

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

ORIGINAL

PRINTED: 01/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/14/2016
NAME OF PROVIDER OR SUPPLIER STURGIS REGIONAL SENIOR CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 949 HARMON STREET STURGIS, SD 57785	
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F 000	INITIAL COMMENTS Surveyor: 20031 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/13/16 through 1/14/16. Areas surveyed included abuse and resident care. Sturgis Regional Senior Care was found not in compliance with the following requirements: F224 and F309.	F 000	*Addendums noted with an asterisk per 3/3/16 per email with facility DON. KW/SDDO/H/L	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to identify and ensure one of one sampled resident (1) had been kept free from physical and verbal abuse by one of one certified nursing assistant (CNA) (E). Findings include: 1. Review of the initial internal investigation report dated 1/7/16 by the director of nursing revealed resident 1 had been physically and verbally abused by CNA E.	F 224	F224 Both F224 and F309 contain related finding to the complaint survey conducted. F224 will be addressed in the Plan of Correction for F309.	*3/4/16 KW/SDDO/H/L

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

TITLE

(X6) DATE

[Signature]

Administrator 2-4-16

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.

FEB 08 2016

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F 224 F 309 SS=G	Continued From page 1 Refer to F309, findings 1 and 3. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to ensure: *Appropriate physical assessment, mental assessment, and psychosocial care had been conducted for one of one sampled resident (1) abused by one of one certified nurse assistant (CNA) (E). *The physical, mental, and psychosocial needs were met regarding the possible physical and/or verbal abuse by one of one CNA (E) for five of five identified residents (2, 3, 4, 5, and 6). Findings include: 1. Review of the initial internal investigation report review dated 1/7/16 by the director of nursing (DON) revealed: **At 1645 [4:45 p.m.] ____ [South Dakota Department of Social Services Specialist] came to the facility to talk to ____ [social services designee] the social worker and I about an	F 224 F 309	F309 DON, Social Worker Coordinator, and Local Ombudsman spoke with resident #1 about the abuse that was reported. Resident made eye contact with the social worker and DON as they talked about the resident being mistreated. Resident continued to shake her head in a "yes" motion. DON made a statement about the resident being hurt by this man and resident #1 stated "Owe, Owe," three times. When asked if she did not want this person to come back resident shook her head "no". All three people present reassured her that she is safe and that she would not be harmed in the future. She was also told that the staff was here to protect her and that we will work very hard to assure this never happens again, resident shook her head "yes" and covered her head with a blanket. All people present felt the resident understood the conversation and was actively participating with them at the time. DON spoke with residents #2, #3, #5, and #6 as these were the residents identified by staff member E at the time of his dismissal as people he may have "lost his patience with". All of these residents are unable to speak except #3 who stated there was never anyone who treated her poorly. Resident #2, #5, and #6 have severe dementia and are unable to communicate any understanding. Education was completed to all staff on 1/13/16 and 1/15/16 in three separate meetings to teach about abuse; what is abuse, how to report abuse and who to report it to, how to recognize the signs and	*3/4/16 KWS/DDC/HJL

