of gloves on from her pocket.  * they: - assisted the resident to stand up, pull down his pants, and assessed the wound on his coccyx. - cleansed and dressed that wound together without any concerns identified. - removed their gloves, assisted the resident to lay down, and left the room.  c. Observation on 8/21/19 at 10:55 a.m. with the interim DON and RN A with resident 40 during multiple dressing changes revealed: * the interim DON gathered several supplies to complete wound care and dressing changes to
Continued From page 28
the resident's wounds.
*She had:
- Placed a clean towel on the resident's bedside table.
- Placed several packages containing dressing supplies on top of it including a plastic bag filled with ointments.
- Placed several clean gloves on top of all those supplies.
*She was not going to clean the resident's wounds prior to applying the ointments and dressings as she just had a bed bath.
*The resident had been laying in bed during the dressing changes.
*The interim DON sanitized her hands and put on a pair of gloves that had been from the pile that were on top of dressing supplies.
*She had:
- Opened the plastic bag and took out a tube of Santyl ointment.
- Opened that tube and put some on her fingers.
- Applied that ointment to two separate wounds on the resident's left arm.
- Removed her gloves, sanitized her hands, and put on another pair of gloves from the pile on the dressing supplies.
*With those gloves on she had:
- Removed the top sheet to expose the resident's left foot with two wounds on it.
- Those wounds were by her ankle and great toe.
*She:
- Opened a package of betadine swabs and used one to clean both of those wounds on her left foot.
- Opened a package and applied the protective dressing to her left ankle.
- Removed her gloves, sanitized her hands, and put another pair of gloves on from the pile on the dressing supplies.
F 880  Continued From page 29

*With those gloves on she had:
- Removed the top sheet and assisted the resident to roll onto her right side.
- Touched and assessed the opened wounds on her bottom.
* The resident had been laying on a bed pad and a soiled sheet.
- That sheet had a palm sized blood stain on it by her left buttock area.
* Without changing her gloves she had:
- Opened a package containing a large protective dressing.
- Applied that dressing to cover multiple wounds on her bottom.
* She had not cleansed the wounds on her bottom prior to applying the protective dressing.
* The interim DON and RN A positioned the resident in her bed, removed their gloves, sanitized their hands, and left the room.

3. Interview on 8/21/19 at 1:51 p.m. with the interim DON and RN A regarding the above personal care for resident 193 and the dressing changes completed on residents 25, 40, and 193 revealed:
* That had been their usual process for completing dressing changes.
* They had not recognized those processes as unsanitary until reviewed with the surveyor.
* They agreed:
- The above processes had been completed in an unsanitary manner and created the potential for infection to the residents' wounds to have occurred.
- The processes above would have interfered with the healing process of those wounds.
- Gloves were not considered clean after they had been stored inside of a pocket or unprotected on top of dressing supplies.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 30 -Multiple wounds should have been cleaned and treated separately to prevent cross-contamination from occurring. -Sanitization or hand washing should have occurred: --When going in and out of resident rooms. --Between changing of gloves. --The outside of surfaces of packages and dressing supplies were not sanitary and should not have been handled prior to touching of a wound. --Even though resident 40 had a sponge bath her sheets were still dirty, and the wounds should have been cleaned prior to treatment of them. --The personal care above for resident 193 had not been completed in a sanitary manner and created the potential for him to develop a facility acquired urinary tract infection. Review of the provider's 5/28/18 Infection Prevention Precautions policy revealed: &quot;Purpose: &quot;To prevent transmission of infectious agents among residents and staff.&quot; &quot;Procedures: -&quot;Hand hygiene is the primary precaution that is best known to prevent transmission of infection.&quot; -&quot;Hand hygiene is to be performed in the following situations. --When hands are visibly soiled. --Before and after application of gloves to provide resident care. --When resident care is completed. --When moving from a dirty to a clean body site.&quot; Review of the provider's 7/1/19 Perineal Care of the Male Resident policy revealed the front perineal area should have been cleaned before the rectal area. Gloves should have been removed after the completion of perineal care.</td>
<td>F 880</td>
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</tbody>
</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**435062**

**NAME OF PROVIDER OR SUPPLIER**

**ALCESTER CARE AND REHAB CENTER, INC**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

101 CHURCH STREET

ALCESTER, SD 57001

<table>
<thead>
<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 31 and sanitation/hand washing should occur.</td>
<td>F 880</td>
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FORM CMS-2567(02-09) Previous Versions Obsolete

