

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/13/2016
NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747	
(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 000	INITIAL COMMENTS Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/11/16 through 4/13/16. Seven Sisters Living Center was found not in compliance with the following requirements: F151, F176, F223, F241, F309, F332, F371, and F425.	F 000	*Addendums noted with an asterisk per telephone per 5/26/16 with facility administrator and DON. MP/SDDOH/EL	
F 151 SS=D	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and admission packet review, the provider failed to ensure one of ten resident's (7) rights had been maintained regarding: *Personal choice for alcohol consumption. *Personal privacy - staff had not gotten	F 151	1. On 5-3-16 a meeting was held with the Medical Director regarding resident rights and personal choice on alcohol consumption. On 5-3-16 Resident #7 was interviewed for personal choice in alcohol consumption. In the future Resident #7 will be informed of any need for room searches and Resident will choose if he wants to be present. 2. All residents are at potential risk. 3. The admission agreement was updated for clarification to include any areas of potential misunderstanding with development of a policy regarding "items brought in from the outside". By 5-12-16 all staff will	

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

John Miller

TITLE

Administrator

(X6) DATE

5/5/16

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 151	<p>Continued From page 1 permission before going through personal items. Findings include:</p> <p>1. Review of resident 7's medical record revealed: *He had been admitted on 8/3/15. *One of his diagnoses was alcohol dependence. *His Brief Interview for Mental Status (BIMS) test score was fifteen indicating he was mentally intact.</p> <p>Review of resident 7's 4/11/16 care plan revealed: *A focus area of "[name] has the potential for a psychosocial well-being problem related to current health condition and history of alcohol abuse." *An intervention of "resident needs to have an escort when leaving related to history of alcohol abuse and recently purchasing alcohol while out of facility."</p> <p>Review of resident 7's following nursing progress notes revealed: *2/19/16, behavior note, The resident had returned from a trip on the transport van and had ten shopping bags. -There had been "9 empty wine bottles and 3 schnapps bottles found in the bags." -"When the resident came back, his face was flushed." -The nurse had informed the resident that alcohol was not permitted at the facility. -A physician's order for a breathalyzer test had been obtained, but the resident "would not blow hard enough for it to register." *4/1/16, The resident had returned from shopping, and the nurse had examined his shopping bags for alcohol. -She had not found any.</p>	F 151	<p>be re-educated on Resident's Rights to include personal privacy, the updated Admission Agreement, and the "items brought in from the outside" policy. A meeting was held on 5-3-16 to revise the Physician Protocols to address alcohol intake for facility events. Staff will be educated by 5-12-16 on the revision and the new policy includes that no alcohol will be stored in the resident's room. All staff will be in-serviced by 5-12-16 to include referring individual requests for alcohol to the physician to obtain a physician's order. The revised Admission Agreement will be reviewed with the residents at the next resident's council meeting on May 10, 2016 and again on May 25, 2016. The interdisciplinary team will review the revised Admission Agreement to include alcohol preference with each Resident/families at their care conferences.</p> <p>4. Social Worker or designee will complete audit for Residents 7, 10, 12 and 15 and one Random resident weekly x 4, monthly x 3 and quarterly x 3. Social Worker or designee will report results of audits to QAPI monthly.</p>	6-2-16

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F 151	<p>Continued From page 2</p> <p>*4/1/16, Staff had found an empty bottle of liquor in his room.</p> <p>*4/2/16, Aides had found an empty and a full bottle of alcohol in a box with a coat over it in his room.</p> <p>-Resident 7 had asked the nurse why "they" had been in his room.</p> <p>*4/6/16, The resident had periods of being "very non compliant with policies regarding alcohol."</p> <p>Interview on 4/13/16 at 8:15 a.m. and at 11:10 a.m. with resident 7 revealed:</p> <p>*He enjoyed a glass of wine before bed and did not see what was wrong with that.</p> <p>*Someone (not nursing home staff) had tried to give him a breathalyzer test in the dining room in front of everyone.</p> <p>-It had not worked or given a reading.</p> <p>-He had been very embarrassed to take it "in front of everyone."</p> <p>-He had felt "like a [swear word] criminal."</p> <p>*He did not drink when he left the facility.</p> <p>*He had kept alcohol in his room in the past, wine or Southern Comfort whiskey.</p> <p>*He had gone back to his room after it had been "ransacked" by staff several times.</p> <p>-He was not happy about staff going through his personal belongings without asking.</p> <p>Interview on 4/13/16 at 9:50 a.m. with the director of nursing (DON) revealed resident 7 had a history of alcohol abuse.</p> <p>Interview on 4/13/16 at 3:30 p.m. with the DON and the chief operating officer (COO) revealed:</p> <p>*In regards to resident 7's alcohol use the DON had stated "That is why he is in here in the first place. They kicked him out of his apartment."</p> <p>*Residents could have alcohol if they had a</p>	F 151		

