

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

ORIGINAL

PRINTED: 03/10/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/02/2016
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401
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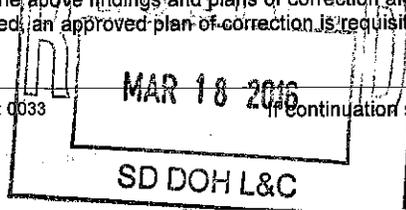
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F 000	<p><i>*Addendums noted with an asterisk per 3/31/16 per F 000 telephone with facility administrator and DON. NPN/SDDOH/EL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 33488</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/29/16 through 3/2/16. ManorCare Health Services was found not in compliance with the following requirement(s): F226, F281, and F282.</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/29/16 through 3/2/16. Areas surveyed included: nursing services. ManorCare Health Services was found not in compliance with the following requirement(s): F309</p>		Aberdeen Plan of Correction for Annual Survey on February 29, 2016.	
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate falls for three of three randomly sampled residents (16, 17, and 18). Findings include: 1. Review of resident 16's 1/6/16 incident report revealed he had fallen asleep in his electric</p>	F 226	<p>The statements on this plan of correction are not admittances to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take action as set forth in the following plan of correction. The plan of correction constitutes the center's assertion of compliance. All alleged deficiencies cited have been or will be corrected by dates indicated.</p> <p>F226 This deficiency has the potential to affect all residents experiencing a fall.</p> <p>Resident #16 has been discharged. Residents #17 & #18 were reviewed with no evidence of abuse/neglect substantiated regarding falls.</p>	

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

Francis Havel *Administrator* *03/17/16*

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



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F 226	<p>Continued From page 1</p> <p>wheelchair. He had fallen forward out of his wheelchair onto the floor. The report had not stated if the fall was witnessed or unwitnessed. There had been no documentation of an investigation into that fall.</p> <p>Review of his 1/1/16 Minimum Data Set (MDS) assessment revealed he had a Brief Interview for Mental Status (BIMS) score of 8. A score of 8 to 12 meant there was moderate cognitive (thinking) impairment.</p> <p>2. Review of resident 17's 1/21/16 incident report revealed he had been found sitting on the floor by a staff member. The resident reported he was going to stand up, and his wheelchair slipped out. He was unable to explain why he was going to stand up. He was wearing gripper socks, and the floor was free from clutter. There had been no documentation of an investigation into that fall.</p> <p>Review of his 2/19/16 MDS assessment revealed he had a BIMS score of 10. A score of 8 to 12 meant there was moderate cognitive impairment.</p> <p>3. Review of resident 18's 1/31/16 incident report revealed she was found on the floor by a staff member. She was laying on her back on the floor with a skin tear to her right elbow and a "goose egg [a swollen area]" to the back of her head. There had been no documentation of an investigation into that fall.</p> <p>Review of her 2/3/16 MDS assessment revealed she had a BIMS score of 6. A score of 0 to 7 meant there was severe cognitive impairment.</p> <p>4. Review of the above incident reports revealed there was no documentation of investigation into</p>	F 226	<p>Administrator, Director of Nursing and Interdisciplinary Team met on 3/10/16 to review the policy and procedure ensuring resident events/incidents are thoroughly investigated.</p> <p>Nurses will follow the November 2011 Patient Protection Abuse, Neglect & Misappropriation Prevention Guide to determine the "who, what, when, where, why & how" for any occurrences to determine the appropriate course of action and response.</p> <p>Staff will complete online training by 3/25/16 on Abuse, Neglect, Mistreatment, Misappropriation and Appropriate Reporting .</p> <p>Nurses will be educated by 3/25/16 on completing a thorough investigation of resident events/incidents.</p>	

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F 226	Continued From page 2 the following: *What had been occurring prior to the fall. *When the residents had last been assisted with activities of daily living. *If call lights had been within reach of the resident. *What staff had been working at the time of the fall. *There had been no staff interviews. *If the individual care plans and fall interventions had been followed. *Possible changes in residents' conditions. *What each environment looked like at the time of the fall. *Recent medication changes. Interview on 3/2/16 at 8:50 a.m. with the director of nursing revealed the incident reports were the investigations. There was no other documentation regarding investigations into the above mentioned residents' falls. Review of the provider's November 2011 Patient Protection Abuse, Neglect & Misappropriation Prevention policy revealed staff should have determined the "who, what, when, where, why, and how for any occurrences to determine the appropriate course of action and response."	F 226	*75% of all NPN/SDDOHEL Resident events/incidents will be audited by Interdisciplinary Team Monday-Friday to ensure thorough investigation was completed X 4 weeks. Director of Nursing will take audit results to monthly QAPI Committee [REDACTED] *until committee advises to discontinue. NPN/SDDOHEL	4/7/16
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	F 281		

