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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CIA
IDENTIFICATION NUMBER:
435004

(x2) MULTIPLE CONSTRUCTION
A. BUILDING

(x3) DATE SURVEY
COMPLETED
C
03/29/2018

NAME OF PROVIDER OR SUPPLIER
MANORCARE HEALTH SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE
400 8TH AVENUE NW
ABERDEEN, SD 57401

(x4) ID
PREFIX
TAG
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG
PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

F 000
INITIAL COMMENTS
Surveyor: 32335
A recertification health survey for compliance with
42 CFR Part 483, Subpart B, requirements for long
term care facilities, was conducted from
3/26/18 through 3/29/18. ManorCare Health
Services was found not in compliance with the
following requirements: F565, F657, and F686.
A compliant survey for compliance with 42
CFR Part 483, Subpart B, requirements for long
term care facilities, was conducted from 3/26/18
through 3/29/18. Areas surveyed included skin
assessments, skin care, and catheter care.
ManorCare Health Services was found in
compliance.

F 565
Resident/Family Group and Response
CFR(s): 483.10(f)(5)(i)-(iv)(G)(7)
§483.10(f)(5) The resident has a right to organize
and participate in resident groups in the facility.
(i) The facility must provide a resident or family
group, if one exists, with private space, and take
reasonable steps, with the approval of the group,
to make residents and family members aware of
upcoming meetings in a timely manner.
(ii) Staff, visitors, or other guests may attend
resident group or family group meetings only at
the respective group's invitation.
(iii) The facility must provide a designated staff
person who is approved by the resident or family
group and the facility who is responsible for
providing assistance and responding to written
requests that result from group meetings.
(iv) The facility must consider the views of a
resident or family group and act promptly upon
the grievances and recommendations of such
groups concerning issues of resident care and life

Aberdeen Plan of Correction for Annual
The statements on this plan of correction are not
admittance to and do not constitute an agreement
with the alleged deficiencies herein. To remain
in compliance with all federal and state
regulations, the center has taken or will take action
as set forth in the following plan of correction.
The plan of correction constitutes the center's
assertion of compliance. All alleged deficiencies
cited have been or will be corrected by the dates
indicated.

1) Nursing, Social Services, Interdisciplinary Team
met to review and revise current dietary procedures
to validate timely meal service and effective offering of
meals.

5/11/18

2) Administrator did discuss with resident council
the change of meal times in the main dining room to
TlODES BSNV AINN DAINING RONN
CHANGED TO ALLOW DIETARY STAFF TO
TRANSITION FROM REHAB DINING ROOM TO
MAIN DINING ROOM FOR SET-UP. TIMES OF
MEALS CHANGED TO 8:15 AM; 12:15 PM; 6:15 PM
GIVING AN ADDITIONAL 15 MINUTES AT EACH
MEAL ALLOWS FOR ADEQUATE SET UP AND
FOR TEMPERATURES TO BE OBTAINED/RECORDED.

3) Will inform residents on 4/16/18 of selective menu
process and change of main dining meal times.

4) Will educate dietary, nursing department and
Interdisciplinary team on selective menus and time
change of main dining room times 4/27/18.

LAbORATORY DIRECTOR'S OR PROVIDER/ SUPPLIER/ REPRESENTATIVE'S SIGNATURE
Darcy Albrecht, Administrator

TITLE

(x5) DATE
04/16/18

FORM CMS-2587(02-99) Previous Versions Obsolete
Event ID: XF211
Facility ID: 0033
If continuation sheet Page 1 of 19
Continued From page 1 in the facility.

(A) The facility must be able to demonstrate their response and rationale for such response.

(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

§483.10(f)(6) The resident has a right to participate in family groups.

§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.

This REQUIREMENT is not met as evidenced by:

Surveyor: 39190

Surveyor: 32335

Based on observation and interview the provider failed to ensure:

*Meals were served on time for two of two observed meals in the main dining room.

*Residents were aware of alternative meal options in one of two dining rooms (main dining room).