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F 151	<p>Continued From page 3</p> <p>physician's order.</p> <p>*There had been no physician's order for resident 7 stating he could or could not have alcohol.</p> <p>*Residents were not allowed to keep alcohol in their rooms, but if a resident wanted to drink alcohol:</p> <ul style="list-style-type: none"> -The resident or the family would be expected to supply it. -Staff would keep it in a secured location (medication room). -Staff would give it to the resident when requested. <p>*The DON had asked resident 7 "a long time ago" if he had wanted her to talk to the physician about him having alcohol, and he had declined.</p> <p>*She had not asked him again, since he had started buying his own alcohol to bring into the facility.</p> <p>*She had thought he would have told her if he had wanted to drink.</p> <p>*They suspected resident 7 of sharing alcohol with other residents but had not been able to prove it yet.</p> <p>*They had started sending staff with him when he left the facility to try to prevent him from buying alcohol.</p> <p>*Staff had gone into resident 7's room and went through his belongings to look for alcohol and confiscate it after he had left to go shopping.</p> <ul style="list-style-type: none"> -He had not been made aware nor had given staff permission to go through his personal belongings. <p>*The COO confirmed there had been no mention of alcohol policies in the resident rights or admission packet explaining a resident's rights and expectations for alcohol.</p> <p>During the above interview in regards to the breathalyzer "incident" it was revealed:</p> <p>*The DON had not been present when resident 7</p>	F 151		

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F 151	<p>Continued From page 4</p> <p>had been given the breathalyzer test. *Hospital staff had come to administer the test. *She did not agree with how it had been handled but: -Staff told her he had refused to leave the dining room to take the test. -The person giving the test had not been nursing home staff. *She had known how upset the resident had been about the incident.</p> <p>Review of their 2012 admission packet revealed: *No mention of the rules regarding alcohol storage or consumption. *No specific alcohol policy. *The facility was not responsible for residents when they left the facility unless it had been a facility trip.</p> <p>Review of the 2012 Resident's Bill of Rights in the admission packet revealed: **"Long term care facilities must inform you both orally and in writing of your rights." **"This information must be given to you before or when you are admitted and during your stay." **"Proof that the information was given to you and any changes must be acknowledged in writing." **"You have all of the rights given to you as a resident of the long term care facility and as a citizen of the United States." **"You have the right to privacy and confidentiality...this includes your accommodations, medical treatment, written and telephone communications, personal care, visits and meetings..." **"You are entitled to a quality of life. A facility must provide care and an environment that contributes to you quality of life including...Maintenance or enhancement of your ability to preserve</p>	F 151			

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F 151	Continued From page 5 individuality, exercise self-determination and control every day physical needs."	F 151		
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to follow their policy for resident self-administration of medications for one of one sampled resident (7) egarding his nasal spray. Findings include:</p> <p>1. Observation on 4/12/16 at 7:45 a.m. revealed resident 7 received his medications from licensed practical nurse (LPN) A. She handed him the bottle of fluticasone nasal spray 50 mcg (dose measurement). The resident administered two sprays of the medication into each side of his nose and returned the bottle to LPN A.</p> <p>Review of resident 7's physician's orders dated 2/25/16 revealed fluticasone nasal spray 50 mcg, one spray in each nostril one time a day. There had not been an order for self-administration of that nasal spray.</p> <p>Review of resident 7's medical record revealed there had been no self-administration of medication assessments. Self-administration of medications had not been included in his last</p>	F 176	<ol style="list-style-type: none"> 1. Self-administration assessment was completed 5-4-16 with Resident #7 by Director of Nursing and discussed with interdisciplinary team. If team feels it is appropriate will get physician's order for Resident to self-administer medication. 2. Currently there are no other Residents choosing to self-administer medications. 3. All staff to be re-educated by 5-12-16 regarding self-administration assessment to be completed with any Resident wanting to self-administer medications. The results will be reviewed with the interdisciplinary team and interventions will be developed. All nurses will be re-educated on the self-administration policy and assessment by 5-12/16. 4. Director of Nursing or designee will complete self-administration audit of Resident 7 and four Random Residents weekly x 4, monthly x 3, and quarterly x 3. Director of Nursing or designee will report results of audits to QAPI monthly. 	6-2-16

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F 176	Continued From page 6 revised care plan of 4/11/16. Interview on 4/13/16 at 11:15 p.m. with LPN A revealed "[name] is his own person and if he feels like taking one spray he does that. If he feels he needs two sprays he takes two sprays. He makes that decision himself." She agreed he did not have an order for self-administration of his nasal spray. Interview on 4/13/16 at 3:30 p.m. with the director of nurses revealed she agreed resident 7 did not have an order for self-administration of medications. She agreed he had self-administered his nasal spray during the observation of 4/12/16. Review of the provider's last revised on 12/14/15 Self Administration of Medications policy revealed the resident was to have had a mental and physical assessment by the staff and a practitioner to determine capability of self-administration of medications.	F 176		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Surveyor: 36413	F 223	1. On 4-13-16 at 5:47 p.m. CNA D reported to the COO that Resident #12 told her that CNA C was rough when providing care. CNA D also reported Resident #15 reported that CNA C was rough with her roommate. During interview with CNA D, no mention was made of Resident #14. CNA C was not on duty on 4-13-16. Director of Nursing and COO interviewed Resident #12 on 4-13-16.	

