

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/06/2016
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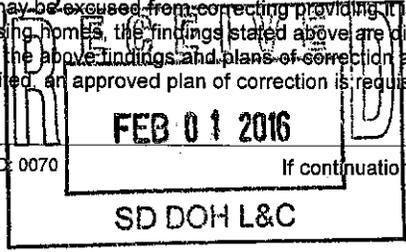
NAME OF PROVIDER OR SUPPLIER CUSTER REGIONAL SENIOR CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/4/16 through 1/6/16. Custer Regional Senior Care was found not in compliance with the following requirements: F274, F283, F334, F354, F371, and F441.</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/4/16 through 1/6/16. Areas surveyed included quality of resident care. Custer Regional Senior Care was found in compliance.</p>	F 000	<p>*Addendums noted with an asterisk per 2/16/16 per telephone with facility DON. MP/SDDOH/EL</p>	
F 274 SS=E	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572</p>	F 274		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wanda Glumett</i>	TITLE <i>President/Administrator</i>	(X6) DATE <i>1/28/16</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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F 274	<p>Continued From page 1</p> <p>Based on record review, policy review, and interview, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessments for 8 of 13 sampled residents (1, 3, 4, 5, 6, 7, 9, and 10). Findings include:</p> <p>1. Review of resident 4's medical record revealed MDS assessments had been completed on the following dates: *8/13/15, a quarterly assessment. *11/03/15, a quarterly assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following activities of daily living (ADLs; assistance with bed mobility, transfer, walking, locomotion, and eating) areas were coded as follows: *Bed mobility (movement in bed): -8/13/15 he needed limited assistance of one person. -11/03/15 he needed extensive assistance of one person. *Transfer (moves between surfaces): -8/13/15 he needed limited assistance of one person. -11/03/15 he needed extensive assistance of one person. *Walking: -8/13/15 he needed supervision with set-up help only. -11/03/15 he needed extensive assistance of one person. *Locomotion (ability to get around in facility): -8/13/15 he needed supervision with set-up help only. -11/03/15 he needed extensive assistance of one person. *Eating:</p>	F 274	<p>All current and future residents are potentially affected by significant changes.</p> <ol style="list-style-type: none"> 1) The resident Assessment Instrument Policy was updated by DON to include information regarding significant change and communication of IDT (interdisciplinary team- includes therapy, dietary, nursing, MDS Coordinator, Activities and Social Service Coordinator) 1/25/16 IDT team notification of new policy completed 1/26/16 2) A new policy regarding significant change notification by staff and residents to be completed by MDS Coordinator and DON by 2/1/16 3) Training and Education to be provided to IDT during consultant visit Feb 1-4, 2016 regarding MDS completion. 4) Documentation training for caregivers to be completed utilizing consultant agency set up for March 9 and 10, 2016 (earliest availability) at various times. 5) MDS Coordinator training by HcPro completed on 1/18-19 and 1/22/16 related to MDS completion. 6) Education will be provided to residents and families during care conferences- utilizing a newly 	

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F 274	<p>Continued From page 2</p> <p>-8/13/15 he needed supervision with set-up help only.</p> <p>-11/03/15 he needed limited assistance of one person.</p> <p>*Bowel continence (ability to hold stool until toileted).</p> <p>-8/13/15 he was always incontinent (not able to hold stool).</p> <p>-11/03/15 he was frequently incontinent.</p> <p>Those same assessments revealed coding of his behaviors had improved as follows:</p> <p>*Wandering (moving place to place without a plan):</p> <p>-8/13/15 behavior occurred daily.</p> <p>-11/03/15 behavior occurred one to three days a week.</p> <p>2. Review of resident 5's medical record revealed MDS assessments had been completed on the following dates:</p> <p>*7/15/15, a significant change in condition assessment.</p> <p>*11/13/15, a quarterly assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following changes in behavior frequency coding:</p> <p>*Little interest or pleasure in doing things:</p> <p>-7/15/15 never occurred or once.</p> <p>-11/13/15 occurred nearly every day.</p> <p>*Feeling tired or staying asleep or sleeping too much:</p> <p>-7/15/15 occurred nearly every day.</p> <p>-11/13/15 occurred several days (two to six days).</p> <p>*Poor appetite or overeating:</p> <p>-7/15/15 never occurred.</p> <p>-11/13/15 occurred half or more days (seven to eleven days).</p>	F 274	<p>developed sign in sheet- regarding notification of status changes to staff. Ongoing</p> <p>7) Education to caregivers regarding notification and documentation of status changes to be completed before 2/15/16 by DON or designee. Staff absent during this time will be educated when available for next shift.</p> <p>8) 24 hour report updated to include ADL changes and behaviors to assist in alerting staff of possible significant changes in resident status to be reviewed at stand up daily starting 2/1/16.</p> <p>9) All resident's identified in annual survey (1, 3, 4, 5, 6, 9 and 10) will be monitored x14 days to determine need for significant change in status. Appropriate steps in changes to care will be completed if indicated after monitoring complete.</p> <p>10) Resident #7 also identified had her MDS opened, completed and transmitted timely but she no longer resides in the facility.</p> <p>11) Audits to be completed on 15% of total census monthly x3 months then quarterly x 3 quarters- regarding behaviors and ADL's by DON or designee.</p>	