Findings include:

1. Interview on 3/28/18 at 4:45 p.m. with the administrator revealed the meal times were:

*In the rehabilitation (rehab) dining room breakfast was served at 7:30 a.m., lunch at 11:30 a.m., and supper at 5:30 p.m.

*In the main dining room breakfast was served at 8:00 a.m., lunch at 12:00 noon, and supper at 6:00 p.m.

Surveyor 39190
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CU Identification Number:**
436004

**Date Survey Completed:**
03/29/2018

**Location:** Manorcare Health Services

**Address:** 400 8th Avenue NW
ABERDEEN, SD 57401

#### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>CHECKMARK</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>F 565</td>
<td>C</td>
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<td>Continued From page 2</td>
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<td>Observation on 3/20/18 from 5:54 p.m. through 6:30 p.m. in the main dining room revealed:</td>
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<td>*At 6:11 p.m. the serving window was closed.</td>
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<td>- No meals had been served yet.</td>
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<td>*At 6:15 p.m. the serving window opened, and the first tray was served.</td>
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<td>- An unidentified resident refused the tray and asked for soup.</td>
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<td>-- She kept the bread and fruit.</td>
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<td>- Three out of four of the residents at the same table refused their tray and only took the fruit.</td>
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<td>Observation and interview on 3/27/18 from 5:13 p.m. through 6:20 p.m. in the dining room revealed:</td>
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<td>*At 6:13 p.m. the serving window was opened.</td>
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<td>- The kitchen had not started serving.</td>
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<td>*Interview at 6:15 p.m. with licensed practical nurse D regarding resident choices for meals revealed:</td>
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<td>- They did not ask the residents prior to the meal as to what they would like to eat.</td>
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<td>-- He stated &quot;We tried that once and it didn't work.&quot;</td>
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<td>-- He said &quot;A resident would order fish for supper and then once supper came they would be like I don't want fish, and the server would say &quot;Yes you ordered this at breakfast today,&quot; and the resident would be like, &quot;No I don't want it, I want something else.&quot;</td>
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<td>-- He thought it worked better now.</td>
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<td>-- They just took the tray with the main menu meal option and if they did not want it they offered the alternative.</td>
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<td>*At 6:15 p.m. the serving window closed.</td>
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<td>*At 6:20 p.m. the first tray was served.</td>
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<td>Interview with a resident representative revealed: &quot;Supper is routinely not served until 6:20 p.m. or 6:30 p.m.&quot;</td>
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F 565 Continued From page 3
- Supper time was 6:00 p.m.
  *The resident would request to go back to her room before she received her meal.
  *"He waits till 6:20 p.m. or 6:30 p.m. to take her to supper in hopes they have started serving supper."

Surveyor 32335
Confidential interview on 3/28/18 at 9:30 a.m. with a group of residents revealed:
*They had not gotten choices for meals.
*They would be served the main meal option, and if they had not wanted it they would be told what the alternative was and could choose then.
*They did not know the alternative options until they turned down the main item.
*They would have liked to had choices and had the alternatives posted on the menu.
*If they did not want the main dish, alternative meal option, or soup then they had to wait until the rest of the residents were served.
*They were not able to recall a time the staff had asked them what they wanted prior to meal services.
*The meal was never served at 6:00 p.m.
  -It was usually 6:20 p.m. or 6:30 p.m. before it was served.
  *They would like the meal to have been served atconst-j0001e72ed68f-19 truncated time.