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F 223	<p>Continued From page 7</p> <p>Based on interview, job description review, and policy review, the provider failed to keep residents safe from mental anguish for one of eleven sampled residents (10). Findings include:</p> <p>1. Group interview on 4/12/16 at 3:00 p.m. with four residents revealed: *One of the residents had seen their roommate handled roughly by certified nursing assistant (CNA) C. -She had reported it to staff but did not remember who that staff was. *One other resident stated she had been treated roughly also from CNA C.</p> <p>Interview on 4/12/16 at 10:00 a.m. with the director of nursing (DON) revealed if abuse was suspected by staff, that staff member would immediately be taken away from the resident's care. That staff person would be on suspension while investigation.</p> <p>2. Interview on 4/13/16 at 9:35 a.m. with resident 15 (roommate of resident 10) revealed: *When CNA C was providing care for her roommate: -She had not closed the curtain between them. -She was holding her legs in the air. -She heard her moaning and thought CNA C had been too rough with her.</p> <p>3. Interview on 4/13/16 at 10:30 a.m. with resident 10 regarding care she received revealed: *A tall, dark-haired woman who did care: -"Threw her legs around" when getting dressed while in bed. -Was too rough. -Was "Just mean". (unable to describe "mean".)</p>	F 223	<p>Investigation continued the morning of 4-14-16 with interviewing staff and cognitive Residents on the south wing. CNA C's primary group is on the south wing and Resident #12 is not in her primary group. Allegations could not be substantiated and it was decided by 1:00 p.m. on 4-14-16 that CNA C would be allowed to report for duty. CNA C was given education on providing care to Resident #12 and was assigned to normal Resident group on south wing. Director of Nursing and COO interviewed Resident #10 on 4-14-16. Interviews continued on north wing with cognitive Residents on 4-18-16 and 4-19-16. Allegations continued to be unsubstantiated. Director of Nursing and COO reviewed CNA C work history, past schedules and revealed in the past two months she cared for the group including Resident #15 and her roommate four times, all during the evening shift.</p> <p>2. All Residents are at potential risk.</p> <p>3. By 5-12-16 all staff will be re-educated on keeping residents safe from mental anguish, including review of abuse and neglect policy to include reporting guidelines and the importance of following that regulation.</p>	

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F 223	<p>Continued From page 8</p> <p>-Had been treated roughly by CNA C about five times.</p> <p>4. Interview on 4/13/16 at 2:00 p.m. with the chief operation officer (COO) revealed: *All abuse allegations were investigated. *First line was not termination. *Staff might be suspended during investigation.</p> <p>5. Interview on 4/13/16 at 5:35 p.m. with CNA D revealed: *Residents (12 and 14) had reported that CNA C had been too rough when providing care. *Resident 15 had reported she had seen her roommates (10) legs in the air when CNA C was providing cares and that she thought she was too rough. -Residents described rough as grabbing them by the arm to assist "hard", always in a hurry or speech was stern or residents requests or questions were ignored.</p> <p>Interview on 4/13/16 at 7:15 p.m. with the DON revealed CNA D had reported the above incidents to her that afternoon. She had not taken any action as of that conversation.</p> <p>Review of the provider's January 2015 Abuse and Neglect policy revealed: *The abuse and neglect prevention program included as a minimum: -Identification of occurrences and patterns of potential mistreatment and abuse. -Timely and thorough investigations of all reports and allegations of abuse. -The reporting and filing of accurate documents relative to incidents of abuse.</p> <p>Review of the provider's CNA job description</p>	F 223	<p>4. Social Worker or designee will complete audit for Residents 7, 10, 12 and Resident 15 and one Random Resident weekly x 4, monthly x 3 and then quarterly. Social Worker or designee will report results of audits to QAPI monthly.</p> <p><i>*The above audits will review resident personal care and call lights. MP/SDDOTT/EL</i></p>	6-2-16

