

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

ORIGINAL

PRINTED: 11/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/22/2015
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NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325
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F 000	INITIAL COMMENTS Surveyor: 32332 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/20/15 through 10/22/15. Areas surveyed included quality of care and treatment, resident abuse, and resident rights. Sanford Chamberlain Care Center was found not in compliance with the following requirement: F226 and F281.	F 000		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to thoroughly investigate and report: *An injury after a fall, verbal abuse to a resident by a staff member, bruises of unknown origin, and altercations between residents to the South Dakota Department of Health (SD DOH) for five of five sampled residents (1, 2, 3, 4, and 5) residents. *A fracture for one of one sampled resident (6) who had an incident with her wheelchair. Findings include: 1. Review of the fall event report for resident 4 revealed:	F 226	F226 -DON, Social Worker, LTC Administrator, Quality Manager, and Medical Director reviewed reporting policy. All facility staff involved in LTC were educated on Nov 4 th , Nov 6 th , Nov 9 th & Nov 10 th . Remaining staff to be educated one on one, over phone or face to face by 11/18/15 or next scheduled shift. Education on mistreatment, neglect & misappropriation of resident property to include hiring & screening of employees, training r/t abuse prohibition practices, prevention, identification, investigation, protection and reporting. Hypothetical resident scenarios were used as teaching examples.. (cont next page)	11/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO	(X6) DATE 11.11.15
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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.

NOV 20 2015
SD DOH L&C
Event ID: LB2944

NOV 12 2015
SD DOH L&C
Facility ID: 0036

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F 226	<p>Continued From page 1</p> <p>*On 9/30/15 he had an unwitnessed fall in his room.</p> <p>*He sustained an approximately two inch laceration (cut) with blood loss and a bump to the back of the head.</p> <p>*Vital signs (blood pressure, pulse, and temperature) and neurological checks (level of alertness, facial movement, hand grasps, eye position, and speech) were completed following the fall.</p> <p>*The resident was able to state he was experiencing mild pain and rated it a 1 on a 0-10 pain scale (0 meaning no pain and 10 being the worst pain).</p> <p>*Emergency room (ER) staff assisted the resident off the floor of his room and transferred him to the ER for evaluation.</p> <p>Review of the nursing progress notes from 10/1/15 at 12:37 a.m. and at 5:50 a.m. for resident 4 revealed:</p> <p>*He returned from the ER with eight staples to the laceration on his head.</p> <p>*New physician's orders were written in the ER for nursing home staff to follow including: -Wound cleansing, dressing changes, monitoring for signs and symptoms of infection, and follow-up for removal of the staples.</p> <p>Interview on 10/21/15 at 2:15 p.m. with the director of nursing (DON) regarding resident 4's fall revealed:</p> <p>*An internal investigation had not been thoroughly completed.</p> <p>*An initial and final event report was not sent to the South Dakota Department of Health (SD DOH) following the fall.</p> <p>*The DON stated the event was not reported to the SD DOH since it involved an injury to the</p>	F 226	<p>F 226 (cont) DON or designee will monitor all reportable events for 3 months and report to QA committee. QA Committee will define thereafter.</p>	<p>including the need to report to the SD DOH thoroughness of the investigation, timeliness of reporting to the SD DOH - EP 11.19.15</p> <p>→ weekly x1 month, then monthly x3 months, then quarterly until QA determines event can be discontinued. QA committee meets monthly. -EP 11.19.15</p>	

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F 226	<p>Continued From page 2 head and had not involved a fracture.</p> <p>Interview on 10/22/15 at 8:30 a.m. with the DON regarding reporting of serious injury events to the SD DOH revealed: *A nurse or certified nursing assistant would start an internal investigation report, and it would be routed to the appropriate personnel. *The social worker would begin an event report to the SD DOH, and the DON would assist as needed. *The algorithm (a set of instructions) on the SD DOH website was used in determining if an event should have been reported. *The fall from 9/30/15 was reviewed by the DON and social worker, and it was determined no report was to be made to the SD DOH for the following reasons: -The fall did not involve a fracture. -The fall did not involve severe pain.</p> <p>Interview on 10/22/15 at 11:05 a.m. with the social worker regarding the reporting of resident 4's 9/30/15 fall to the SD DOH revealed: *The fall required the resident be evaluated and treated in the emergency room. *The fall could be viewed as a serious injury requiring a report to the SD DOH.</p> <p>Review of the provider's April 2012 Fall Prevention and Follow-up Reporting Policy revealed, "A report will be sent to the State Department of Health if a resident has a fracture or serious injury from the fall."</p> <p>Review of the provider's May 2013 Abuse: Reporting/Response Policy revealed, "The Social Worker or DON will complete a nursing facility event reporting for each alleged abuse or neglect</p>	F 226		