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F 274	<p>Continued From page 3</p> <p>*Moving or speaking so slowly that people could have noticed, or being so fidgety or restless causing moving around a lot more than usual: -7/15/15 occurred nearly every day. -11/13/15 never occurred or once.</p> <p>Those same assessments revealed coding of her ADL areas were coded as follows: *Bed mobility: -7/15/15 she needed extensive assistance of two or more persons. -11/13/15 she needed extensive assistance of one person. *Walking: -7/15/15 she needed extensive assistance of two or more persons. -11/13/15 she needed limited assistance of one person. *Locomotion: -7/15/15 she needed supervision with set-up assistance. -11/13/15 she needed extensive assistance of two or more persons.</p> <p>Those same assessments revealed coding of her urinary continence (ability to hold urine without leaking) as follows: -7/15/15 she had been occasionally incontinent. -11/13/15 she had been always incontinent.</p> <p>3. Review of resident 6's medical record revealed MDS assessments had been completed on the following dates: *9/10/15, an admission assessment. *11/08/15, a quarterly assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following ADL areas were coded as follows:</p>	F 274	<p>12) Findings will be reported to QAPI monthly meeting by DON or Designee x 12 months</p> <p>***QAPI is the quality assurance process improvement committee that meets once monthly to discuss findings and interventions for improvement of resident care. QAPI team involves the Medical Director quarterly to assist with any changes in programs if needed. ***</p>	2/25/16

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F 274	<p>Continued From page 4</p> <p>*Transfer: -9/10/15 he needed limited assistance of one person. -11/03/15 he needed limited assistance of two or more persons.</p> <p>*Walking: -9/10/15 he needed limited assistance of one person. -11/03/15 he needed limited assistance of two or more persons.</p> <p>*Locomotion on the unit: -9/10/15 he needed limited assistance of one person. -11/03/15 he needed supervision with set-up assistance.</p> <p>*Locomotion off the unit: -9/10/15 he needed limited assistance of one person. -11/03/15 he needed extensive assistance of two or more persons.</p> <p>*Toilet use: -9/10/15 he needed extensive assistance of one person. -11/03/15 he needed extensive assistance of two or more persons.</p> <p>Review of the above assessments revealed the following: *Wandering (moving place to place without a plan): -9/10/15 that behavior occurred daily. -11/03/15 that behavior occurred one to three days a week.</p> <p>*Change in behavior or other symptoms: -9/10/15 had been coded not applicable. -11/03/15 had been coded improved.</p> <p>4. Interview on 1/6/16 at 11:12 a.m. with the MDS coordinator confirmed:</p>	F 274			

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F 274	<p>Continued From page 5</p> <p>*She used the 2015 RAI manual as a reference. *A significant change in condition MDS should have been completed for residents 4, 5, and 6.</p> <p>Surveyor: 26632</p> <p>5. Review of resident 1's medical record revealed MDS assessments had been completed on the following dates: *7/29/15, an annual assessment. *10/28/15, a quarterly assessment.</p> <p>Review of the above MDS assessments for the resident revealed coding of her Brief Interview for Mental Status (BIMS) had declined as follows: *On 7/29/15 it was a score of eleven that indicated moderate impairment of decision making skills. *On 10/28/15 it was a score of six that indicated severe impairment of decision making skills.</p> <p>Those same assessments indicated an improvement of her depression score as follows: *On 7/29/15 it was a score of twelve that indicated moderate depression. *On 10/28/15 it was a score of four which indicated minimal depression.</p> <p>6. Review of resident 10's medical record revealed MDS assessments had been completed on the following dates: *9/9/15, a quarterly assessment. *12/8/15, an annual assessment.</p> <p>Review of the above MDS assessments for the resident revealed coding indicated a decline of her depression score as follows: *On 9/9/15 it was a score of three that indicated minimal depression. *On 12/8/15 it was a score of five that indicated</p>	F 274		