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F 223	Continued From page 9 revealed: *"Performs safety to ensure a safe environment for the residents and staff". *"Interacts in a professional manner with residents". *"CNAs would demonstrate warm, caring, feelings about the residents".	F 223		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to ensure the dignity of residents was maintained as evidenced by: *Failure to ensure one of fourteen sampled resident's (7) personal choice for alcohol consumption and personal privacy was allowed. *Failure to ensure three of fourteen sampled residents (10, 12, and 14) were safe from mental anguish. Findings include: 1. Interview on 4/13/16 at 8:15 a.m. and 11:10 a.m. with resident 7 revealed: *He enjoys a glass of wine before bed. *He had kept alcohol in his room in the past. *He has gone back to his room after it has been "ransacked" by staff. -He was not happy about staff going through his personal belongings without asking.	F 241	1. Residents #7, #10, #12, #14. Refer to F 223. Refer to F 151. (WP) 2. All residents are at potential risk. 3. Inservice will be done by 5-12-16. 4. Social Worker or designee will complete audit for Residents #7, #10, #12 and #15 and one Random Resident x 4, monthly x 3 and then quarterly x 3. Social Worker or designee will report results of audits to QAPI monthly.	6-2-16

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F 241	<p>Continued From page 10 Refer to F151.</p> <p>2. Group interview on 4/12/16 at 3:00 p.m. with four randomly selected residents revealed: *One of four residents (15) had seen their roommate handled roughly by certified nursing assistant (CNA) C. -The resident had reported that to a staff person but did not remember who that staff person was. *One of four residents (12) stated she had been treated roughly from the same CNA C. Refer to F223.</p> <p>3. Residents 12 and 14 had reported to CNA D that CNA C had been too rough when providing cares. Refer to F223.</p> <p>4. Interview on 4/13/16 at 10:30 a.m. with resident 10 revealed: *A tall, dark-haired woman who did care: -Threw her legs around when getting dressed while in bed. -Was "too rough." -Was "Just mean." (unable to describe mean) Refer to F 223.</p>	F 241		
F 309 SS=D	<p>Surveyor: 36413 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p>	F 309		

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, observation, interview, and policy review, the provider failed to ensure ongoing pain monitoring and prevention methods had effectively managed pain for 1 of 5 sampled residents with pain (7). Findings include: 1. Review of resident 7's complete medical record revealed: *He had been admitted on 8/3/15. *He had diagnoses of: -Pain. -Psoriatic arthropathy (form of arthritis causing joint inflammation). -Other chronic pain. -Osteoarthritis of knee. Review of his current physician's orders revealed the following for pain medication: *Diclofenac Sodium Gel for shoulder pain related to chronic pain (started 2/26/16). *Methotrexate 2.5 mg, once a week for psoriatic arthropathy (started 2/26/16). *Acetaminophen tablet 325 milligrams (mg), two tablets every 4-6 hours as needed for pain (started 2/25/16). *Hydrocodone-acetaminophen tablet 5-325 mg, one tablet every 8 hours as needed for pain (started 3/8/16). Further review of resident 7's complete medical record revealed: *He had gone to the hospital at the end of February.	F 309	1. Resident #7 pain management assessment was completed on 5-3-16 by Director of Nursing, results reported to [redacted] and new orders obtained 5-3-16. <i>*residents physician MP/SDDO/H/EL</i> 2. All Residents are at potential risk. 3. The staff will be reeducated by 5-12-16 regarding pain assessment and management. <i>(MP)</i> 4. Director of Nursing or designee will complete pain audit of Resident #7 and four Random Residents weekly x 4, monthly x 3 and quarterly x 3. Director of Nursing or designee will report results of audits to QAPI monthly. <i>*All residents with a potential for pain and per the casper reports were interviewed and assessed for pain. MP/SDDO/H/EL</i>	6-2-16

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F 309	<p>Continued From page 12</p> <p>*The hospital had discontinued most of his pain medications when he returned to the nursing home.</p> <p>*Resident 7's physician had not ordered most of those medications again.</p> <p>*The pain medications that had been discontinued on 2/25/16 when he came back from the hospital included:</p> <ul style="list-style-type: none"> -Etanercept Solution 50 mg/ml, injected every Wednesday for psoriatic arthropathy (started 7/29/15). -Morphine Sulfate Extended Release tablet 15 mg, twice a day for chronic pain (started 1/19/16). -Naproxen tablet 500 mg, twice a day for chronic pain (started 1/21/16). -Tramadol HCl tablet 50 mg, three times a day for psoriatic arthropathy (started 9/17/15). -Hydrocodone-Acetaminophen tablet 10-325 mg, one tablet every 6 hours as needed for severe pain (started 7/27/15). -Diclofenac Sodium Gel for shoulder pain related to chronic pain (reordered 2/26/16). -Methotrexate 2.5 mg, once a week for psoriatic arthropathy (reordered 2/26/16). -Acetaminophen tablet 325 milligrams (mg), two tablets every 4-6 hours as needed for pain (reordered 2/25/16). <p>*His pain level indicated on his March medical administration record (MAR) had typically been a 7, 8, or 9 out of 10.</p> <p>Review of resident 7's nursing progress notes revealed:</p> <ul style="list-style-type: none"> *2/29/16, Resident's mother called, because she was worried he was not on enough pain medication. *3/2/16, Resident refused Tramadol and had stated it did not work. *3/11/16, Documented resident had complained 	F 309			