Event ID: OKE311

Facility ID: 0036

If continuation sheet Page 32 of 32
<table>
<thead>
<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>Surveyor: 18560</td>
<td>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities, was conducted from 8/20/19 through 8/22/19. Alcester Care and Rehab Center, Inc. was found in compliance.</td>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature]

TITLE: Administrator

DATE: 9/13/2019
<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Action</th>
<th>Date</th>
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<tbody>
<tr>
<td>K000</td>
<td>INITIAL COMMENTS</td>
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<tr>
<td>10/11/2019</td>
<td>Maintenance personnel or designee will address the east wing door by replacing the magnetic lock components that prevented egress. Maintenance personnel or designee will address the whirlpool room door that is causing it to not be easily set in motion. All other egress doors will be tested to ensure that they are operating effectively.</td>
<td>Maintenance director or designee will audit all egress doors to ensure they are operating correctly weekly for 4 weeks and monthly for two months.</td>
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<tr>
<td>9/13/2019</td>
<td>Maintenance director or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.</td>
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</table>

Any deficiency statement ending with an asterisk (*) denotes a deficiency within the facility may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. 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.
<table>
<thead>
<tr>
<th>ID</th>
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<th>PROVIDERS PLAN OF CORRECTION</th>
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</thead>
<tbody>
<tr>
<td>K222</td>
<td></td>
<td>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:</td>
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<tr>
<td>(X4) ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LTD IDENTIFYING INFORMATION)</td>
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</table>
**ALCESTER CARE AND REHAB CENTER, INC**

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</table>
| **K 222** |     | Continued From page 3  
The deficiency affected 100% of the building occupants.  
Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a) | **K 222** |     |                                                                                                  |                 |
| **K 311** | **SS=E** | Vertical Openings - Enclosure  
**CFR(s): NFPA 101**  
Vertical Openings - Enclosure  
2012 EXISTING  
Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour.  
An atrium may be used in accordance with 8.6.  
19.3.1.1 through 19.3.1.6  
If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 27198  
Based on observation and interview, the provider failed to maintain a one-hour, fire-resistive enclosure from the basements at two randomly observed locations (bottom of the stairs to the main basement and the bottom of the stairs to the administration [admin] wing basement). Findings include:  
1. Observation at 11:07 a.m. on 8/20/19 revealed the fire-rated door at the bottom of the lone interior stairway to the main basement had been propped open with a door wedge. To maintain the fire-rating of any vertical opening the door must close automatically. That door wedge negated the | **K 311** |     | The door wedges, including the bricks used to prop open, have been removed at the bottom of the stairs to the main basement and the bottom of the stairs to the administration wing basement. All other door wedges have been removed from operation for doors leading into vertical openings.  
Maintenance director will be re-educated on checking all fire doors for proper operation. Maintenance director will include checking all fire doors for proper operation on his annual Preventative Maintenance (PM) checklist.  
Administrator or designee will audit vertical opening enclosure doors, and all other fire rated doors, to ensure no wedges or props are used to prevent proper operation of all the fire rated doors monthly for three months.  
Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring. | 10/11/2019 |

*Event ID: GKO321*  
*Facility ID: 0026*
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>435062</td>
<td>A. BUILDING 01 - MAIN BUILDING 01</td>
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<tr>
<td></td>
<td>B. WING ______________________</td>
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<td>___________ 08/20/2019 _______</td>
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**NAME OF PROVIDER OR SUPPLIER**

ALCESTER CARE AND REHAB CENTER, INC

**STREET ADDRESS, CITY, STATE, ZIP CODE**

101 CHURCH STREET
ALCESTER, SD 57001

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| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) |

**K 311**

Continued From page 4
required fire rating for the door in that location.

Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware that door wedge caused an issue with the fire-rating of that door. Further interview with the maintenance director revealed he was not aware of the requirement to check all fire doors for proper operation at least annually.

2. Observation at 4:11 p.m. on 8/20/19 revealed the fire-rated door at the bottom of the lone interior stairway to the admin wing basement had been propped open with bricks bunched together. To maintain the fire-rating of any vertical opening the door must close automatically. Those bricks negated the required fire rating for the door in that location.

Interview with the maintenance director at the time of the observation confirmed that finding.

3. Both impediments to the closing of the above fire doors were removed at the time they were found.

This deficiency affected 100% of the building occupants.