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F 274	<p>Continued From page 6 mild depression.</p> <p>Review of the above MDS assessments for the resident revealed the following ADL areas were coded as follows: *Locomotion: -9/9/15 she needed limited assistance of one person. -12/8/15 she needed extensive assistance of one person. *Bathing: -9/9/15 she needed extensive assistance of one person. -12/8/15 she needed total assistance of one person.</p> <p>Surveyor: 32573 7. Review of resident 3's medical record revealed MDS assessments had been completed on the following dates: *8/10/15, a quarterly assessment. *11/10/15, an annual assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following assessment areas were coded as follows: *Daily decisions: -Independent on 8/10/15. -Moderately impaired on 11/10/15. *Urinary continence: -Always continent on 8/10/15. -Frequently incontinent on 11/10/15.</p> <p>9. Review of resident 7's medical record revealed: *Her most recent MDS assessment had been completed on 12/14/15. *She started to receive hospice care on 12/23/15. *There had not been an MDS assessment</p>	F 274			

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F 274	<p>Continued From page 7</p> <p>initiated since she had been receiving hospice care.</p> <p>-A significant change MDS assessment should have been initiated within fourteen days of her entering hospice care.</p> <p>10. Review of resident 9's medical record revealed MDS assessments had been completed on the following dates: *An annual assessment on 9/16/15. *A quarterly assessment on 12/15/15.</p> <p>Review of the above MDS assessments for the resident revealed the following activities of daily living (ADL; assistance with eating and bathing) areas were coded as follows: *Eating: -Limited assistance on 9/16/15. -Extensive assistance on 12/15/15. *Bathing: -One person assistance on 9/16/15. -Two or more person assistance on 12/15/15.</p> <p>Interview on 1/6/16 at 11:12 a.m. with the MDS coordinator confirmed: *She used the 2015 RAI manual as a reference. *An MDS assessment should have been started for resident 7 when she went on hospice care. *A significant change in condition MDS should have been completed for residents 3 and 9.</p> <p>Surveyor: 32572</p> <p>11. Review of the provider's 9/17/15 Resident Assessment Instrument (RAI) policy revealed "The Interdisciplinary Assessment Team (IDT) will utilize the current RAI manual for reference.</p> <p>Review of the 2015 RAI manual online revealed: "A 'significant change' is a decline or</p>	F 274		

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F 274	Continued From page 8 improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan."	F 274			
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, policy review, and interview, the provider failed to ensure: *One of one discharged resident (15) had a summary of her stay. *One of one discharged resident (15) had a completed transfer form for going to another facility. Findings include: 1. Review of resident 15's closed record revealed: *A 12/15/15 physician's order indicated it was alright for her to discharge to another nursing facility out of state.	F 283			

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F 283	Continued From page 9 *No summary of her stay had been located in the closed record. *No transfer form had been located in the closed record. *There was no documentation to have indicated when she had been discharged. Review of the provider's undated Discharge policy did not state was expected for the nursing documentation. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 477, revealed "Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice." Interview on 1/6/16 at 1:30 p.m. with the director of nursing revealed her expectation had been the medical record should have included: *A summary of her stay in the facility. *A copy of the transfer form that had been sent to the facility where she transferred to. *Documentation in the interdisciplinary notes at the time of her discharge.	F 283	All current and future residents are potentially affected by the discharge process. 1) The facility discharge policy was updated to include nursing responsibility upon a resident's discharge. 2) Nursing staff responsible for discharges will be educated regarding processes and documentation by 2/15/16. Staff absent during this time will be educated when available for next shift. 3) Resident #15 chart will not be updated d/t no longer in the facility 4) Audits of 100% of Discharge resident's charts will be completed by the DON or designee monthly x6 months 5) Findings will be reported to QAPI committee monthly by DON or designee x 6 meetings.	2/25/16	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334			

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F 334	<p>Continued From page 10</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal</p>	F 334			

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NAME OF PROVIDER OR SUPPLIER CUSTER REGIONAL SENIOR CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730
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F 334	<p>Continued From page 11</p> <p>representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure 2 of 13 sampled residents (2 and 8) had been offered or had received the pneumococcal (pneumonia) vaccination upon admission to the facility. Findings include: Surveyor: 29162 1a. Review of resident 2's medical record revealed he had: *An admission date of 1/3/15. *A 1/13/15 vaccine consent form signed by the resident's representative. -That consent form had a check mark beside the statement "I do want the pneumococcal pneumonia vaccine." *A 10/14/15 vaccine consent form signed by the health unit coordinator and a staff licensed practical nurse stating telephone authorization</p>	F 334	<p>All current and future residents are affected by vaccinations.</p> <ol style="list-style-type: none"> 1) All charts of current residents have been audited by Quality Specialist to identify pneumococcal vaccination status. 1/22/16 2) Outreach to clinics and primary providers requesting information not found in charts for possible past vaccinations initiated by Quality Specialist 1/22/16. 3) Immunization policy reviewed by Quality Specialist and DON for current data- no revisions noted at this time. 1/22/16 4) Education to nursing staff including responsibility of immunizations and documentation and follow through to be completed by DON or designee by 2/15/16. Staff absent during this time will be educated when available for next shift. 5) Current residents who have not been vaccinated or don't have information regarding vaccinations of Pneumonia vaccine will be re-consented and immunizations to be done by 2/25/16 6) Resident #2- chart was audited; no record found of vaccination, clinic outreach revealed need for 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2016
FORM APPROVED
OMB NO. 0938-0391