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F 309	<p>Continued From page 2</p> <p>anonymous complaint that they had that came in on a hotline. These were serious allegations against a male CNA in our facility that took care of _____ [resident 1]. According to the DSS worker this male CNA had lifted this resident who is care planned as a hooyer lift, and he lifted her by hand and "threw" her into bed, covered her mouth with his hand to make her "shut up," stated a camera was placed in the room and there is proof to these allegations as well as the resident having "multiple broken bones. There have been no broken bones since this writer has been employed to the facility since 2013, May." **1-8-2016 0930 [9:30 a.m.] a call came in from the lawyer for the _____ facility and it was then stated that more allegations of slapping the resident hitting the resident and threats to hit her if she didn't be quiet were made, these also were not DSS allegations, and that the video that was obtained by the family was going to be given to us today and we would determine from these what to do."</p> <p>Phone interview on 1/12/16 at 3:57 p.m. between the complaint coordinator for the South Dakota Department of Health Office of Licensure and Certification and the DON revealed the DON had viewed the five video clips _____ [resident 1's] family attorney shared with the facility today. The five video clips showed CNA E's interactions with the resident as follows: a. "Clip one and clip two dated 10/4/15 revealed CNA E pulling _____ [resident 1] head backwards, leaning her forwards, and throwing her legs into bed." *Note: Resident 1 was care planned to use a lift. -"CNA E started perineal [peri]-care [hygienic care of personal areas], resident 1 'trills' [rapid fluttering of two tones together], and CNA E slaps</p>	F 309	<p>symptoms of abuse as well as how it will be handled when investigating abuse. Many topics were discussed at these meetings and staff are aware of the need to monitor all residents including residents #1,2,3,4,5,6,7,8,9,10,11,12, and 13 for signs of abuse. Staff were very actively involved in this education and asked many questions to increase their knowledge base to ensure they are able to recognize abuse in the future. Abuse will be mentioned by DON as an educational piece in all staff meetings monthly for the next 12 months.</p> <p><i>*DON completed all education to staff. Evaluation of resident #1 was completed by the DSS ombudsman, LSW, and the DON and all three felt professional counseling was not needed as resident is not exhibiting signs of depression or further issues with the abuse. Family was made aware of the process and findings. Plan for any suspected abuse would be on a case by case basis and will be monitored closely. Following policies of the facility to report the abuse, seek assistance for professional or facility counseling for the resident or residents involved. All staff will monitor for signs and symptoms of abuse. —————> Next page</i></p>	
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F 309	<p>Continued From page 3</p> <p>her hard enough to be heard on the video." -"CNA E resumes peri-care roughly, ___ [resident 1] 'trills', CNA E covers her mouth and possibly her nose, while pushing her head down onto the bed." b. "Clip three dated November 18th reveals CNA E 'ripping' off ___ [resident 1] shirt, leaves her with not shirt on, before he leaves he places his fist to the side of her face in a 'warning stance'. *Pulled her into the bed naked, and left her there uncovered for a period of time. *Was rough with her while placing her legs onto the bed." c. "Clip four dated October 18th revealed ___ [CNA E] and a new hire [CNA F] transferring the resident without a lift under the arm pits. It looks like she was dropped, but she was not it was an awkward transfer. * ___ [CNA E] is then alone with ___ [resident 1], covers her mouth again while she is lying in bed. * ___ [CNA E] also grabs ___ [resident 1] L [left] arm which is contracted, twists it and hold it off to the side." d. "The last clip, no date given, he pulls her forward and hits her on the back hard with his fist."</p> <p>Review of resident 1's medical record and care plan revealed: *No interdisciplinary progress notes (IPN) regarding the above physical and verbal abuse. *No IPN that indicated her primary physician had been notified of the physical abuse. *No IPN of any physical assessment for any injuries. *Her care plan had not been updated to include monitoring for any signs or symptoms of emotional distress or a change or increase in any behaviors.</p>	F 309	<p>*The DON will continue monthly meetings for education on signs and symptoms of abuse. DON or designee will monitor monthly at meetings and is available on a daily basis for staff to report issues. Weekends the DON is available by phone or designee (charge nurses) are available daily for reporting abuse. Monthly reports will be given to the QAPI committee by the DON.</p> <p>KW/SDDO/H/EL</p>	