**K 712**

Fire Drills

SS=D

K 712

Unable to provide documentation for evening or night shift for quarter 4 of 2018 and noted. Unable to provide documentation for the day shift for quarter 1 of 2019 and noted.

<table>
<thead>
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| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |

**K 712**

**10/11/2019**
### K 712

**Established Routine.** Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7

This **Requirement** is not met as evidenced by:

**Surveyor:** 27198

A. Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills). Findings include:

1. Record review at 1:05 p.m. on 8/20/19 revealed there was no documentation of evening or night shift fire drills for quarter four (October, November, and December) 2018. The only drill occurred in October during the day shift. There was no documentation of day shift fire drills for quarter one (January, February, and March) 2019.

   *Interview with the maintenance supervisor at the time of the record review confirmed those findings. He was aware the minimum number of fire drills per the required frequency had not been met for each shift in 2018 and 2019.*

   The deficiency had the potential to affect 100% of the occupants of the building.

B. Based on observation, interview, and procedure review, the provider failed to ensure staff were familiar with the provider’s fire drill procedures (closing the door for the fire location). Findings include:

1. Observation at 3:25 p.m. on 8/20/19 revealed two certified nursing assistants (CNA) responding...
K 712 Continued From page 6
to the simulated fire in resident room 109. Those CNAs removed the resident from the room but failed to close the room door to the corridor.
When the dietary staff arrived to extinguish the fire the door to the affected room was still open. The dietary staff walked into the room with a fire extinguisher and simulated putting out the fire.
The fire drill procedure was RACE (Rescue, Alarm, Confine, and Extinguish). The corridor doors should have been closed (Confine) prior to attempting to fight the fire (Extinguish).

Interview with the maintenance supervisor at the time of the observation confirmed those findings.

The deficiency had the potential to affect 100% of the occupants of the building.
**Compliance/Noncompliance Statement**

Surveyor: 27198

A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/20/19 through 8/22/19. Alcester Care and Rehab Center, Inc. was found not in compliance with the following requirements: S195, S236, and S322.

**44:73:03:02 General Fire Safety**

Each facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system shall be sounded each month.

This Administrative Rule of South Dakota is not met as evidenced by:

Surveyor: 27198

Based on record review and interview, the provider failed to sound the fire alarm for one month calendar (January) year 2019. Findings include:

1. Record review at 1:15 p.m. on 8/20/19 revealed there was no documentation the fire alarm was sounded in January 2019. A fire drill was not conducted that month.

Interview with the maintenance director at the time of the record review confirmed that finding. He revealed he was unaware of the requirement to sound the alarm monthly and stated he had missed conducting a fire drill that month.

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:

Unable to correct the noncompliance for the missing documentation for January 2019's sounded fire drill.

Fire policy and procedure will be reviewed and revised as necessary to ensure monthly sounded drills are conducted as required.

Maintenance director and all other staff responsible for conducting fire drills will be re-educated that a monthly sounded fire alarm will be performed and documented.

Administrator or designee will audit sounded fire alarms monthly for 6 months. Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.
Tuberculin screening requirements for healthcare workers or residents are as follows:
(1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;