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F 334	<p>Continued From page 12</p> <p>from resident 2's representative had been received for a pneumococcal pneumonia vaccine. *A 12/1/15 signed physician's order for "Pneumococcal immunization 0.5 milliliters (ml) subcutaneous (SC) or intramuscularly (IM) with permission of resident or surrogate. (If not previously given)." -That consent form had a check mark beside the statement "I do want the pneumococcal pneumonia vaccine." *No documentation was found to support he had received or declined a pneumococcal vaccination from the provider after he had been admitted.</p> <p>b. Review of resident 8's medical record revealed she had: *An admission date of 8/12/13. *A 12/5/15 signed physician's orders sheet stating "Pneumococcal immunization 0.5 milliliters (ml) subcutaneous (SC) or intramuscularly (IM) with permission of resident or surrogate. (If not previously given)." *No documentation was found to support she had received or declined a pneumococcal vaccination from the provider after she had been admitted.</p> <p>Review of the provider's reviewed 3/16/15 Pneumococcal Vaccine policy revealed: **"Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine, and when indicated, will be offered the vaccination within thirty days of admission to the facility unless medically contraindicated or the resident has already been immunized." **"Pneumococcal vaccinations will be administered to residents per our facility's physician-approved pneumococcal vaccination protocol."</p>	F 334	<p>vaccination, POA notified, consent re-obtained and vaccine given 1/22/16.</p> <p>7) Resident #8- chart was audited; no record found of vaccination, POA notified, consent re-obtained and vaccine given 1/22/16.</p> <p>8) Audits to be completed by Quality Specialist for immunization, completion, and documentation on new 10% new residents monthly x6 months.</p> <p>9) Findings to be reported to QAPI committee monthly by Quality Specialist x 6 meetings.</p>	2/25/16	

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

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F 334	Continued From page 13	F 334		
F 354 SS=D	<p>Interview on 1/6/16 at 9:15 a.m. with the director of nursing (DON) revealed she confirmed the above residents had no documentation of receiving or declined a pneumococcal vaccination upon admission.</p> <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on schedule review, interview, and policy review, the provider failed to ensure the director of nurses (DON) did not serve as a charge nurse at the provider's facility that had a census greater than sixty residents. Findings include:</p> <p>1. Review of the licensed nurses schedule revealed the DON had been scheduled as charge nurse on the following shifts: *12/4/15 for one-half of the evening shift and the entire night shift.</p>	F 354	<p>All current and future residents are potentially affected by staffing.</p> <p>Staffing needs and levels will be monitored by Director of Nursing to assure adequate staffing is achieved for all shifts.</p> <p>Quality Specialist RN will audit and report to QAPI any deviation from policy 6154-136 "Staff Planning Nurse" monthly x 12 months or longer if determined by QAPI the reporting period should be extended.</p> <p><i>*The Staff Planning nurse policy says the director of nursing may not serve as charge nurse at any time in a facility with an average daily occupancy of sixty or more residents. MP/SD/DH/EL</i></p>	2/25/16

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

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F 354	Continued From page 14 *12/28/15 on the day shift. *12/29/15 on the day shift. *12/30/15 on the evening shift. Interview on 1/6/16 at 9:30 a.m. with the DON revealed she: *Had worked as the charge nurse recently. *Believed it had been an expectation of management that she covered licensed nursing shifts as charge nurse. Review of the provider's undated director of nurses (DON) policy numbered 3154-104 revealed the DON was employed full-time and worked on the day shift. Review of the provider's staff planning nurse policy numbered 3154-136 revealed the DON was not to serve as charge nurse at any time in a facility that had an average daily census of sixty or more residents.	F 354			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 26632	F 371			

