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	43A067	A. BUILDING _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM	3515 BROADWAY AVE YANKTON, SD 57078

(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
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities, was conducted from 7/13/21 through 7/14/21. SD Human Services Center - Geriatric Program was found in compliance.	E 000		
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/13/21 through 7/14/21. SD Human Services Center - Geriatric Program was found not in compliance with the following requirements: F686, F761, and F880.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, for one (18) of two residents	F 686	F686: Resident 18's treatment plan was reviewed and revised; the problem for skin impairment was updated to reflect a pressure ulcer with an associated goal. An intervention for repositioning was added. Physical therapist was consulted for updated wound care recommendations including dressing options and skin interventions. Dietician was consulted for updated dietary recommendations. Resident 18 was referred outside the facility to a wound specialist for treatment recommendations. Resident 18's Braden Pressure Ulcer Risk Assessment score was recalculated. The charge nurse of each unit will be the assigned wound nurse for their unit. In their absence, another charge nurse will be assigned to cover. The charge nurses will be educated on wound assessment at a mandatory training where they will sign for thier attendance. Charge nurses will be required to demonstrate competency in wound assessment.	8/4/21 8/23/21

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

Amelia Henderson, NHA | Program Director | 08/06/2021

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 686	Continued From page 1 with facility-acquired pressure ulcers the provider failed to: *Ensure the stage two pressure ulcer had not worsened. *Reassess the pressure ulcer treatment to prevent worsening of the ulcer. *Develop/modify a pressure ulcer care plan with interventions to prevent worsening of the ulcer. Findings include: 1. Interview on 7/13/21 at 10:00 a.m. during an initial tour with registered nurse (RN) charge nurse J regarding resident 18 revealed she: *Had a facility-acquired pressure ulcer on her right buttock that had recently worsened. *Had stated: -The ulcer began as a Stage 2 (partial thickness skin loss). -The skin surrounding the open area had now become discolored. --They began measuring the wound itself and the large discolored area because it was worsening. -Her doctor had discussed her pressure ulcer with RN charge nurse that morning and had decided to consult a surgeon to review treatment options. Observation and interview on 7/13/21 at 10:15 a.m. with resident 18 revealed: *She was lying on her bed. *A pillow was lying next to the right side of her back. -The pillow was not providing pressure relief. *She: -Stated she had a pressure ulcer and wanted to know how to make it heal. -Had a walker in her room. -Moved very slowly and repositioned herself in	F 686	All nurses will be re-educated on how to calculate Braden scores and on pressure ulcer care through required reading and a knowledge test. Policies were reviewed and revised to include: *Assigned wound nurses will be required to demonstrate competency in wound assessment annually. *All nurses will receive pressure ulcer education annually. *When a new pressure ulcer is identified, the provider will assess, consult with physical therapist and dietician, prescribe treatment, and identify interventions to prevent worsening. *The charge nurse or designee will update the treatment plan to include a pressure ulcer with interventions to prevent worsening of the ulcer and an intervention for repositioning. *The provider will assess any pressure ulcer and review the treatment plan weekly until it has healed. All staff will be educated on policy changes at a mandatory meeting where they will sign for thier attendance. Providers will be educated on policy changes through required reading. When physical therapist or dietician receives a consult for a pressure ulcer, they will use a newly developed form to track the date of each consult and follow-up until the pressure ulcer has healed. A copy of the form will be provided to the QAPI nurse at the end of each month. Physical therapist and dietician will receive education on the tracking process through required reading.	8/23/21 8/4/21 8/23/21 8/23/21

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F 686	Continued From page 2 very small increments on the bed. Observation and interview on 7/14/21 at 1:55 p.m. with RN I during a wound measurement and dressing change for resident 18 revealed: *RN I measured the wound at 2.5 centimeters (cm) by (X) 1.1 cm x 0.3 cm deep. *The yellow/white eschar (dead skin tissue) covering the ulcer had begun to detach leaving an opening large enough to allow the nurse to measure the depth with the cotton end of a cotton-tipped applicator. *RN I stated: -The pressure ulcer had worsened to a stage 3 (full thickness tissue loss). -There was a new closed dark purple area that was also on the right buttock below the stage 3 ulcer. --That area was identified on 7/6/21. -The staff were to have encouraged her to reposition herself every two hours because she was able to get out of bed by herself and walk. -The dietitian followed her and she received Juven (a dietary supplement) twice daily for protein. -The total wound circumference had been measured as 6 cm X 4 cm including the red surround on 7/13/21. -The wound had a foul odor. *RN I applied an Aquacel Extra/Optifoam dressing. Review of resident 18's Skin Status Record for Wounds weekly flowsheet revealed: *The initial pressure ulcer had been identified as Stage 2 on 2/3/21 and measured 2.0 cm X 0.5 cm. -An Optifoam dressing was applied.	F 686	The QAPI nurse or designee will audit each new pressure ulcer for provider assessment, consultation with physical therapist and dietician, treatment plan update, and a repositioning intervention for 100% compliance for a minimum of 6 new pressure ulcers. After monitoring of 6 new pressure ulcers demonstrating expectations are being met, auditing frequency will be reviewed and determined by the QAPI committee and Medical Director. The QAPI nurse or designee will audit existing pressure ulcers for provider assessment, physical therapist and dietician follow-up, repositioning intervention, and treatment plan reviews/revisions for 100% compliance at a minimum of weekly for 4 weeks. After 4 weeks of monitoring demonstrating expectations are being met, monitoring will be reduced to twice monthly for one month. After one month of twice monthly monitoring demonstrating expectations are being met, monitoring will be reduced to monthly. After two months of monitoring demonstrating expectations are being met, auditing frequency will be reviewed and determined by the QAPI committee and Medical Director.	