Interview on 3/28/18 at 2:43 p.m. with the administrator regarding meal service revealed and confirmed:
*They had complaints of beverages being served warm, so they had changed that system.
*The meal was served late due to the change in the beverage system.
*She knew the meals were not served on time.
*Residents had not gotten a choice for their meal.
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<tr>
<td>F 565</td>
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<td>Continued From page 4 meals until they refused the main meal item. *The alternative meal option was not listed on the posted menu.</td>
<td>F 565</td>
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<td>1) The facility reviewed and revised the following care plans: #60 To reflect the presence of pressure ulcer to her left heel.</td>
<td>5/11/18</td>
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<tr>
<td>F 657</td>
<td>SS=D</td>
<td>Care Plan Timing and Revision CFR(483.21(b)(2)(i)-(iii))§483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</td>
<td>F 657</td>
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<td>2) Residents with presence of pressure ulcers, at risk for altered skin integrity and pressure ulcers and those with noted focus areas have the potential to be affected.</td>
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<td>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to update</td>
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<td>3) Director of Nursing or designee will educate professional nurses on need for careplanning of presence of pressure ulcers; appropriate interventions are implemented to prevent skin alterations or pressure ulcers and focus areas of congestive heart failure.</td>
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<td>ANTI COAGULATION THERAPY, INSULIN R/T DIABETES. DIURETIC TREATMENT RELATED TO HEART FAILURE and respiratory distress have adequate information noted in interventions to monitor the focused area.</td>
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<td>4) Reviewed and revised as needed all residents' care plans with pressure areas or at risk for skin alterations or breakdown to ensure presence of careplans related to skin. Reviewed and revised resident care plans with congestive heart failure, anticoagulation therapy, insulin r/t diabetes, diuretic treatment related to heart failure and respiratory distress to validate resident-specific information is noted to monitor the noted focus areas.</td>
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| F 657 | Continued From page 5 and revise care plans for 3 of 18 sampled residents (8, 28, and 60). Findings include:  
1. Review of resident 60's medical record revealed she had developed a pressure ulcer to her left heel on 3/12/18. Her care plan had not been updated to reflect that information. Refer to F686, finding 1.  
Surveyor: 38557  
2. Review of resident 8's 12/5/17, 2/14/18, and 3/16/18 care plans for skin integrity and pressure ulcers revealed a gap in documentation with no preventative interventions for a resident with a history of pressure ulcers. Refer to F686, finding 2.  
Surveyor: 39190  
3. Review of resident 28's undated care plan revealed she:  
*Was admitted on 11/10/17.  
*had two hospitalizations, and her last readmission date was 1/31/18.  
*had focus areas for: congestive heart failure, anticoagulant therapy, insulin r/t (related to) diabetes, diuretic therapy r/t heart failure, and respiratory distress.  
*Interventions and tasks such as:  
**"Labs as ordered.  
-Monitor blood sugar, lab results as ordered by physician.  
-Administer medication per physician orders."  
-Interventions and tasks were not resident specific.  
-Did not have adequate information to provide interventions and methods to monitor above areas.
| F 657 | 5) Unit Managers/designee will audit 5 careplans per week x 4 weeks to validate appropriate interventions have been implemented to prevent skin alterations/breakdown; pressure ulcers have been acknowledged; and listed focus diagnoses have resident-specific interventions in place. QAPI MEETS MONTHLY. AUDITS WILL BE BROUGHT TO MEETING FOR REVIEW BY THE QAPI TEAM. AT THIS TIME A DECISION WILL BE MADE FOR THE AUDITS TO CONTINUE OR TO BE RESOLVED.  
6) Director of Nursing will take audit results to monthly QAPI for review and further recommendations. |
Continued From page 6

4. Interview on 3/29/18 at 7:50 a.m. with the minimum data set (MDS) nurse regarding care plans revealed:
   * The initial care plan was created from the nurses admission assessment.
   * The first of the year they had started a new process with the care plans where if a resident was admitted and then discharged upon return to the facility, the care plan had to be completely regenerated.
   * Previous to the first of the year the care plan could be used from before.
   * The nurses were not comparing the previous care plan to the current care plan.
   * Interventions and tasks had not been brought forward.
   * Care plans were not complete.
   * She stated resident 25's care plan would be corrected today.
   * She had been reviewing them upon quarterly review, resident 25 had been in and out of hospital, so her care plan had not been reviewed at this time.
   * She agreed the areas of insulin/diabetes, anticoagulant therapy, cardiac diagnoses, and respiratory distress did not have adequate information to provide interventions and methods to monitor those areas.