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

PRINTED: 01/14/2016
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F 371	<p>Continued From page 15</p> <p>Based on observation, interview, and policy review, the provider failed to:</p> <p>*Follow appropriate technique while checking the food temperatures by one of one observed cook (A).</p> <p>*Follow appropriate handwashing and glove use for one of one cook (B) in the kitchen during one of one observed meal.</p> <p>Findings include:</p> <p>1. Observation on 1/4/16 from 4:25 p.m. through 5:00 p.m. revealed cook A took the temperatures of the ham, pork and beans, zucchini, ground ham, pureed ham, pureed chicken and noodles. He poked the food thermometer through the foil covering each container of the above foods.</p> <p>Review of the provider's revised April 2009 Food Temperatures policy revealed no procedure in how to properly take food temperatures.</p> <p>2. Observation on 1/5/16 11:00 a.m. through 12:15 p.m. revealed cook B:</p> <p>*Washed his hands and put on gloves.</p> <p>*He then:</p> <ul style="list-style-type: none"> -Brought the cart of plate warmers and covers to the serving line. -Brought the plate warmer cart to the serving line and plugged it in. -Dished food up on plates. -Retrieved food items from other parts of the kitchen while dishing up food. -Changed gloves two times without washing his hands. <p>Review of the provider's revised April 2009 Handwashing policy revealed hands would have been washed before and after using gloves.</p>	F 371	<p>All current residents are potentially affected with food preparation and storage.</p> <ol style="list-style-type: none"> 1) Policies updated regarding testing of food temperature and dietary glove use completed by Dietician and Dietary Manager (Ops manager of Food and Nutrition services) 1/22/16 2) Policy review completed by Dietician and Manager regarding food preparation without revision 1/22/16. 3) Education to dietary personnel regarding food preparation/ monitoring of food temperatures and hand washing/ glove use to be completed by Dietician, Quality Specialist or Dietary manager by 2/1/16. Staff absent during this time will be educated when available for next shift. 4) Audits by Dietary Manager, QS or designee to include hand washing 2-3 staff weekly x4 then 10% dietary personnel monthly x 6months. 5) Audits of staff taking temperatures at meal times by Dietary Manager or designee 3 times daily at meals x one week then 2 times per week x3 weeks then weekly x3 months. 	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 16 3. Interview on 1/5/15 at 4:00 p.m. with the dietary manager revealed: *He was unsure why cook A had taken food temperatures through the foil. He had given education on the proper way to take food temperatures. *He agreed cook B had not used gloves in an appropriate manner while serving food and had not washed his hands between glove changes.	F 371	6) Findings to be reported to QAPI committee monthly by Dietary director or designee x 6 months.	2/25/16
F 441 SS=C	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 17</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to maintain the eight of eight computer kiosks (electronic documentation stations on the walls) in a clean and sanitary manner. Findings include:</p> <p>1. Random observations from 1/4/16 through 1/6/16 revealed two of two kiosk work stations in the secured unit had a film on the screen, and it had a rough texture.</p> <p>Interview on 1/5/16 at 10:40 a.m. with the housekeeping supervisor confirmed there was no routine cleaning schedule for the kiosks for the housekeeping staff.</p> <p>Surveyor: 32573 2. Observation throughout the survey from 1/4/16 through 1/6/16 revealed all the kiosks used for resident charting had been dusty and smudged. Staff used their fingers and touch pens to enter resident information on those kiosks.</p> <p>Interview on 1/6/16 at 8:30 a.m. with the director of nursing revealed nurse aides should have</p>	F 441	<p>No residents are affected by staff using kiosks. Current and future staff is affected by kiosk use for documentation.</p> <ol style="list-style-type: none"> 1) Equipment policy updated regarding cleaning schedule of kiosks. 2) Current kiosks have been placed on a cleaning schedule by environmental service staff. 3) Education on new policy overview at all staff meeting 1/26/16 then with future staff during onboarding process by supervisors. Staff absent during this time will be educated when available for next shift. Ongoing 4) Audits by Environmental service or designee of hand washing before and after use of kiosk will be 5-10 staff weekly alternating shifts x 1 week then 10% staff weekly x4 weeks, then 10% staff monthly x 6 months. 5) Audits of kiosk cleanliness by environmental services or designee will include 3 to 5 kiosk weekly x 4 weeks then 3 to 5 kiosk monthly x 6 months. 6) Findings to be reported to QAPI monthly by Environmental Service staff or designee x 6 months. 	2/25/16

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

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F 441	Continued From page 18 been cleaning the kiosks after each use. Interview on 1/6/16 at 9:40 a.m. with certified nursing assistant C revealed she had been unaware of who was responsible for cleaning the kiosks. She thought it might be housekeeping or maintenance. Review of the 9/10/15 equipment policy revealed "All equipment used in resident care must be cleaned with appropriate cleaner between resident. This includes but is not limited to lifts, electric vital towers, stethoscopes, kiosks for documentation etc."	F 441			