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F 686	Continued From page 3 -Interventions included a ROHO cushion (decreases amount of pressure, allows air flow aids in weight distribution) and pressure reduction mattress. *On 2/11/21 the wound measured 2 cm X 3 cm total, with a 2 cm X 0.9 cm eschar center. -The wound dressing had changed to Aquacel Extra and Optifoam. *Weekly wound documentation from 2/11/21 through 4/27/21 indicated: -Scant drainage. -Slight odor at times. -A consistent white center with red or pink surround. -Wound measurements were not consistent, ranging between 3 cm X 2 cm to as small as 0.4 cm X 0.1 cm. *Juven was added on 2/23/21 for protein. *On 5/11/21 the total wound area was documented as 2 cm X 1 cm with the white center at 0.2 cm X 0.1 cm. -The wound color had changed to beefy red with a white center. *From 5/25/21 through 6/15/21 the pressure ulcer was documented as closed. *On 6/22/21 wound documentation indicated the total area had increased to 2 cm X 2 cm, with the white center measuring 2 cm X 1 cm. -The wound was draining. *On 6/29/21 the total area measured 3 cm X 4.5 cm. -The color was red with a yellow center. -The yellow center measured 2.7 cm X 1 cm. -The wound was identified as a Stage 3 pressure ulcer. -There was a foul odor. *On 7/6/21 the above documentation and measurements remained the same.	F 686		

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F 686	Continued From page 4 -There was a foul odor. *On 7/13/21 the total wound measurement was 6 cm X 4 cm. -The yellow/white center measured at 3 cm X 1.8 cm X 1 cm deep. -There was a foul odor. The above pressure ulcer interventions had not been updated for: *Use of a pressure-reducing mattress and ROHO chair cushion since the wound was identified. *The wound dressing since 2/11/21. *Dietary changes since 2/23/21. Review of a new 7/6/21 Skin Status Record for Wounds flowsheet belonging to resident 18 indicated: *On 7/6/21 a Stage 1 (a discolored, non-blanchable area of skin) pressure ulcer was identified below the first wound on her right buttock. The area: -Measured 3 cm X 2 cm. -Was closed and purple purple. *A 7/13/21 documentation of the wound indicated there was no change in measurements or color. *The interventions identified for the above wound on 7/6/21 and 7/13/21 had been: -Aquacel/Optifoam dressing. -Juven. -Pressure reduction mattress. -ROHO cushion. Review of resident 18's requested physician progress notes requested from the date the pressure ulcer was identified through 7/14/21 revealed: *A 2/11/21 Physical Therapy (PT) progress note revealed:	F 686		

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F 686	Continued From page 5 -She was referred for wound care recommendations. -The wound measured 3 cm X 2 cm with center eschar of 2 cm X 0.9 cm. -There were "two layers of eschar." --The center was more firm to the touch. -Recommendations included: --Aquacel Extra covered with Optifoam or Allevyn dressing. --Staff and patient education regarding the importance of repositioning including wedges when in bed for sidelying to offload to the left side. --Dressing changes weekly and as needed. --PT to follow up with the patient and nursing and make any further recommendations. -Goals to have been met in one month: --the resident would be compliant with repositioning when in bed. --The wound would decrease in size and show increased granulation tissue. --The resident would have no further areas of skin breakdown. *A 4/20/21 recertification summary by certified physician assistant (PA-C) K revealed: -Her Braden Pressure Ulcer Risk Assessment score was 19 (indicating there was no risk for a pressure ulcer). -She has dark pink area below her breasts. --A treatment was ordered for that. -Resident 18 was reviewed for medical and psychiatric needs during rounds with PA-C K, her psychiatrist, and RN/charge nurse J. -There was no mention of her pressure ulcer. *A 6/15/21 recertification summary by PA-C K revealed: -She "does have an area to her right buttock that was open, but in assessing it today, it is closed.	F 686		