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F 309	<p>Continued From page 13 of a "skullbuster" (headache). *3/20/16, "Resident was in too much pain and would not turn to have dressing change done." *3/23/16, A complaint of "hurting all over." *4/9/16, Resident wished to have a higher dosage of pain medication.</p> <p>Review of resident 7's 4/11/16 care plan revealed: *A focus area of "Resident has acute/chronic pain related to arthritis, chronic physical disability, fibromyalgia, postoperative abdominal discomfort." -That area had been initiated 8/10/15 and revised 4/11/16. *Interventions of: - "Administer analgesia as per orders. Give 1/2 hour before treatments or care and physical therapy." -"Anticipate the resident's need for pain relief and respond immediately to any complaint of pain." -"Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain." *A focus area of "Actual impairment to skin integrity of the bilateral 2nd toes, L [left] lateral lower leg related to non-pressure ulcers." *An intervention of weekly wound care at the wound care clinic in Rapid City.</p> <p>Observation and interview on 4/13/16 at 8:15 a.m. with resident 7 revealed: *He wished he could be back on his old pain medication. *The pain pills he was on now had not been working very well, and he "might as well be on a sugar pill." *No signs of pain such as grimacing, calling out, shifting weight in his wheelchair, leaning or</p>	F 309		

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F 309	<p>Continued From page 14</p> <p>changing positions frequently were noticed during the interview.</p> <p>Interview on 4/13/16 at 9:50 a.m. with the director of nursing (DON) regarding resident 7 revealed: *The hospital physician had discontinued most of his pain medications, because he had been on a lot of them. *He had a history of narcotic abuse. *He had set his alarm to receive his narcotics (morphine) at night in the past. *She stated "He will always tell you his pain is a 7, 8, 9, or 10 no matter what." *He should have been getting pain medications before treatments as ordered.</p> <p>Review of resident 7's complete medical record revealed no documentation showing he had a history or problem with "narcotic abuse."</p> <p>Interview on 4/13/16 at 10:15 a.m. with the DON regarding resident 7 revealed: *She had been unaware his care plan had said to give him pain medication one half-hour before all treatments. *She was not sure how that would have been possible, because his wound clinic was an hour away. *He had never been given any pain medication at the wound clinic. *She would call his usual physician to see if they could send anything with him.</p> <p>Interview on 4/13/16 at 11:10 a.m. with resident 7 revealed: *He had not received his pain medication right before he left for the wound clinic. *He was not given any other pain medication while at the wound clinic.</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>*The amount of pain medication they gave him did not do much to help his pain. *"It would be a blessing" to give him different and better pain medication like he had before. *He had refused the Tramadol, because he did not like it. -It made him feel "like fingernails on a chalkboard". -He would rather be in pain than take Tramadol. *When asked about his pain, mentioning he had not looked like he had been in pain earlier in the day, the resident replied "I hide it very well. I am in pain most of the time." *When asked if nursing staff inquired about his pain, he laughed and indicated they don't go out of their way "like in one ear and out other." *While walking up to resident 7 sitting in his wheelchair in the hallway with another resident revealed he had become much more fidgety (moving around in his chair, leaning forward so his shoulders had not been against the wheelchair, and moving his legs back and forth). He grimaced and stated "ow" as he shifted in his wheelchair.</p> <p>Interview on 4/13/16 at 3:30 p.m. with the DON and the chief operation officer (COO) regarding resident 7 revealed: *Staff had tried repositioning and music as other ways to help manage his pain. *They had tried Tramadol, but he hated it and refused it. *They had not been able to find something (in regards to pain management) that really had helped him manage his pain since his medications had been changed. Surveyor: 36413 Interview on 4/12/16 at 11:00 a.m. with resident 7 revealed:</p>	F 309			

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F 309	Continued From page 16 *His pain level has been at its highest level when at the wound clinic, and they were debriding (cutting off scabs and dead skin) his toes. *Wound clinic staff had not given him pain medications. *Usually he had not gotten medications before he went to clinic. *Rated pain between eight to ten on one to ten pain scale while at the wound clinic.	F 309			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure 2 of 28 medications were administered according to physicians' orders for two randomly observed residents (7 and 13) for an error rate of 7.1 percent (%). Findings include: 1. Observation on 4/12/16 at 7:45 a.m. of licensed practical nurse (LPN) A while she was passing medications revealed she allowed resident 7 to administer his fluticasone nasal spray himself. He took two inhalations of the medication while LPN A observed. Review of resident 7's medication administration record revealed he was to have had one inhalation of the medication.	F 332	1. The Director of Nursing completed self-administration assessment 5-3-16 for Resident #7 and discussed assessment with interdisciplinary team and the Medical Director/Provider. Medication administration policy was revised 5-3-16 to include nasal spray. LPN A educated on changes to medication administration policy on 5-5-16. *That education included the use of nasal spray. 2. All Residents receiving nasal spray are at potential risk. 3. All nurses and medication aides will be in-serviced by 5-12-16 regarding changes to the medication administration policy. M.P/S/D/O/H/J/L 4. The Director of Nursing or designee will complete medication pass audit of Residents #7, #13 and three Random Residents weekly x 4, monthly x 3, and quarterly x 3. Director of Nursing or designee will report results of audits to QAPI monthly.	6-2-16	