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F 226	<p>Continued From page 3</p> <p>including injury of unknown origin incident and notify the SD DOH and the local Ombudsman within the regulated 24 hours of the incident..."</p> <p>Surveyor: 32332</p> <p>2. Review of resident 6's 10/5/15 physical harm/injury report revealed: *Interviews with certified nursing assistants (CNA) D and F regarding the events on 10/4/15-10/5/15 prior to x-ray results of a leg fracture. *The interviews indicated: *Resident 6 had a blanket wrapped around her and under the wheel of her wheelchair. *The CNAs pulled the blanket out from under the wheelchair. *The CNAs later placed her in bed using a mechanical lift. *Resident 6 complained of foot pain and reported: -Her foot got caught in the strap of the lift during the transfer. -Her "foot got caught on the pedal."</p> <p>The DON interviewed RN B, the nurse on duty the night of the injury. The event report had not indicated if she had asked the staff if the wheelchair pedals had been used at the time the blanket had become caught in the wheelchair.</p> <p>3. Review of resident 3's 3/25/15 resident-to-resident altercation (struck another resident) event report revealed: *There was no initial report. *There was no date on the report indicating when the Department of Health had been notified of the event. *The 4/2/15 final (5-day) report of an allegation of verbally inappropriate comments from a staff member toward the resident.</p>	F 226			

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F 226	<p>Continued From page 4</p> <p>*The findings revealed the investigation had been completed, and the was no injury or negative outcome to the resident.</p> <p>*The report had not contained: -Who had been interviewed. -What had caused the investigator to come to the conclusion the report not substantiated (proven).</p> <p>Interview on 10/21/15 at 11:20 a.m. with the social worker revealed: *She had done the initial report but was not sure where it was. *She had not been sure who had been interviewed to determine no injury had been caused to the resident.</p> <p>4. Review of an undated event occurrence combined Initial and Final report indicated it was reported 5/4/15 that resident 3 had struck resident 1 on 5/1/15. There had been no documentation regarding: *What the investigation had included. *Who might have been interviewed as part of the investigation. *Any events that might have caused the resident to strike another resident.</p> <p>Interview on 10/22/15 at 11:20 a.m. with the social worker revealed there was no more to report regarding the above incident.</p> <p>5. Review of an 8/31/15 event report with allegation of physical harm related to a bruise on resident 5 revealed: *The resident had a bruise of unknown origin (cause). *The bruise had been investigated on 8/31/15. *The resident was unable to tell staff how the bruise had occurred.</p>	F 226		

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F 226	<p>Continued From page 5</p> <p>*The resident had been observed at times at night with behaviors.</p> <p>*During those times he might have hit his arm on a table, chair, or bed.</p> <p>*There were no documented interviews with the staff.</p> <p>*There were no specific dates or times of those behaviors.</p> <p>Interview on 10/22/15 at 11:00 a.m. with the director of nursing revealed:</p> <p>*She had seen resident 5 pound on furniture in the past.</p> <p>*She had been told by the Department of Health that she had provided too much information with previous reports in the past.</p> <p>*She had made another report after an interview with this surveyor on 10/21/15 at 5:00 p.m. that had indicated she had seen the resident pound on furniture.</p> <p>6. Review of the provider's July 2011 Abuse Investigation policy revealed:</p> <p>*It was done to provide a manner by which alleged (claimed) abuse violations would have been investigated.</p> <p>*The social services designee and/or director of nursing would investigate alleged violations.</p> <p>*They would interview any resident, visitor, and staff involved. Depending on the circumstances coworkers and other residents would be interviewed.</p> <p>*That investigative report would be faxed to the State Department of Health within five days of the original report.</p> <p>Review of the provider's June 2011 Event Reporting Policy and Procedure revealed:</p> <p>*The purpose was to provide a tracking device for</p>	F 226		

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F 226	Continued From page 6 the provider so that care being given could be evaluated against the established standards of practice and corrective measures could be taken to improve quality of care. *The supervisor/department head or designee was to have recorded incidents as quickly as possible, not exceeding twenty-four hours. *The supervisor/department head should have conducted initial investigations of each situation as soon as possible to assure all facts were accumulated, that the report was completed accurately and that corrective actions were taken to prevent recurrence. *The quality management/improvement committee would have completed the investigation by consulting with other involved departments.	F 226		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, policy review, and job description review, the provider failed to document and report concerns for one of one sampled resident (6) with severe pain and possible injury. Findings include: 1. Review of resident 6's medical record revealed: *A late entry recorded on 10/5/15 at 6:50 a.m. for 10/4/15 in the nursing progress notes by registered nurse (RN) B had indicated "Resident	F 281	F281 - DON, LTC Admin, & Quality Manager developed & reviewed LTC Nursing 093, Nursing Assistant & CMA Duties General Guidelines For Certified Medication Aides/ Certified Nurse's Aides. An in-service was provided to all staff serving in CMA capacity on Nov 6th & 9th to provide education & review med aide policy as well as a competency exam was completed on Nov 6 & 9th. DON or designee will report QA monthly audit results on safe medication administration to QA (cont next page)	11/18/15 Remove ZUP 11-19-15