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F 281	<p>Continued From page 3</p> <p>Based on record review, interview, and procedure review, the provider failed to:</p> <ul style="list-style-type: none"> *Have resident specific parameters for blood glucose (sugar) results for one of five sampled residents (10) who required blood sugar monitoring for diabetes. *Notify the physician for seven of eight abnormal blood sugar levels below 60 milligrams/deciliter (mg/dL) (measure the amount of glucose on the blood) for one of five sampled residents (10) who required blood sugar monitoring. *Document interventions performed to increase eight of eight abnormal blood sugar levels for one of five sampled residents (10) who required blood sugar monitoring. *Document repeat finger sticks to indicate eight of eight abnormal blood sugar levels had improved for one of five sampled residents (10) who required blood sugar monitoring. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 10's medical record revealed: <ul style="list-style-type: none"> *He had been admitted on 10/9/15. *He had a diagnosis of diabetes and required blood glucose tests four times a day and insulin to maintain his blood sugar. *His February and March 2016 blood sugar tests had indicated abnormally low blood sugars (60 or below): <ul style="list-style-type: none"> -2/6/16: 59. -2/10/16: 57. -2/12/16: 52. -2/13/16: 53. -2/17/16: 56. 2/23/16: 60. 2/24/16: 55. 3/1/16: 54. 	F 281	<p>F281</p> <p>Resident #10's physician and family have been updated on low blood sugars and parameters have been received.</p> <p>Diabetic residents receiving accuchecks have the potential to be affected. Parameters have been received.</p> <p>Director of Nursing and Interdisciplinary Team reviewed and revised Nursing Procedure: Hypoglycemia Treatment to include the need to obtain physician orders for blood sugar parameters.</p> <p>Director of Nursing/Unit Manager will Educate nurses by 3/25/16 on ensuring the diabetic residents receiving accuchecks have high & low parameters; physicians are notified per orders. Interventions are documented if indicated and repeat finger sticks are completed to indicate improvement.</p>	<div style="background-color: black; width: 100px; height: 20px; margin-bottom: 5px;"></div> <p>*NPN/SDDH/EL</p>

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F 281	<p>Continued From page 4</p> <p>Review of his February and March 2016 electronic medical record progress notes revealed:</p> <ul style="list-style-type: none"> *No documentation resident 10's physician had been notified of any abnormal blood sugar levels. *No documentation to indicate what interventions had been performed to increase his low blood sugar levels. *No documentation to indicate repeat blood sugar levels had been obtained to monitor the effectiveness of any interventions that might have been performed. <p>Review of his 12/9/15 care plan revealed "Review glucometer (device to measure blood sugar) readings and report abnormalities as ordered."</p> <p>Interview on 3/1/16 at 4:25 p.m. with licensed practical nurse (LPN) D revealed regarding resident 10:</p> <ul style="list-style-type: none"> *He had faxed the resident's physician regarding the low blood sugar that morning (3/1/16) and had just received orders for insulin changes. *When asked about abnormal blood sugar protocol he stated most residents requiring blood sugar monitoring had parameters to indicate when to have notified the physician of abnormal levels. *He had been unable to locate blood sugar parameters for resident 10. *He had given him orange juice the morning of 3/1/16 to increase the blood sugar level when it was 54. *He had not documented the physician had been notified of the abnormal blood sugar. *He had not documented the effectiveness of the orange juice. <p>Interview on 3/1/16 at 5:15 p.m. with the director</p>	F 281	<p>The Director of Nursing/Unit Manager will audit 5 random residents per week for four weeks to ensure the following: parameters are in place; physicians have been notified per orders; interventions are documented if indicated and if necessary; repeat finger sticks are completed to indicate improvement.</p> <p>The Director of Nursing will take audit results to monthly QAPI Committee</p> <p><i>*diabetic NPN/SDDO/H/EL</i></p> <p><i>*Until Committee advises to discontinue. NPN/SDDO/H/EL</i></p>	4/7/16