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F 332	<p>Continued From page 17</p> <p>Interview on 4/13/16 at 11:15 a.m. with LPN A revealed she agreed: *Resident 7 had received the incorrect dose of his inhaler. *He was to have had only one inhalation of the medication. *She allowed him to decide himself how many inhalations he wanted to take. *He had received the wrong dose of fluticasone inhalation.</p> <p>Interview on 4/13/16 at 3:30 p.m. with the director of nurses revealed she agreed resident 7 had received the incorrect dose of fluticasone.</p> <p>2. Observation on 4/12/16 at 7:55 a.m. of LPN A while she administered medication to resident 13 revealed she gave the resident fluticasone 50 mcg, one inhalation in each side of her nose.</p> <p>Review of resident 13's noted Physician's Orders dated 4/11/16 revealed an order for "Flonase (fluticasone) 2 sprays each nostril QD [everyday] X [for] 1 month."</p> <p>Interview on 4/13/16 at 11:20 a.m. with LPN A revealed she agreed she the resident had received a dose not ordered.</p> <p>3. Interview on 4/13/16 at 3:30 p.m. with the director of nurses confirmed the above medication administrations had been incorrect.</p> <p>Review of the provider's last revised 1/2015 Standards of Medication Administration policy revealed residents were to have received the correct dosage of medication.</p>	F 332			

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<p>F 371 F 371 SS=D</p>	<p>Continued From page 18 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview and policy review, the provider failed to: *Ensure appropriate hand hygiene was completed by one of one observed cook. *Safely cook unpasteurized eggs for all residents who had fried eggs during two of two breakfast meals observed. Findings include:</p> <p>1. Observation on 4/11/16 at 5:30-6:15 p.m. with staff F revealed she: *Touched the clip board and pen while serving trays. *Went out of kitchen to the dining room and returned to the tray line. *Went out of the tray line to get plastic wrap and returned to tray line. *Went into the walk-in freezer and returned to tray line. *Had her hand in her pocket while serving trays in tray line.</p>	<p>F 371 F 371</p>	<ol style="list-style-type: none"> 1. Dietary staff member F has been spoken with about hand hygiene and proper handwashing and has verified understanding. Dietary staff member E has been spoken with about using only pasteurized eggs when offering to residents sunny side up/over easy eggs at breakfast. She has verified understanding the need for only using pasteurized eggs. 2. All dietary staff will be in-serviced by the CDM and dietitian on the policy for pasteurized eggs, handwashing, hand hygiene and disposable gloves by 5-12-16. 3. The CDM or designee will monitor breakfast for the use of pasteurized eggs 3 x per week and will share results monthly to the QAPI committee. 4. The CDM or designee will monitor weekly x 4, biweekly x 3 and monthly x 3 to ensure proper hand hygiene and handwashing is being followed by all dietary staff. Results will be shared monthly at QAPI with further follow up as recommended by the committee. <p><i>*The certified dietary manager will report audit results to QA. MP/SDRAT/EL</i></p>	<p>6-2-16</p>
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F 371	Continued From page 19 Interview on 4/11/16 at 6:30 p.m. with staff F revealed she should have washed her hands anytime when leaving and then returning to the tray line. Interview on 4/13/16 at 10:25 a.m. with the dietary manager revealed she would expect hand washing anytime the server leaves the tray line. 2. Observation on 4/12/16 and 4/13/16 during breakfast hours in the main kitchen revealed unpasteurized eggs were used when eggs were cooked and served over easy. Interview on 4/13/16 at 8:30 a.m. with staff E revealed: *Over easy eggs were requested by multiple residents on 4/12/16 and 4/13/16 for breakfast. *She had prepared the eggs using unpasteurized eggs although she had pasteurized eggs available. Interview on 4/13/16 at 10:35 a.m. with the dietary manager revealed she would expect that pasteurized eggs be used on all special orders if they had not been not fully cooked. Review of the provider's February 2016 Procedure for Eggs policy revealed residents may have sunny side/over easy eggs from pasteurized eggs.	F 371			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425			