This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 32355
Based on record review, interview, and policy review, the provider failed to ensure the two-step Mantoux tuberculin (TB) skin test had been completed upon admission or within fourteen days of being admitted for two of four sampled...
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| S 236 | Continued From page 2 residents (191 and 193). Findings include:  
1. Review of resident 191's medical record revealed:  
*He had been admitted on 8/15/19.  
*He had received the TB skin test on 8/15/19.  
*There was no documentation to support:  
  - That TB skin test had been assessed within seventy-two hours to ensure no negative outcome had occurred.  
  - A second TB skin test had been initiated.  
Review of resident 193's medical record revealed:  
*He had been admitted on 8/8/19.  
*There was no documentation to support an initial TB skin test had been completed nor a second one initiated.  
Interview on 8/22/19 at 10:41 a.m. with the interim director of nursing revealed she:  
*Was not aware the above residents' TB skin tests had not been reviewed within seventy-two hours of given nor was a second one initiated.  
*Stated:  
  - "Those should have been completed and read within fourteen days."  
  - "We have a no failure system with these."  
  - "After initial set-up it will tell when to read it."  
  - "After you read it, it will tell you to set-up the next one."  
  - "There is no reason why they were not completed."  
Review of the provider's undated TB Screening Protocol policy revealed:  
*Purpose: "All residents entering facility as an admit or re-admit need to be tested for exposure to TB."  
*Protocol:  |
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<td>S 236</td>
<td></td>
<td></td>
<td>Continued From page 3</td>
<td>S 236</td>
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<td></td>
<td>Administrator, Interim DON, and interdisciplinary team reviewed and revised as necessary the policy and procedure for medications leaving the facility.</td>
<td>10/11/2019</td>
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<tr>
<td>S 322</td>
<td>44:73:08:05</td>
<td>Control and Accountability of Medications</td>
<td>S 322</td>
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<td></td>
<td>All Licensed Practical Nurses, Registered Nurses, and anyone else responsible for the transfer or discharge of residents will be re-educated on obtaining a physician order and proper documentation of medications leaving the facility.</td>
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<td>Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication shall be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from their receipt through administration, destruction, or return.</td>
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<td>Unable to account for the amount of Resident 41's medication when she was discharged on 5/27/19. DON or designee will audit the documentation of medication for all residents that are discharged or transferred, including obtaining a physician order for release, weekly for four weeks and monthly for two months.</td>
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<td>This Administrative Rule of South Dakota is not met as evidenced by:</td>
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<td>Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring.</td>
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<td>Surveyor: 18560</td>
<td>Based on interview, record review, and policy review, the provider failed to document the disposition of medications for one of one sampled resident (41) who left the facility against medical advice (AMA). Findings include:</td>
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<td>1. Review of resident 41's medical record revealed:</td>
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<td>*She left the facility on 5/27/19 AMA. *A 5/28/19 1:03 p.m. health status note stated:</td>
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<td>*Resident phones facility and states that she wanted out of here. She states she will be down today to pick up her personal medication [meds] bag with personal meds &amp; her facility medications are packed up as well except for her Tramadol which will be destroyed at the facility.</td>
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### Summary Statement of Deficiencies

<table>
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<tr>
<th>ID PREFIX</th>
<th>ID TAG</th>
<th>Summary Statement</th>
<th>Corrective Action</th>
<th>Date Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>S 322</td>
<td></td>
<td>*No physician's order to release the medications to the resident.</td>
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<td>*No documentation of the quantity, drug name, or strength of the medications released to the resident.</td>
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<td>Interview on 8/22/19 at 2:30 p.m. with the interim director of nursing regarding resident 41 confirmed:</td>
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<td>*She had left the facility AMA.</td>
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<td></td>
<td>*She had returned to the facility for her medications.</td>
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<td>*There was no physician order to release the medications to her.</td>
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<td>*There was no documentation in her medical record of the quantity, drug name, or strength of the medications released to her.</td>
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<td>Review of the provider's revised November 2011 Disposal of Medications and Medication-Related Supplies policy revealed no information on documentation of medications released to a resident upon discharge.</td>
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<td>S 000</td>
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<td>Compliance/Noncompliance Statement</td>
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<td>Surveyor: 18560</td>
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<td>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 8/20/19 through 8/22/19. Alcester Care and Rehab Center, Inc., was found not in compliance with the following requirement: S030.</td>
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<td>S 030</td>
<td></td>
<td>44:74:02:06 Required to Pay Costs of Training/Evaluation</td>
<td>Facility will reimburse all nurse aides hours who completed the training at home that are still employed.</td>
<td>10/11/2019</td>
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<tr>
<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
<td>ID PREFIX TAG</td>
<td>PROVIDER'S PLAN OF CORRECTION</td>
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<td>S 030</td>
<td>Continued From page 5 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 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. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18560 Based on interview, the provider failed to pay all costs for nurse aides completing their nurse aide training program. Findings include: 1. Interview on 8/22/19 at 11:45 a.m. with the administrator revealed: *Nurse aides would either complete the training program at the facility or at their own home. *If the training program had been completed at the facility the nurse aide's training hours were paid. *If the training program had been completed at the nurse aide's home the nurse aide's training hours were not paid. *He confirmed not all of the training costs were</td>
<td>S 030</td>
<td>Installment payments will be paid out during the first twelve months of employment. 09/11/19 The nurse aide training program will review and revise as necessary the policy and procedure to ensure all training costs are reimbursed to the nurse aide. Administrator and other staff responsible for the nurse aide training program will be re-educated. Administrator or designee will audit monthly for 3 months on nurse aides to ensure all training costs are reimbursed. Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring.</td>
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<td>ID</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<td>S 030</td>
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08/22/2019