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

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FORM APPROVED
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/12/16. Custer Regional Senior Care was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K038, K062, K076, and K143 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation, testing, and interview, the provider failed to ensure three randomly observed marked exits were readily accessible at all times (main exit, core area/400 wing exit, and the exit behind the kitchen). Findings include: 1. Observation at 8:15 a.m. on 1/12/16 revealed the main entrance/exit door was equipped with a magnetic lock. *Testing of the magnetically locked door by pressing against the panic bar would not initiate a	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Wm... [Signature]* TITLE *President/Administrator* (X6) DATE *1/28/16*

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

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K 038	<p>Continued From page 1</p> <p>delayed egress unlocking sequence. A second test by the plant operations supervisor initiated the delayed egress unlocking sequence. He stated the magnetic locks had recently been serviced by the contractor.</p> <p>*The sign stating the door was magnetically locked and how to egress was mounted on the wall to the left of the door, approximately five feet away. It was not in a conspicuous location.</p> <p>*Interview with the plant operations supervisor at the time of the observation and testing confirmed those conditions. He stated he was unaware the sign location was not correct.</p> <p>2. Observation at 8:45 a.m. on 1/12/16 revealed the exit door between the core area and the 400 wing was a magnetically locked door.</p> <p>*Testing of the magnetically locked door at the time of the observation revealed it functioned as a delayed egress type lock. The sign stating how to egress with the delayed egress function was mounted on the wall to the right of the door, approximately five feet away. It was not in a conspicuous location.</p> <p>*Interview with the plant operations supervisor at the time of the observation and testing confirmed those conditions. He stated he was unaware the sign location was not correct.</p> <p>3. Observation at 9:35 a.m. on 1/12/16 revealed the exit door behind the kitchen in the service wing was equipped with a magnetic lock.</p> <p>*There was not a sign stating how to egress the magnetically locked door using the delayed egress function.</p> <p>* Testing of the magnetically locked door by pressing against the panic bar would not initiate a delayed egress unlocking sequence.</p> <p>*Interview with the maintenance supervisor at the</p>	K 038	<p>A1. The door identified has been serviced by a contractor and is functioning properly. A duplicate egress sign has been ordered and will be placed directly on the door immediately upon receipt. The PM for the exit doors will have a sign check added to it for monthly inspection. The doors will be checked by the Plant Operations staff on a monthly basis for proper function and for the sign to be in place on the door at all times. The Plant Operations Supervisor will review the door PM's on a monthly basis and report any and all findings to the QAPI meetings every month.</p> <p>A2. The door identified will have a sign for delayed egress instructions installed on the center of the door by the Plant Operations staff. This door will be added to the door PM and will be checked on a monthly basis by the Plant Operations staff for proper function and to make sure the delayed egress sign is in place. The Plant Operations Supervisor will review the door PM on a monthly basis and report any and all findings to the QAPI meetings every month x 6 months.</p> <p>A3. The door identified has been repaired by a contractor and will have a delayed egress sign installed in the</p>	

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K 038	<p>Continued From page 2</p> <p>time of the observation revealed that lock was not a delayed egress style lock.</p> <p>The deficiency had the capability to affect 100% of the building occupants.</p> <p>B. Based on observation, testing, and interview, the provider failed to ensure marked paths of egress (with lit exit signs) were functional and correct for one randomly observed marked exit location (core area through the 300 wing/secured wing). Findings include:</p> <p>1. Observation at 10:10 a.m. on 1/12/16 revealed the cross-corridor doors from the core area at the nurses' station to the 300 wing were marked with a lit exit sign. Testing of the magnetically locked door revealed it did not function as a delayed egress type lock. Interview with the plant operations supervisor revealed the 300 wing was a secure (locked) wing. As such, marking the door as an EXIT would not ensure the door was available for egress under all emergency conditions.</p> <p>The EXIT sign would need to be removed from that location and the building evaluated for egress requirements and marking of exits in accordance with the emergency policy and procedures for evacuation routes. Interview with the plant operations supervisor at the time of the observation confirmed that finding.</p> <p>The deficiency had the capability to affect 100% of the building occupants.</p>	K 038	<p>center of the door.</p> <p>This door will be added to the door PM and will be checked on a monthly basis by the Plant Operations staff for proper function and to make sure the delayed egress sign is in place. The Plant Operations Supervisor will review the door PM on a monthly basis and report any and all findings to the QAPI meetings every month x 6 meetings.</p> <p>B1. The exit sign identified will be removed.</p> <p>After evaluating the egress requirements it is determined that an exit sign will be placed in the center of hall three at the intersection where hall three exits the facility to the outside. The sign will have an arrow pointed to the door exiting the building to the outside.</p> <p>The exit signs in the facility are all on a daily PM to insure that all signs are lit at all times. This new sign will be added to this PM. The daily PM's are conducted by the Plant Operations staff.</p>	2/25/16
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are</p>	K 062		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435032	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2016
NAME OF PROVIDER OR SUPPLIER CUSTER REGIONAL SENIOR CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY ST CUSTER, SD 57730	
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K 062	<p>Continued From page 3</p> <p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, measurement, and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector so the water discharge was not interrupted in one randomly observed location (storage room next to the maintenance office). Two randomly observed sprinklers in the reception room were found obstructed. (See attached Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge.) Findings Include:</p> <p>1. Observation at 9:30 a.m. on 1/12/16 revealed sprinklers were obstructed by boxes kept on top of rolling files in the storage room adjacent to the maintenance office. Interview with the plant operations supervisor at the time of the observation revealed he was not aware of the obstructed sprinklers.</p> <p>2. Observation at 9:45 a.m. on 1/12/16 revealed the sprinkler in the oxygen transfilling room was obstructed by items stored on the top shelf. Interview with the plant operations supervisor at the time of the observation revealed he was not aware of the obstructed sprinkler.</p> <p>This deficiency affected one of several components for maintaining automatic fire sprinkler systems.</p>	K 062	<p>1. The obstruction identified has been corrected. The items on top of the rolling cabinets have been removed by Plant Operations staff. A monthly PM will be generated to make sure the cabinets stay clear of such obstructions. Plant Operations staff will inspect the cabinets for obstructions on a monthly basis x 6 months. The Plant Operations Supervisor will review this PM and report any and all findings at the monthly QAPI meetings x 6 meetings.</p> <p>2. The deficiency identified will be corrected by removing the shelving and replacing the shelving with non-combustible metal shelving at a lower height. This will be added to the monthly PM generated for items within the 18 inch rule for the above deficiency. Plant Operations staff will inspect the O2 room for any items obstructing the sprinkler head. The Plant Operations Supervisor will review this PM and report any and all findings at the monthly QAPI meetings x 6 meetings.</p>	2/25/16