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F 425	<p>Continued From page 20 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure the procedure for medication administration through a feeding tube was completed in a manner that promoted the complete and accurate dosage of medications for one of one observed resident (10) with a feeding tube by one of one licensed practical nurse (LPN) (B) observed. Findings include:</p> <p>1. Observation on 4/12/16 at 10:10 a.m. of LPN B while she prepared and administered medications to resident 10 revealed she: *Accurately measured liquid Tylenol and iron in plastic medication cups. She then poured both of those liquid medications into a Styrofoam cup. *Opened an acidophilus capsule and gabapentin 300 mg capsule and put the contents of those two</p>	F 425	<ol style="list-style-type: none"> 1. Medication administration policy was revised 5-3-16 to add medication administration through a gastrostomy tube. LPN B was educated on 5-4-16 on changes to medication administration policy. 2. No other Residents are currently at risk. 3. By 5-12-16 all nurses will be in-serviced to changes to medication administration policy to include medication administration through a gastrostomy tube. 4. Director of Nursing or designee will complete audit of medication administration through a gastrostomy tube with a day nurse and evening or night nurse weekly x 4, monthly x 3 and quarterly x 3. Director of Nursing or designee will report results of audits to QAPI monthly. <p>→ *resident 10's medications are administered according to the new policy. MP/SD/DH/EC</p>	6-2-16

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F 425	<p>Continued From page 21</p> <p>capsules in to a plastic measuring cup. *Crushed the remainder of resident 10's medication tablets and put them in with the capsules contents. *Dumped the crushed tablets and capsule contents into the liquids medications and stirred them. *Proceeded to verify feeding tube placement and residual stomach contents for the resident. *Administered one hundred cubic centimeters (cc) of water through the feeding tube. *Administered the liquid, capsule contents, and crushed medication through the feeding tube. *Instilled fifty cc of water through the feeding tube.</p> <p>Observation on 4/12/16 at the same time revealed there were small pieces of the crushed and capsule medications in the bottom of the cup. LPN B did not rinse the cup with water after she drew the medication into the syringe.</p> <p>Interview on 4/12/16 at 11:00 a.m. and on 4/13/16 at 3:00 p.m. with the director of nurses revealed she would have expected LPN B to have prepared and administered the liquid medications separately. She stated she would have expected LPN B to have dissolved the crushed medications and capsule contents in warm water before she administered them to the resident.</p> <p>Interview on 4/12/16 at 11:45 a.m. with LPN B revealed she agreed she had not rinsed the Styrofoam cup that had contained the medications. She agreed the crushed medications and capsule contents had not been completely dissolved in the liquid Tylenol and liquid iron.</p>	F 425		

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

PRINTED: 04/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2016
NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747		
(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 425	Continued From page 22 Review of the providers's last revised 1/23/15 Enteric Feeding via NG (A tube placed in through the nose going to the stomach) or Gastrostomy tube policy revealed no mention of medication preparation prior to administration. Review of the provider's last revised 1/23/15 Standards of Medication Administration policy revealed: *The policy statement stated there should be a safe method of administering medications. *The procedure revealed the right dose should be administered, and there should be methods to address the right administration techniques.	F 425			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435072	MULTIPLE CONSTRUCTION A. BUILDING: 03 - SEVEN SISTERS B. WING _____	DATE SURVEY COMPLETE: 4/12/2016
NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD	

ORIGINAL

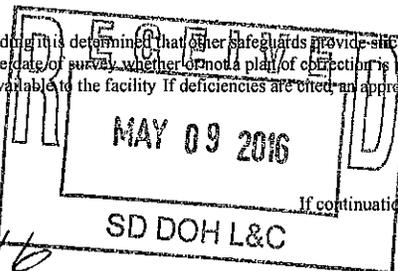
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 011	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition Communicating openings occur only in corridors and shall be protected by approved selfclosing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>Based on observation and interview, the provider failed to maintain the fire-resistive characteristics of the two hour fire-resistive wall between the nursing home and the hospital The wall had unsealed penetration openings above the lay-in ceiling (in the corridor by the kitchen and the ninety minute doors). Findings include:</p> <p>1. Observation at 9:30 a.m. on 4/12/16 revealed the two hour, fire-rated wall between the hospital and the nursing home had unsealed penetration openings above the lay-in ceiling at control wiring locations. Interview with the environmental services supervisor at the time of the observations revealed the penetrations were from recent installations by contractors. He was unaware the two hour, fire-rated wall had not been adequately repaired after the installations.</p> <p>The deficiency had the potential to affect one of two smoke compartments</p>
K 038	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>Based on observation, testing, and interview, the provider failed to ensure one of three marked exits were readily accessible at all times (main exit). Findings include:</p> <p>1. Observation at 9:00 a.m. on 4/12/16 revealed the main entrance/exit door was equipped with a magnetic lock. 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 door. The sign was a paper sign taped to the door (the sign must be a durable sign affixed to the door). Further observation and testing revealed the opposite side of the door was also equipped with a delayed egress magnetic lock but had no signage.</p> <p>Interview with the environmental services supervisor at the time of the observation and testing confirmed those conditions. He stated he was unaware the sign configuration was not correct</p> <p>The deficiency had the capability to affect 100% of the building occupants.</p>