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F 281	<p>Continued From page 5 of nursing revealed:</p> <ul style="list-style-type: none"> *There was no policy for abnormal sugar levels. The provider used the December 2009 Nursing Procedures - H: Hypoglycemia Treatment, referenced from the American Dietetic Association. *There was no policy to obtain physician's orders for blood sugar parameters. *If the physician wanted the resident to have blood sugar parameters he would have written the order. <p>Review of the provider's December 2009 Nursing Procedures - H: Hypoglycemia Treatment revealed:</p> <ul style="list-style-type: none"> *For low blood sugars (60 or below) the provider was to "Follow physician's orders for Blood Sugar parameters and treatment." -If alert the resident was to have been given milk or juice. -The provider was to repeat a blood sugar level as ordered by the physician, usually every fifteen minutes. -Documentation would have included repeat blood sugar levels, the resident's condition, vital signs, and other interventions including communication with the physician. <p>Interview on 3/2/16 at 8:45 a.m. with the director of nursing regarding resident 10 revealed she agreed:</p> <ul style="list-style-type: none"> *The physician had not been contacted for blood sugar parameters. *The physician had not been contacted for seven of eight abnormal blood sugars levels. *There had been no documentation of interventions performed, repeat blood sugar levels, or the effectiveness of the interventions. 	F 281		

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F 281	Continued From page 6 Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, page 1039 revealed if the blood sugar level was below the target range the nurse was to have: *Continued to monitor the patient. *Checked the medical record to see if there was a medication order for deviations in the blood sugar level. *Contacted the physician if there were no medication orders. *Given a carbohydrate food or drink (to increase the blood sugar level). *Notified the physician of the patient's response to the intervention. *Recorded the blood sugar results and described patient's response to the interventions.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to follow the care plan and provide extensive assistance of one staff person for one of three sampled residents (12) who needed assistance at meals. Findings include: 1. Observation on 2/29/16 from 5:40 p.m. through 6:00 p.m. of resident 12 revealed she was served	F 282	F282 Resident 12's assistance needs have been reviewed and careplan revised to reflect same. Of note, resident did consume 75% of evening meal on 2/29/16; 75% of noon meal on 3/1/16; and 50% of evening meal on 3/1/16. Residents requiring assistance with meals have the potential to be affected. Careplans on these residents have been reviewed/ revised as needed.	

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F 282	<p>Continued From page 7</p> <p>her food at 5:50 p.m. She had not received assistance from staff to eat during that entire time. She picked up the sandwich a few times and took some bites but had not attempted to eat the soup. She had been looking around the dining room and was not eating.</p> <p>Observation on 3/1/16 at 11:55 a.m. of resident 12 revealed staff were sitting at the table feeding her. She had eaten what they had given to her.</p> <p>Observation on 3/1/16 from 5:30 p.m. through 5:50 p.m. of resident 12 revealed she had been served her food at 5:37 p.m. Staff had not sat down to assist her. She picked up the fork and took one bite of the dessert. She looked around the room and was moving the extra clothing protector around on the table. She then moved a paper around and was not eating. She took one more bite and attempted to cut her bread with her spoon. She had not received assistance from staff to eat during that entire time.</p> <p>Review of resident 12's 12/18/15 Minimum Data Set assessment revealed she needed extensive assistance of one staff person for eating. She had long and short term memory problems.</p> <p>Review of resident 12's undated care plan revealed staff were to "Provide max [maximum] assist with eating, feed patient slowly, place finger foods, glasses, cups, etc within her reach. OT/ST [occupational therapy/speech therapy] is providing services."</p> <p>Review of resident 12's weight logs revealed she had weighed 164.8 pounds (lb) on admission on 12/14/15. On 3/1/16 she weighed 160.0 lb.</p>	F 282	<p>The Director of Nursing/designee will educate staff responsible for care planning by 3/25/16 on ensuring the careplan is accurate for the care and wellbeing of the residents.</p> <p>The Director of Nursing/designee will audit four random residents a week for four weeks to ensure the careplan is accurate and reflects the needs of the resident.</p> <p>The Director of Nursing will take audit results to the monthly QAPI Committee</p> <p><i>*until committee advises to discontinue. NPN/SDDOHEL</i></p>	4/7/16

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F 282	Continued From page 8 Interview on 3/2/16 at 8:50 a.m. with the director of nursing regarding resident 12 revealed: *OT/ST were not providing assistance at all meals. *They had been helping during some meals per her therapy goals. *Her therapy would end on 3/4/16, and she would be staying as a long term care resident. *She stated sometimes she had not wanted help, but agreed that had not been care planned. Review of the provider's undated Care Plan policy revealed care plans were to be individualized to the resident's specific needs. The care plan should have guided the ongoing provision of care and assisted in the evaluation of the care.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on closed record review, interview, job description, and professional standards review, the provider failed to appropriately identify, intervene, and notify the physician of symptoms of potential sepsis (a severe infection) in a timely manner for one of two sampled residents with an infection (14). Findings include:	F 309	F309 Resident 14 has been discharged from facility. Residents with elevated temp two degrees above baseline have the potential to be affected. Administrator, Director of Nursing and Interdisciplinary Team met and reviewed the Carepath Interact Version 4.0 tool on 3/10/16.	