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K 076 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain storage requirements for oxygen storage over 3000 cubic feet capacity for two of two oxygen storage locations (liquid oxygen transfilling room and compressed gas oxygen bottle storage room). The provider must comply with the National Fire Protection Association (NFPA 99), Standard for Health Care Facilities, section 8-3.1.11 Storage Requirements. (See attachment.) Findings include:</p> <p>1. Observation at 9:00 a.m. on 1/12/16 revealed the liquid oxygen transfilling room was approximately six feet wide by six feet deep and contained five liquid oxygen dewars for transfilling small personal use containers. The wall on the left side of the room had shelves with numerous amounts of plastic bags filled with soft plastic personal care items (combustible items) for oxygen breathing equipment use. Those items</p>	K 076	<p>1. The deficiency identified will be corrected by taking down the shelving and adding a non-combustible shelf. All of the combustible items have been removed and only non-combustible items will be kept in the O2 room. A monthly PM will be generated to ensure that only non-combustible items are kept in the O2 room. Plant Operations staff will inspect the O2 room on a monthly basis x6 months. The Plant Operations Supervisor will review the monthly PM and report any and all findings at the monthly QAPI meetings x6 meetings.</p> <p>2. The deficiency identified will be corrected by installing a one hour fire rated door with an automatic door closer. This door will be added to the monthly door PM that is in use now to make sure the door closer is operating correctly. The PM will be reviewed on a monthly basis by the Plant Operations Supervisor and will report any and all findings to the monthly QAPI meetings x 6 meetings.</p>	2/2516

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K 076	Continued From page 5 were within five feet of the liquid oxygen dewars. It was not determined if the light switch and electrical receptacles in the room were at least sixty inches above the floor. 2. Observation at 10:25 a.m. on 1/12/16 revealed eight racks holding approximately two hundred e size oxygen compressed gas cylinders were kept in storage in a room in the 100 wing. The quantity of oxygen e cylinders surpassed the 3000 cubic feet of storage capacity which then would require the storage room to be one hour fire-rated. *The corridor door was a solid bonded wood core door that did not have a one hour fire-rated label affixed to it. *The corridor door was not equipped with a door closer.	K 076		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas	K 143		