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F 309	<p>Continued From page 4</p> <p>Review of the CNA schedules for the Massa unit from 7/19/15 through 1/7/16 revealed: *CNA E worked Monday through Thursday evenings (2:00 p.m. to 10:00 p.m.) and then the week-end for one week. *Then Tuesday through Friday evenings with the week-end off on the next week. *That schedule rotated every two weeks.</p> <p>Interviews on 1/14/16 from 8:30 a.m. through 2:30 p.m. with CNA's A, B, C, F, G, and licensed practical nurse D revealed they had all worked with CNA E. None of them revealed any knowledge of abuse by any staff to any residents.</p> <p>Interview on 1/14/16 at 3:43 p.m. with the long term care supervisor revealed: *The provider had not interviewed other employees who had worked with or had interaction with CNA E. *The provider had not interviewed resident 1 or any other resident who had interaction with CNA E. *The licensed nurses and CNAs did not have a set schedule. Although some of the CNAs who had been at the facility for some time, such as CNA E, might have had a set working pattern during the week. *She tried to watch and audit CNAs and other employees on her shift. But was busy and did not audit resident care behind closed doors all the time. *It was policy that two staff must attend to a resident when using a lift. But she "may not always catch everyone to do a two person." *The charge nurse would delegate where the CNAs would work on a particular unit. *The provider had put no monitoring of resident</p>	F 309		

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F 309	<p>Continued From page 5</p> <p>care in place for staff or residents.</p> <p>*The CNAs in training worked under the RNs and licensed practical nurses. But would work one-on-one with other CNAs while in a resident's room.</p> <p>*There was a resident who "shied away" from male staff due to one instance with a male CNA "a while ago." But she had not noticed anything since that time.</p> <p>Interview on 1/14/16 at 3:55 p.m. with the DON revealed:</p> <p>*On 1/7/16 a 4:45 p.m. she and the SSD were notified by the DSS specialist of the alleged abuse of resident 1 by a male CNA. At that time she and the president had let CNA E work with supervision on the same unit in the skilled nursing facility, but on a different wing of that unit as advised by the provider's counsel. The DON confirmed CNA E was the only male CNA on the Massa unit.</p> <p>*Only she and the provider's counsel had viewed the video clips and interviewed CNA E on the alleged complaint.</p> <p>-She stated CNA E had admitted to the following regarding resident 1:</p> <p>--Twisting her contracted arm.</p> <p>--He had been losing his patience with her and five other residents (2, 3, 4, 5, and 6) for the past six months.</p> <p>--Putting her to bed in a "rough" manner.</p> <p>--He would forget what he was doing during her care. He would leave her in bed naked and leave the room.</p> <p>*After the interview with CNA E and his admittance to the abuse of resident 1 and others you could see a pattern with the residents he chose to abuse.</p> <p>-They all had some type of dementia.</p>	F 309			

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F 309	<p>Continued From page 6</p> <p>--All but one or two: --Could not display emotions. --Were non-verbal. --Had very little to zero family involvement</p> <p>*She confirmed there were no progress notes to indicate resident 1's physician had been notified. She stated she had not had time to do a late entry. She stated the on-call physician at the hospital had been notified of the incident with resident 1.</p> <p>*There had been no physical examination of resident 1 by a physician.</p> <p>*The SSD had not spoken with resident 1 or any other residents. The SSD felt it would interfere with the police department's investigation.</p> <p>*She had not interviewed any other employees, as she was told it would interfere with the police department's investigation. She felt CNA E's "admittance to the abuse was enough."</p> <p>*She had started mandatory training regarding abuse and neglect as of today, 1/13/16.</p> <p>*Neither she nor the president had considered the idea of counseling for resident 1 or the other residents. She was told they "needed to see to what extent we need to talk with her [resident 1] after the police investigation."</p> <p>*Neither she nor the president had implemented monitoring of staff on various shifts and with various types of care.</p> <p>2. Continued interview with the DON confirmed after CNA E had admitted to losing his patience with five other residents: *There were no progress notes to indicate other physicians had been notified after CNA E had admitted to the abuse of another five residents (2, 3, 4, 5, and 6). *She had not interviewed resident's 2, 3, 4, 5, and 6.</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>Review of the Brief Interview of Mental Status scores revealed: *Resident 1 was zero (could not respond). *Resident 2 was zero. *Resident 3 was fifteen (highest score to understand). *Resident 4 was eleven. *Resident 5 was three. *Resident 6 was three.</p> <p>Review of resident's 2, 3, 4, 5, and 6's medical records revealed: *No IPN regarding any possible physical and verbal abuse. *No IPN that indicated their primary physicians had been notified of possible physical abuse. *No IPN of any physical assessments for any injuries. *Their care plans had not been updated to include monitoring for any signs or symptoms of emotional distress or a change or increase in any behaviors.</p> <p>3. Exit interview on 1/14/16 at 5:30 p.m. with the facility president revealed: *He was made aware of the incident and complaint on 1/7/15. On that same day the provider's counsel advised the DON and himself to let CNA E work on another unit, away from resident 1, and with supervision. *He had not viewed the video clips. *He was not present when CNA E admitted to the abuse nor present for the termination of CNA E. *CNA E had been suspended since Friday 1/8/16 and relieved of duties as of 1/12/16 at 4:00 p.m. *He had relied on updates from the DON. *Neither he nor the DON had conducted any employee or resident interviews, as they might</p>	F 309			