Surveyor: 32335
Review of the provider's March 2018 Interdisciplinary Care Planning policy revealed:
   """The patient's [residents] care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs.
   * It also identifies the types of methods of care that the patient should receive.
   * The care plan should focus on:
**MANORCARE HEALTH SERVICES**

| F 657 | Continued From page 7  
|       | -Preventing avoidable declines in function.  
|       | -Managing patient risk factors.  
|       | -Preserving and building on patient's strengths.  
|       | -Patient's goals and individualized preferences.  
|       | -Evaluating care and progress toward goals.  
|       | -Respecting the patient's right to decline treatment.  
|       | -Using an interdisciplinary approach.  
|       | -Involving the patient and family.  
|       | -Planning to care to meet the patients needs.  
|       | -Involving direct care staff.  
|       | *The care plan should:  
|       | -Include patient-specific measurable objectives and time frames.  
|       | -Include collaboration with other agencies that provides services to the patient (i.e. hospice or dialysis) including who provides that service.  
|       | -Describe the services that the facility is to provide.  
|       | -Describe any services that the patient should have, but refuses.* |
| F 686 | Treatment/Svcs to Prevent/Heal Pressure Ulcer  
| SS=E | CFR(s): 483.25(b)(1)(i)(ii)  
|       | §483.25(b) Skin Integrity  
|       | §483.25(b)(1) Pressure ulcers.  
|       | Based on the comprehensive assessment of a resident, the facility must ensure that-(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable, and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. |
F 686 Continued From page 8

This REQUIREMENT is not met as evidenced by:
By: Surveryor 39190

Surveyor: 32335

Based on observation, interview, record review, and guideline review, the provider failed to ensure interventions were in place for two of three sampled residents (8 and 60) who developed pressure ulcers. Findings include:

1. Interview on 3/27/18 at 2:11 p.m. with licensed practical nurse (LPN) E and the administrator regarding the list of residents with pressure areas revealed:
   *Three out of the seven residents had suspected deep tissue injuries (SDTI).*
   *If the area was deep purple or the blister was blood filled, it would indicate it was a deep tissue injury.*
   *The Braden Risk Assessment tool was completed on the computer.*
   *The Pressure Ulcer Scale for Healing (PUSH) tool was completed on paper.*
   *The registered nurses staged the skin areas.*
   *They had identified resident 60's left heel had a SDTI due to the blister being filled with blood.*

Observation and interview on 3/27/18 at 2:38 p.m. with LPN D and the director of nursing (DON) revealed:
   *They were completing a dressing change to resident 60's left heel.*
   *The resident was sitting in her wheelchair.*
   *She had a wound vac on the outer side of her left foot.*
   *They were not to do anything with that at that time, as she had just returned from an appointment for it.*

4) Will re-educate professional nurses on the utilization and completion of the Braden scale to identify the risk level for skin breakdown of residents, and implementing careplanning appropriate interventions to prevent pressure ulcers/skin breakdown by 4/27/18.

5) CNA's B and C were re-educated on the location and viewing of resident careplans and their role in alleviating pressure ulcers or worsening of pressure areas.

6) Will re-educate nurse aides on their role in alleviating pressure ulcers or worsening of current ulcers and the availability of the interventions on the resident Kardex by 4/27/18.

7) Unit managers or designees will audit 5 care plans per week x 4 weeks to reflect appropriate interventions have been implemented to prevent pressure ulcers based on admitting and quarterly Braden score or presence of pressure ulcer. QAPI meets monthly; audits will be brought to meeting for review by QAPI team. At this time a decision will be made for the audits to either continue or to be resolved.

8) Unit managers or designees will audit 5 membeers from the nursing department (professional nurse or or CNA) to confirm they are aware of and can locate interventions on kardex and careplans.