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F 281	<p>Continued From page 7</p> <p>states that her leg was caught in the wheel chair on 10/4/15 during a transfer. She is now complaining of severe pain. PRN [as needed medication] for pain has been given. Resident has rested most of the night."</p> <p>*No other entries had been documented on 10/4/15.</p> <p>*A 10/5/15 entry in the nursing progress notes at 8:58 a.m. by licensed practical nurse (LPN) C indicated the resident had shown a recent increase in left leg pain. The nurse had notified the physician's assistant on call, and an appointment was made for her to be seen.</p> <p>*A 10/5/15 entry in the nursing progress notes at 12:32 p.m. by LPN C indicated the x-ray report had confirmed a fracture to the left tibia and fibula (lower bones of leg).</p> <p>Review of 10/8/15 investigation statements of the possible events that could have led to the injury revealed on the night before the leg fracture was noted certified nursing assistant (CNA) D:</p> <p>*Documented resident 6 had been restless and calling out most of the night of 10/4/15 and 10/5/15.</p> <p>*CNAs D and E had placed her in a wheelchair and brought her to the dining room. (The exact time was unknown, however interviews had concluded the hour was around 2:30 a.m.).</p> <p>*She remained restless and had been pushing her wheelchair away from the desk.</p> <p>*Documented resident 6 had a blanket caught under the wheel of her wheelchair.</p> <p>*Pulled the blanket up and lifted the chair off of it.</p> <p>*Placed the resident in bed later, and the resident stated her foot got caught in the strap of the lift.</p> <p>*Pulled her sock off and noticed some bruising on the foot.</p> <p>*Notified the nurse of the above events, and the</p>	F 281	<p>F281 (Cont) - Committee for 3 months. QA Committee will define thereafter.</p> <p>All RN/LPN were educated on Nursing Report Procedure on Nov 6th, Nov 9th, Nov 10th and Nov 12th. DON or designee will monitor Nursing Report Procedure and report to QA monthly for 3 months, with QA Committee defining thereafter.</p> <p>by DON - ep 11-19-15</p> <p>weekly x 1 month, then monthly x 3 months, then quarterly until QA determines the audits can be discontinued. - ep. 11-19-15</p>	<p>documentation of assessments and - ep 11-19-15</p> <p>DON provided 1-1 education to staff member B on proper reporting of handoffs: importance of accurate documentation regarding resident 6. - ep 11-19-15</p>	

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F 281	<p>Continued From page 8 "Nurse looked at foot also."</p> <p>Interview on 10/21/15 at 10:55 a.m. with RN B revealed: *He had not been aware something had happened to resident 6. *The CNAs had told him the residents leg had not been caught in the lift strap during the transfer. *He had looked at her foot at that time, but had not noticed any bruising. *He had not found anything unusual about her. *He had not documented the above concerns. *He stated the resident often: -Called out at night. -Reported pain symptoms. -Reported being injured during routine care from the direct care staff. *Her behaviors on that night had been her usual behaviors. *He didn't find anything unusual about her. *He had given her lorazepam (medication for anxiety) for her restlessness with some relief. *He had not reported any of the above concerns to the oncoming nurse.</p> <p>Interview on 10/21/15 at 1:45 p.m. with LPN C revealed: *She came on duty the morning of 10/5/15. *Nothing new for resident 6 had been reported to her from RN B. *Resident 6 had complained of pain during her shift but had been unable to tell her where the pain was. *She reported the pain to RN B when he returned to work that evening. *RN B told her he had forgotten to report to her the resident had gotten her foot caught in the wheelchair.</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>Interview on 10/21/15 at 1:30 p.m. with the director of nursing revealed: *She was aware RN B had not documented on resident 6 on 10/4/15 at the time of her restless behaviors. *She was aware RN B had not reported any concerns regarding resident 6 to the oncoming nurse on the following morning. *She had already counseled RN B regarding the importance of documentation and reporting off to the oncoming shift.</p> <p>Review of the provider's 5/25/12 charge nurse job requirements revealed the charge nurse was to have: *Performed ongoing assessments of residents with complete and appropriate documentation. *Provided pertinent, organized, and concise shift-to-shift report.</p> <p>Review of the provider's March 2012 Nursing Report policy revealed: *Report was to have been completed at the change of shift without exception by the charge nurse of each household. *The nurse was to have reported: -The condition of each resident. -Any condition change. -Any incidents, falls, wounds, status of residents, orders to have been followed. -The last dose of any PRN medication administered and the effectiveness of the medication given.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, p. 481, "High-quality documentation and reporting are necessary to enhance efficient, individualized client care.</p>	F 281			

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F 281	Continued From page 10 Quality documentation and reporting have five important characteristics: they are factual, accurate, complete, current, and organized.	F 281			