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K 143	<p>Continued From page 6 Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the oxygen transfilling room in accordance with National Fire Protection Association (NFPA) 99, Standard for Health Care Facilities, section 8-6.2.5 Gases in Cylinders and Liquefied Gases in Containers (See attachment). Findings include:</p> <p>1. Observation at 9:15 a.m. on 1/12/16 revealed signs stating transfilling was occurring were not evident at the liquid oxygen transfilling room.</p> <p>Interview at 9:25 a.m. on 1/12/16 with the plant operations supervisor revealed the certified nursing assistant would sometimes hold the corridor door open (with her foot) while transfilling. That way she could hear alarms or resident call signals.</p> <p>Interview with the plant operations supervisor at the time of the above observations confirmed those findings.</p>	K 143	<p>All current and future residents and staff are potentially affected by oxygen safety.</p> <ol style="list-style-type: none"> 1.)The oxygen safety and storage police was updated by DON and Administrator. 1/26/16 2.)At the time of the inspection the surveyor explained to the staff member the need to keep the door closed. She no longer works at this facility. 3.)A sign will be placed on the oxygen storage/trans filling room when available to show evidence that Trans filling is occurring by maintenance. 4.)Education at all staff meeting provided to caregivers and staff regarding oxygen safety policy changes and need to keep the door closed during trans filling of oxygen.1/26/16 5.)Education to new staff regarding oxygen safety to be done by supervisors during on-boarding processes continuously. 6.)Audit by DON or designee for safety precautions during oxygen trans-filling of 3-5 staff daily x1 week then weekly x4 weeks then 10% staff monthly x 6 months. 7.)Findings to be reported to QAPI meeting monthly x 6 meetings. 	2/25/16

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER CUSTER REGIONAL SENIOR CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1065 MONTGOMERY CUSTER, SD 57730
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S 000	Compliance/Noncompliance Statement Surveyor: 29162 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 1/4/16 through 1/6/16 and on 1/12/16. Custer Regional Senior Care was found not in compliance with the following requirement: S253.	S 000	* Addendums noted with an asterisk per 2/16/16 per telephone with facility DON. MP/SDDOHT/EL	
S 253	44:73:04:14 Memory Care Units Each facility with memory care units shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming shall be provided and shall be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity shall be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement shall be communicated to the resident's family; (5) Locked doors shall conform to Sections: 18.2.2.2 and 19.2.2.2 of NFPA 101 Life Safety Code, 2012 edition; and (6) Staff assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver shall be on duty on the memory care unit at all times.	S 253		

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

TITLE

(X6) DATE

Harvey Smith, President/Administrator

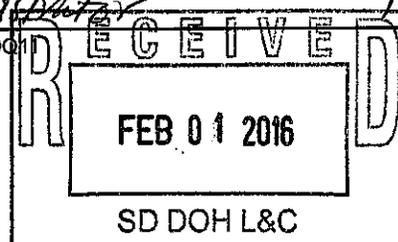
1/28/16

STATE FORM

6899

TK901

continuation sheet 1 of 3



South Dakota Department of Health

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S 253	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32572 Based on observation, record review, interview, and policy review, the provider failed to obtain physicians' orders for three of three sampled residents (4, 5, and 6) residing in the secured unit. Findings include:</p> <p>1. Random observations from 1/4/16 through 1/6/16 revealed residents 4, 5, and 6 resided in the secured unit of the facility.</p> <p>Review of resident 4's medical record revealed on 12/29/15 a signed physician's orders with no mention of the need to reside in the secured unit.</p> <p>Review of resident 5's medical record revealed on 12/15/15 a signed physician's orders with no mention of the need to reside in the secured unit.</p> <p>Review of resident 6's medical record revealed on 11/24/15 a signed physician's orders with no mention of the need to reside in the secured unit.</p> <p>Review of the provider's 12/1/15 Admission/Discharge from Secure Unit policy revealed "There must be an order specifically directed toward care on the secure unit."</p> <p>Review of the provider's undated Physician Services policy revealed: **"Each resident shall be under the care of a licensed physician." **"Advice about and treatment related to the appropriate level of care needed for each resident."</p> <p>Interview on 1/6/16 at 9:15 a.m. with the director of nursing confirmed there should have been a</p>	S 253	<p>All current residents and future residents are potentially affected by admission/ discharge to secure unit.</p> <ol style="list-style-type: none"> 1) Admission/Discharge policy reviewed and updated by SS and DON 1/22/16. 2) Current residents residing on secure unit chart audited for orders for admission to the unit and working with providers to receive orders. 3) Education to nursing staff regarding need for orders to reside on the secure unit to be completed by 2/15/16 Staff absent during this time will be educated when available for next shift. 4) Resident #4- staff working on orders to discharge from the secure unit because he no longer meets the criteria. 5) Resident # 5- Working with MD to receive orders regarding need for secure unit. 6) Resident #6- chart not addressed as he no longer resides in the facility. 7) Audits to be done by DON or designee on 100% of residents residing on the secure unit and new residents placed on the secure unit monthly x 6 months. 8) Findings to be reported to QAPI team meeting monthly x 6 months. <p><i>*The findings will be reported by the DON or Designee. MR/S DOOTHEL</i></p>	2/25/16
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South Dakota Department of Health

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S 253	Continued From page 2 physician's order to admit to the secured unit and to remain in that unit.	S 253		