5 MEMBERS OF THE NURSING DEPARTMENT (PROFESSIONAL NURSE OR CNA) WEEK X 4 WEEKS. QAPI MEETS MONTHLY, AUDITS WILL BE BROUGHT TO MEETING FOR REVIEW BY THE QAPI TEAM. AT THIS TIME A DECISION WILL BE MADE FOR THE AUDITS TO EITHER CONTINUE OR TO BE RESOLVED.

9) Director of Nursing will take audits to monthly QAPI meeting for further review and recommendations.
F 686  Continued From page 9

*The orders were for a foam dressing and betadine.

*She had a heel protector on her left foot.

*The SDTI was approximately the size of a quarter.

-it was unopened but dark purple and black in color.

*It had developed while she had been a resident in the facility.

Observation on 3/27/18 at 4:15 p.m. of resident 60 revealed she was in her room visiting with a visitor. She was sitting up in her wheelchair.

Observation on 3/27/18 at 5:14 p.m. of resident 60 revealed she was propelling herself in her wheelchair going to the dining room.

Observation on 3/28/18 at 8:39 a.m. of resident 60 revealed she was in therapy.

Review of resident 60's medical record revealed:

*Her admission date had been 1/17/18.

*Her diagnosis included:

-Personal history of diabetic foot ulcer.

-Unspecified injury of unspecified kidney, initial encounter.

-Other specified sepsis.

-Charcot's arthropathy.

-Chronic kidney disease, stage 4.

-Acidosis.

-Hypokalemia.

-Mantle cell lymphoma, unspecified site.

-Type 2 diabetes mellitus with diabetic chronic kidney disease.

-Peripheral vascular disease, unspecified.

-Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified.

*Upon admission she had the following skin
**MANORCARE HEALTH SERVICES**

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| F 686               | Continued From page 10  
concerns:  
-G- Coccyx: opened area 3 centimeters (cm) x (by) 2.5 cm.  
-G- Groin: redness.  
-L- Left groin: pin point incision 0.1 cm x 0.1 cm.  
-B- Bottom left ulcer: 5 cm x 2 cm x 1.5 cm.  
-R- Right foot: lateral aspect, excoriated area 8 cm x 2.2 cm.  
Review of resident 60's 1/24/18 Braden Scale for Predicting Pressure Sore assessment revealed her score had been seventeen indicating she was at risk for developing pressure ulcers.  
Review of resident 60's undated care plan revealed interventions for the current left foot ulcer and for potential skin breakdown had been:  
*N* Nutrition supplements two times per day initiated on 1/24/18 and revised on 3/11/18 by the registered dietician.  
*A* Administer treatment per physician's orders.  
*R* Report evidence of infection such as purulent drainage, swelling, localized heat, increased pain, etc. Notify physician prn (as needed) initiated on 1/17/18.  
*F* For wound care, treat wound as needed. Currently had magg therapy with nursing staff to reinforce dressing as needed only, initiated on 2/22/18.  
*E* Encourage to reposition as needed, use assistive devices as needed, initiated on 1/17/18 and revised on 3/13/18.  
*P* Pressure redistributing device on bed/chair per facility protocol, initiated on 3/13/18.  
*P* Provide preventative skin care routinely and prn, initiated on 3/13/18.  
*They* had been no interventions for the left heel pressure ulcer or the use of the heel protector. | F 686 | | |
MANORCARE HEALTH SERVICES

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| F 686 | Continued From page 11 | Interview and record review on 3/29/18 from 9:58 a.m. through 9:35 a.m. with LPN E and the DON regarding resident 60 revealed:  
*The left heel pressure ulcer or SDTI had developed on 3/12/18.  
*They thought it had developed because her heel rested on the foot pedal.  
*She had to hold her foot at a different angle due to the wound vac on the side.  
*She had not had a heel protector on at that time.  
*She had worn a gripper sock on that foot.  
*The heel protector had been initiated after the left heel pressure ulcer had been found.  
*She was not one to lay down throughout the day and was very active.  
*A progress note indicated the physician had been notified, but there were no physician's orders in her record.  
*At 9:32 a.m. we went into LPN E's office for her to look as she thought she remembered writing it down.  
*She could not locate the physician's order for treatment.  
*The DON stated the process was to write the phone order, put it in the resident's chart, and send off the part to the doctor to have it signed.  
*They could not find that part.  
*The left heel pressure ulcer had not been on the care plan.  
*They both agreed it should have been.  
Surveyor: 38557  
2. Interview on 3/27/18 at 10:22 a.m. with resident 6 revealed:  
*She knew she had a "bed sore on her backside."  
*She did not know why it had developed.  
*There had not been any pain.  
*It had caused her pain once when the adhesive from a dressing was being removed.  
*She was mostly numb from the waist down; not | F 686 | | | | | |
Continued From page 12