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

The above isolated deficiencies pose no actual harm to the residents

John Miller
Administrator

5/5/16



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435072	MULTIPLE CONSTRUCTION A. BUILDING: 03 - SEVEN SISTERS B. WING _____	DATE SURVEY COMPLETE: 4/12/2016
NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<p>K 144</p> <p>K 144</p>	<p>Continued From Page 1</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Surveyor: 18087 Based on interview and document review, the provider failed to conduct five minute cool-down periods following the required thirty minute monthly emergency generator load tests for 2015. Findings include:</p> <p>1. Interview with the environmental services supervisor at 1:30 p.m. on 4/12/16 revealed the emergency generator was exercised weekly with a load test performed once per month Review of the generator log (hour meter readings) revealed the load test runs were performed for a period of thirty minutes A five minute cool-down run time is required after the thirty minute load run Interview with the environmental services supervisor at 2:00 p.m. on 4/12/16 indicated he was unaware of the requirement for the five minute cool-down period following the full load test</p> <p>The deficiency had the potential to affect 100% of the building occupants.</p> <p>K011</p> <ol style="list-style-type: none"> 1. The two hour, fire-rated wall between the hospital and the nursing home where the unsealed penetration openings were above the lay-in ceiling at control wiring locations were closed up and fire caulked in two locations on 4-20-16 by the Environmental Services Supervisor. 2. A policy for outside contractors doing work in the facility will be put into place to ensure the building is put back to its original condition. Outside contractors that Fall River Health Services hires to work in the facility will report directly daily to the Environmental Services Director. 3. The Environmental Services Supervisor will be educated on the policy for outside contractors. 4. The Environmental Services Director will monitor for three months all outside contractors work to ensure the building was repaired back to its original condition after working on the building and this will be reported monthly to the QAPI committee for a quarter and then reevaluated for continued reporting. <p style="text-align: right;">6-2-16</p>
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John Miller, Administrator

5/5/16

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2016
NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747	
(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)
S 000	Compliance/Noncompliance Statement Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/11/16 through 4/13/16. Seven Sisters Living Center was found not in compliance with the following requirement: S290.	S 000	*Addendums noted with an asterisk per telephone per with facility DON and administrator. MP/SDDOH/EL
S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods adequate to meet the planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of their emergency preparedness plan. Military meals ready to eat (MRE) are not a substitute for the nonperishable food supply for residents, but may be used to address other emergency food supply needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 36413 Based on observation, testing, interview, and policy review, the provider failed to prepare foods that were tasteful and nutritive value was retained for one of one meals tested. 1. Randon interview on 4/13/16 at 10:05 a.m. with resident 8 revealed the food was usually: *Overcooked. *Veggies were mushy *Bland Observation and testing in the kitchen on 4/12/16 at 4:50 p.m. revealed the mixed vegetables were: *Mushy and did not have flavor. -Taste-tested by four survey staff. *Taste testing had been done forty minutes before	S 290	<ol style="list-style-type: none"> 1. Resident #8 will be visited by the CDM about concerns of food quality, nutritive value and palatability. 2. All residents are at risk. CDM or designee will attend Resident Council monthly and inquire residents' opinions of the quality, palatability, nutritive value of the foods prepared. 3. All cooks will be in-serviced by the CDM and dietician by 5-12-16 regarding citation of "provider failed to prepare foods that were tasteful and nutritive value" by overcooked, mushy vegetables. Quality food preparation policy and procedure will also be reviewed. 4. The CDM or designee will monitor meal service 3 times per week. Four random residents will be audited once a week on food quality. Results will be reported *by the certified dietary manager to QAPI monthly, then quarterly or as recommended by the QAPI committee. <p style="text-align: right;">MP/SDDOH/EL 6-2-16</p>

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

John Miller

TITLE

Administrator 5/5/16

(X6) DATE

STATE FORM

5899

R09T11

RECEIVED

MAY 09 2016

SD DOH L&C

If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2016
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S 290	Continued From page 1 first tray would have been served. Review of the provider's February 2016 Quality of Food Preparation policy revealed: *Avoid cooking foods too far in advance of serving. *Overcooking foods too long causes loss of pleasing texture, color and loses some nutrients. *Overcooking spoils the appearance and decreases taste of most foods. *Do not overcook "strong" vegetables. Review of the provider's undated Cook's Review Check-off List revealed to cook vegetables close to serving time to aid in preventing mushy veggies.	S 290		