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F 309	<p>Continued From page 8</p> <p>interfere with the police investigation.</p> <p>*He had not implemented any internal or outside resources to aide in psychosocial well-being counseling for resident 1 or the other five residents.</p> <p>Review of provider's final internal investigation report review by the DON revealed:</p> <p>*"...on January 12th this writer was asked to go view the videos of the complaint and validate that it was indeed one of our staff members.</p> <p>*At that time I witnesses several counts of abuse on the videos and was able to identify the person doing the assaulting as one of our staff member, ___ [CNA E].</p> <p>*This writer and another staff nurse are going thru all of the files of the residents that CNA E had cared for and area looking for any other signs of further abuse. None have been found at this time."</p> <p>* ___ [CNA E] did state in the meeting at the time of his termination that there were four other residents that he 'might' have lost his patience with. these residents files have been looked over and nothing found to indicate abuse occurred, such as bruises or falls unexplained etc."</p> <p>*"The allegations of abuse have been found to be true and the videos have been viewed by this writer and the staff member involved has been terminated.</p> <p>*All of the residents named are unable to speak for themselves in any way to confirm or deny the abuse.</p> <p>* ___ (DSS specialist) has been contacted to receive advise on how to proceed with the follow up with the resident involved from a social worker view as well as our social worker involvement to proceed with talking with the resident to assure she is ok, as well as the other residents."</p>	F 309		

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F 309	<p>Continued From page 9</p> <p>Review of the provider's 7/20/11 Suspected Abuse or Neglect of Elderly or Disabled Adults policy revealed:</p> <p>*1. Abuse, physical harm, bodily injury, or attempt to cause physical harm or injury, or the infliction of fear or imminent physical harm or bodily injury on an elder or disabled adult.</p> <p>*A. 5. The social work/discharge planning staff will coordinate with the Department of Social Services, the state's attorney's office or law enforcement during the investigative process.</p> <p>*A. 6. Contact and plans will be documented in the Ancillary Progress Notes of the patient's chart.</p> <p>*D. 3. Psychological (Emotional): -"The person may exhibit these behaviors but of themselves they do not indicate psychological abuse or neglect. However, there may be clues to staff to ask more questions and look beyond the obvious..."</p> <p>Review of the provider's 7/20/11 Reporting of Suspected Abuse or Neglect of Elderly or Disabled Adults policy revealed "4. The investigative report must include approaches put in place for prevention."</p> <p>Review of the provider's April 2009 Abuse Investigations, Protection of Residents During policy revealed: *"Policy Statement: Residents will be protected form harm or retaliation during an abuse investigation.</p> <p>*A. 1. employees accused of participating in the alleged abuse may be immediately reassigned to duties that do not involve resident contact or will be suspended until the findings of the investigation have been reviewed by the administrator or designee."</p>	F 309			

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F 309	Continued From page 10 Review of the provider's undated Social Service Department and Care Planning policy revealed: *The social service department was primarily responsible for helping the residents manage social and emotional concerns. *The social service department should have focused on problems and needs that included emotional adjustment for expression of feelings, problems, and concerns.	F 309			