a new condition.

-Staff were aware that she had limited sensation from the waist down.

*She was able to readjust herself in her wheelchair, but she forgot because it did not hurt.

-Staff did not remind her to readjust herself.

-She was able to demonstrate how she could reposition herself but stated that if she were to lean too far forward she would lose control of her upper body and fall out of her wheelchair.

Review of resident B's medical record revealed:

*An admission date of 3/25/17.

*Diagnoses included but were not limited to:

- Early onset cerebellar ataxia.

- Muscle weakness.

- Need for personal care.

- Unspecified dorsiagia.

* A 3/23/18 cognition score of fifteen indicated she had intact cognition.

* Her initial 3/25/17 Braden Scale for Predicting Pressure Sore Risk score had been nineteen indicating she had no risk of developing pressure ulcers upon admission.

Review of her initial 3/25/17 care plan revealed:

* A focus area: "At risk for alteration in skin integrity related to: impaired mobility fracture of right wrist" had the following interventions:

- Observe skin conditions with activities of daily living and report abnormalities.

- Use pressure redistributing device on bed/chair.

- Provide preventative skin care routinely and as needed.

* The above focus area had been resolved on 9/1/17 resulting in no care plan to address skin integrity.

Review of her Braden Scale for Predicting...
Continued From page 13

Pressure Score Risk scores for the following revealed:

*For 7/18/17 and 10/2/17 had scores of sixteen indicating she had been at risk.
*For 12/5/17 had a score of twelve indicating high risk.

Review of her 12/5/17 Pressure Ulcer Healing Chart form revealed:

*A pressure ulcer was now present.
*The length times width had been 3.1 to 4.
*The exudate amount had been light.
*The tissue type had been epithelial.

Review of her 12/5/17 care plan revealed:

*She had a stage two pressure ulcer to the right buttock related to decreased mobility and decreased sensation.
*Interventions had included:
  -To assist with repositioning her in wheelchair and when in bed.
  -Complete a daily body audit.
  -To receive dietary supplements.
  -To encourage her to lie down during the day to reduce pressure to coccyx.
  -She had voiced agreement in lying down one hour per day.
  -Offer a whirlpool on shower days to help with circulation.
  -Place a pressure redistributing mattress on the bed and cushion to the wheelchair.

Review of the 1/30/18 Pressure Ulcer Healing Chart form revealed the pressure ulcer had resolved.

Review of the 12/5/17 care plan revealed it had been resolved on 1/30/18; there had been no care plan for skin integrity.
Review of her 2/14/18 care plan revealed:

* A new focus area for risk of alteration in skin integrity: related to history of pressure ulcers, impaired mobility, and incontinence had been initiated.

* Interventions included:
  - Barrier cream to perineal area/buttocks as needed.
  - Encouragement to reposition as needed and use of assistive devices as needed.
  - Observation of skin condition with activities of daily living and report abnormalities.
  - Use of pressure redistributing device on bed and chair.

Review of the 3/16/18 Braden Scale for Predicting Pressure Sore Risk tool revealed a score of twelve indicating high risk.

Review of 3/16/18 Pressure Ulcer Healing Chart form revealed:

* A pressure ulcer was now present.
* The length times width had been 2.1 to 3.
* The exudate amount had been none.
* The tissue type had been epithelial.