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F 309	<p>Continued From page 9</p> <p>1. Review of resident 14's medical record revealed she: *Was admitted from the hospital on 3/27/15 with a past medical history of: -High blood pressure. -Sleep apnea that required the use of a C-PAP machine (special breathing machine) with oxygen to have been used only at night. -Mild chronic obstructive pulmonary disease (COPD). -An ulcer on her buttock that had been previously infected and was currently being treated with intravenous antibiotics. *Had not shown any signs of sepsis according to her operative note when her ulcer was debrided (the removal of non-living tissue from a wound) dated 3/22/15. *Had been seen by an infectious disease specialist on 3/22/15 while in the hospital and was found to be "quite stable from an infectious disease standpoint."</p> <p>Review of resident 14's nursing notes revealed: *On 3/27/15 she was admitted, and lung sounds were noted to be clear. She had no complaints at that time. *On 3/28/15 her oxygen level was documented as slightly low at 92 percent (%) on room air (normal is 94% to 100% and oxygen is usually given when levels fall below 90%). That would have been expected with her diagnosis of mild COPD. Her Foley catheter (tube that drained urine out from the bladder) was draining clear urine at that time. *On 3/29/15 her vital signs continued to remain within normal limits and her urine remained clear. *On 3/30/15 at 11:32 a.m. licensed practical nurse (LPN) A documented the drainage from her wound vac (a vacuum dressing to promote</p>	F 309	<p>Education will be provided to nurses responsible for assessment <i>*NPN/SDDO/H/L</i></p> <p>utilizing the Carepath Interact Version 4.0 tool by 3/25/16. <i>NPN/SDDO/H/L</i></p> <p><i>*Infection Control Coordinator</i> designee will complete five random chart audits per week X 4 weeks to ensure accurate assessment, evaluation and timely physician notification of change in status, <i>*NPN/SDDO/H/L</i></p> <p>Director of Nursing will take audit results to monthly QAPI Committee for review and further recommendations. <i>4/7/16</i></p> <p><i>*to identify initial signs and symptoms of infection, and physician notification to prevent sepsis.</i></p> <p><i>* and tracking, trending and provide surveillance on sepsis infections.</i> <i>NPN/SDDO/H/L</i></p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 10</p> <p>healing in a wound) was serosanguinous (clear with a slightly bloody tinge). There was no odor or other indicators of infection documented at that time.</p> <p>*Later that same day at 6:41 p.m. registered nurse (RN) B documented the resident had "large amounts of cloudy yellow drainage [from her Foley catheter]....no concerns at this time."</p> <p>*On 3/31/15 at 10:30 a.m. LPN A documented "Resident voices she feels warm and a little hard for her to breathe. Temperature 99.6 degrees Fahrenheit (F). Encouraged resident to remove one of her blankets." There was no mention the physician had been notified by nursing staff.</p> <p>*Later that same day at 10:03 p.m. she had large amounts of cloudy-colored urine.</p> <p>On 4/1/15 at 3:30 a.m. LPN E documented the resident's oxygen levels dropped to 86% on room air. She then administered oxygen at two liters per minute (L/min) to the resident.</p> <p>*The primary care physician's office was not notified until 3:30 p.m., twelve hours later the resident's oxygen level had dropped to 86%. A fax was sent stating "Need order for oxygen as needed." There was no mention of the increase in the resident's temperature, difficulty breathing, or the cloudy urine that had been documented by staff in the previous two days.</p> <p>*That fax was returned that same day at 4:06 p.m. as "order ok" and had been signed by physician's assistant F.</p> <p>On 4/1/15 at 9:30 p.m. LPN C documented the resident's oxygen saturation had dropped again while off oxygen to 84%. Oxygen was re-administered. The resident now had a productive cough with green phlegm. They were going to continue to monitor her condition. There</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
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F 309	<p>Continued From page 11</p> <p>was no mention of contacting the physician with that new information. There were no other vital signs noted in the documentation supporting further assessment was made by nursing staff at that time.</p> <p>On 4/2/15 at 7:30 a.m. the resident's vital signs were taken prior to her transfer to a hospital in Sioux Falls for elective surgery to close the ulcer on her buttocks. Those vital signs were as follows:</p> <ul style="list-style-type: none"> *Blood pressure: 106/60 millimeter of mercury (mm/Hg) (normal range 120/80 mm/Hg). *Temperature: 101.4 degrees F (normal is 98.6 degrees F). *Pulse: 116 beats per minute (bpm)(normal is 60-100). *Breathing rate: 29 respirations per minute (normal is 10-20 breaths per minute). *Oxygen level 93% with the use of 2 L oxygen administered continuously. *She was noted to have a loose productive cough with yellow phlegm and wheezing in her lungs. *No notification to her primary physician had been documented. *On 4/2/15 at 8:10 a.m., nursing documentation showed the resident had left facility per [name] transfer service per gurney for appointment in Sioux Falls and necessary paperwork included with transfer along with C-PAP machine. Resident scheduled for surgery at 2:15 p.m. today. "Per paperwork, Dr updated on elevated temperature, lung sounds, etc." <p>Review of the provider's 4/2/15 transfer paperwork to the hospital in Sioux Falls for surgery revealed the 4/2/15 7:30 a.m. abnormal vital signs noted above were written on the transfer sheet . That was the only documented</p>	F 309		