Review of the 3/16/18 care plan revealed:

* She had a stage two pressure ulcer to the right buttock related to decreased mobility and decreased sensation.

* Interventions had included:
  - A daily body audit.
  - Dressing changes as ordered.
  - To encourage resident to lie down during the day.
  - Offer a whirlpool on shower days.
  - Use a pressure redistributing support surface-air pressure mattress on bed and "ish-dish" cushion.
**MANORCARE HEALTH SERVICES**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
400 8TH AVENUE NW
ABERDEEN, SD 57401

### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
</table>
| F 686         |               | Continued From page 15 to wheelchair. **Interview on 3/27/18 at 3:52 p.m. with RN unit manager A regarding resident 8 revealed:**
|               |               | *She had been admitted on 3/25/17 with no pressure ulcers.*
|               |               | *She had not been at risk on her initial assessment but should have been due to decreased feeling/sensation in her lower body, and because she was often wet due to incontinence.*
|               |               | *Some preventative measures had been put into place.*
|               |               | *She had not been as talkative when she had first been admitted to the facility, so she might not have told her about the decreased sensation in her lower extremities.*
|               |               | *She had then developed a stage two pressure ulcer.*
|               |               | *A new care plan had been developed to reflect the stage two pressure ulcer to the right buttock related to decreased mobility and decreased sensation.*
|               |               | *When the pressure ulcer had closed on 1/30/18 she had stopped the treatment on that day.
|               |               | -She felt she could have continued the treatment longer.*
|               |               | *She did not know why there had not been preventative measures in place between 1/30/18, when the first pressure ulcer had been resolved, and 2/14/18 when the skin integrity care plan had been re-initiated.*
|               |               | -She agreed there should have been a skin integrity care plan after the first pressure ulcer had healed.*

Surveyor: 39190
**Observation on 3/28/17 at 1:45 p.m. of resident 8's pressure ulcer revealed:**
MANORCARE HEALTH SERVICES  

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** 435004

**X2 MULTIPLE CONSTRUCTION**
- **A. BUILDING:**
- **B. WING:**

**X3 DATE SURVEY COMPLETED:** 03/29/2018

**NAME OF PROVIDER OR SUPPLIER:** MANORCARE HEALTH SERVICES

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
- **460 5TH AVENUE NW**
- **ABERDEEN, SD 57401**

---

**044 ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION):**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>055 COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 686</td>
<td>Continued From page 16</td>
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<tr>
<td></td>
<td>*She was lying on her left side, and had been in bed lying down to allow pressure relief to coccyx.</td>
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<tr>
<td></td>
<td>*The dressing had been removed prior to observation.</td>
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<tr>
<td></td>
<td>*The wound on the coccyx was almost healed.</td>
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<tr>
<td></td>
<td>*Area was cleansed with wound cleanser.</td>
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<td></td>
<td>*Hydrocolloid dressing was applied per physician order.</td>
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</tr>
</tbody>
</table>

**Surveyor:** 38557

**Interview on 3/29/18 at 7:23 a.m. with the DON regarding resident 8 revealed:**

*All newly admitted residents had a skin assessment completed.
*A skin care plan would have been developed for every new resident.
*It was not as individualized towards her specifically as it could have been.
*If a skin issue were to develop another care plan would have been created.
*She agreed after the first pressure ulcer had healed they should have created an in-depth, individualized care plan to prevent further pressure ulcers.