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 12</p> <p>communication to the receiving facility regarding the current health of the resident.</p> <p>Review of the receiving hospital's 4/2/15 emergency room history of present illness report revealed:</p> <p>*The resident arrived for surgery by the transfer service and was taken to the surgical center for preparation. Vital signs were taken. She was given 2 L oxygen by nasal canula (tubing into her nostrils) at that time. Staff noticed large amounts of phlegm. Her oxygen level decreased to 84-85% and oxygen had to be increased to 3 L per min.</p> <p>*The resident's heart rate became higher than normal, she began to sweat, her cough increased, and her temperature was noted to be 101.7 degrees F. She was then suctioned for airway support, switched to an oxygen mask and the level of oxygen was increased to 4 L per minute.</p> <p>*The surgeon was notified, surgery was canceled and she was sent to the emergency room for evaluation.</p> <p>*Evaluation in the emergency room revealed her diagnosis to be pneumonia and sepsis.</p> <p>Record review and interview on 3/2/16 at 9:30 a.m. with the director of nursing (DON) regarding resident 14 revealed:</p> <p>*None of the nursing staff who had documented the resident's above condition were available for interview at that time.</p> <p>*In reviewing the nurses notes documentation she agreed:</p> <p>-The resident showed no fever, shortness of breath, need for continuous oxygen, or cloudy urine upon admission to the facility as documented by nursing staff from 3/27/15 until</p>	F 309			

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401	
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F 309	Continued From page 13 3/30/15. -Nursing staff had not appropriately identified, intervened, or notified the primary care physician completely and in a timely manner for three days from 3/30/15 to 4/1/15. -The surgeon had not been notified of the resident's declining health status appropriately or in a timely manner. *Based on the last vital signs taken prior to departure from the facility and a shared review of the following 2012 Surviving Sepsis Campaign: International Guidelines for Surviving Sepsis and Septic Shock Diagnostic Criteria listed below she agreed the resident had displayed signs and symptoms of a probable sepsis condition prior to leaving the facility. *Per the above criteria a documented or suspected infection and some of the following may include: -Temperature of 100.9 degrees F or higher or less than 96.8 degrees F. -Pulse greater than 90 bpm. -Respiration rate over 20 per minute. -Cloudy urine. -Decreased oxygen levels. *Her expectation was nursing staff should have: -Called the primary care physician in a timely manner. -Included the details of fever and cloudy urine. -Requested the resident be evaluated. Review of the provider's January 2016 RN and LPN job description revealed the nurses' job duties included: *Identifying and reporting changes in resident's condition to the supervisor, physician, and family. *Evaluate the effectiveness of care interventions, identify problems and trends, and develop alternative interventions.	F 309		

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 14 Review of the provider's 2014 Care Path, a algorithm document nursing staff followed as professional standard guideline revealed: *An increase in temperature of two degrees over baseline would require physician notification. *A decreased oxygen level less than 90 would require physician notification. *Signs and symptoms of urine infection (cloudy urine) would require physician notification.	F 309			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2016
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/1/16. ManorCare Health Services (building 01) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Francis Mastel* TITLE *Administrator* (X6) DATE *03/17/16*

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/1/16. ManorCare Health Services (building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Francis Mastel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>03/17/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/02/2016
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 2/29/16 through 3/2/16. ManorCare Health Services was found in compliance.</p>	S 000		

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

Frances Mastel

STATE FORM

6889

TITLE

Administrator

(X6) DATE

03/17/16

If continuation sheet 1 of 1