**Observation and interview on 3/29/18 at 9:50 a.m. with resident 8 revealed:**

*She was lying on her left side in bed with a pillow propped under her back and hip area.
*She was watching her television.
*She stated she was laying down, because it was good for her bottom.
*She had agreed to lie down more often.
*She did not like to lay down.
*Some days they asked her to lay down, and some days they did not.
*She did like whirlpools.
*If she sat in her wheelchair too long she could sometimes feel burning in her buttocks.
<table>
<thead>
<tr>
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<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 686 | Continued From page 17 | F 686 | Interview on 3/29/16 at 10:00 a.m. with certified nursing assistant (CNA) B revealed:  
*When residents had skin issues she was informed through verbal report.  
*Resident 8 was one resident they encouraged to lay down.  
-It was over a month ago that she was informed resident 8 needed to lay down every day.  
*They carried a sheet with residents' names and the type of assistance needed.  
-The sheets did not address if the residents had skin issues.  
Interview on 3/29/18 at 10:05 a.m. with CNA C revealed:  
*She did not usually work on the hall resident 8 resided on.  
*Verbal report had informed her resident 8 should have been encouraged to lay down.  
-There were other instructions had been given to her regarding her skin interventions.  
-She was not aware she should have encouraged resident 8 to reposition herself in her wheelchair.  
3. Interview on 3/29/18 at 10:10 a.m. with RN unit manager A revealed:  
*All different nurses were currently completing the Braden Scale for Predicting Pressure Sore Risk tool.  
*A new MDS coordinator had recently been hired, and she would be doing the quarterly assessments to promote consistency.  
*Communication to CNAs had been given during the daily verbal report.  
-There was also a communication book and an area to leave a communication note at the nurses station. |
**MANORCARE HEALTH SERVICES**

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<th>ID TAG</th>
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</thead>
</table>
| F 686  | Continued From page 18  
Surveyor: 32335  
Review of the providers January 2013 Skin Practice Guide revealed:  
*The Braden assessment provides data on general pressure ulcer risk and assists clinicians to plan care accordingly.  
*The subscale scores provide information on specific deficient’s such as moisture, activity, nutrition, and mobility.  
*Those areas could have been specifically addressed in the care plan.  
*Upon completing an evaluation, the interdisciplinary team develops a patient specific care plan to include prevention and management interventions with measurable goals. | F 686  |  |  |

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>PROVIDER/SUPPLIER/CIL/A IDENTIFICATION NUMBER</th>
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<tr>
<td></td>
<td>436004</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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**STREET ADDRESS, CITY, STATE, ZIP CODE**

408 8TH AVENUE NW  
ABERDEEN, SD 57401

**DATE OF SURVEY COMPLETED**

03/29/2018
E 000 Initial Comments

Surveyor: 32335
An initial health survey for compliance with 42 CFR Part 483, Subpart B, Emergency Preparedness requirements for long term care facilities, was conducted from 3/26/18 to 3/29/18. ManorCare Health Services was found in compliance.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Darcy Albrecht

TITLE
Administrator

DATE
04/16/2018

RECEIVED
APR 16 2018
SD DOH-OLC
**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/Clinical Lab Identification Number</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
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<tbody>
<tr>
<td>435004</td>
<td>A. Building 01, 02</td>
<td>03/27/2018</td>
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<tr>
<td>B. Wing</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Name of Provider or Supplier</th>
<th>Street Address, City, State, Zip Code</th>
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<tbody>
<tr>
<td>ManorCare Health Services</td>
<td>400 8th Avenue NE ABERDEEN, SD 57401</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>(X4) ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>(X5) Completion Date</th>
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<tbody>
<tr>
<td>K 000</td>
<td></td>
<td>Initial Comments</td>
<td>K 000</td>
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</table>

Surveyor: 14180
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/27/18.
ManorCare Health Services (building 01) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2012 LSC for existing health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.

Surveyor: 14180
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/27/18.
ManorCare Health Services (building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2012 LSC for existing health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.

Laboratory Director's or Provider/Supplier Representative's Signature:

Darcy Abrecht

Title: Administrator

04/16/2018

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 above deficiency and findings are due to the facility 14 days following the date these documents are made available to the facility. If deficiencies are cited, evacuation plan correction is required to continued program participation.
<table>
<thead>
<tr>
<th>ID</th>
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<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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</tr>
</thead>
<tbody>
<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement</td>
<td>S 000</td>
<td>Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44.73, Nursing Facilities, was conducted from 3/26/18 through 3/29/18. ManorCare Health Services was found in compliance.</td>
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