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F 686	Continued From page 6 But that area is quite small, but still now, although the skin area is closed, there is a darker pigmentation of almost bluish purplish at the area and at this time, we are going to continue with observing that and watching that closely for the next week." -She walked slowly with a walker. --She had previous orders for physical therapy but she was refusing to go so therapy was discontinued. -Staff assisted her in toileting during the day because she was incontinent of bowel and bladder at times. -There was discussion with PA-C K, physician M, and RN/charge nurse J regarding medical and psychiatric concerns during rounds. -There were no order changes. *A 6/21/21 recertification summary by resident 18's physician M revealed: -"She was seen today, June 15, in doctor's rounds." -The physician also seen on the unit after rounds. -She was incontinent of bowel and bladder and required the assistance of one staff. -There was an open area on her right buttock that opened at times, but was closed on June 15. -There were no order changes. No further PT or physician notes had been provided when they were requested. Review of Resident 18's Treatment Plan regarding her pressure ulcers revealed: *A problem indicating the resident was at risk for skin impairments. -The skin impairment problem area had not been updated to add the pressure ulcer. *The goals were to have no skin breakdown due	F 686		

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F 686	Continued From page 7 to pressure or incontinence. *5/4/21 Interventions included: -Weekly skin assessments. -Head to toe assessments checking pressure areas with hygiene care. -Protecting the skin from contamination. -Avoiding friction and shearing. -Staff were to have checked her skin with toileting. -The nurse was to have checked her legs and feet daily. -"Continue to keep pressure off areas and monitor for breakdown." *ROHO cushion. *Aquacel and Optifoam dressing. Change weekly with a bath and as needed. *On 7/6/21 "To right lower buttock" had been added. *The problem had not indicated the resident had pressure ulcers. *The skin impairment treatment plan had not included a repositioning intervention. *A self-care deficit revealed "[Resident 18] is independent with repositioning, transfers, and mobility." Review of the nursing pressure ulcer progress notes regarding communication with the PA-C or physician revealed the communication had been documented on 3/16/21, 3/23/21, 3/30/21, and 5/4/21. Record review and interview on 7/14/21 at 3:50 p.m. with RN/charge nurse J, RN I, and RN L regarding resident 18's pressure ulcer treatment revealed: *RN/Charge nurse J and RN I confirmed the pressure ulcer had worsened.	F 686		

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F 686	Continued From page 8 *The pressure ulcer treatment had not been revised for: -More appropriate dressing options. -Updating skin interventions. *The treatment plan: -Had not identified the problem as a pressure ulcer. -Had not addressed repositioning the resident. *RN/charge nurse J confirmed the pressure ulcer dressing had not been updated. -She was not sure why changes had not been made in the treatment. *RN I stated the resident's pressure ulcer had changed slowly and then rapidly declined from a Stage 2 to a Stage 3. -She confirmed the pressure ulcer had been present for five months. *RN L stated the most recent pressure ulcer education for the nursing staff had occurred in March 2019. *RN/charge nurse J confirmed: -The provider did not have a specified wound nurse. -The nurse who was assigned to the floor did the wound assessments for the day. -The wound assessments were not consistent. *RN/charge nurse J stated in regard to physician communication for wounds : -The PA-C came to the floor frequently and visited with the staff. -The communication had not been documented, but it should have been documented. Interview on 7/20/21 at 9:30 a.m. with director of nursing (DON) C confirmed: *The provider had not had a wound nurse since the COVID-19 outbreak. *The nursing staff had not received pressure	F 686		

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F 686	Continued From page 9 ulcer education since March 2019. *Resident 18's facility acquired pressure ulcer had worsened with the current treatment. -The wound treatment had not been updated. Review of the provider's revised February 2021 Skin/Wound Care policies revealed: *Positioning/Turning: -The nurse was to have assessed the patient's condition, ability to change positions independently and skin tolerance to pressure. -A repositioning schedule would be considered for those residents that were immobile, declining health status, needed assistance with position changes, needed reminders to shift weight when sitting or in bed and those residents with the head of the bed or back of the chair raised thirty degrees. -The nurse was to have evaluated residents that could change positions independently and determined if those residents required supportive devices and frequent reminders to facilitate position changes every fifteen minutes. -The nurse was to have initiated a repositioning schedule on residents at risk for skin breakdown and demonstrating the above conditions. -The nurse would direct the staff on the frequency of turning the patient based on their condition and their skin's tolerance to pressure. *Decubitus Ulcer - Prevention and Care: -Prevention and care of pressure ulcers would be provided to treat pressure ulcers. -Prevention had included: --Heel or elbow protectors. --Pillows for positioning. --"Egg crate or alternating pressure mattress, air, gel or water cushions." -The nurse was responsible for informing the	F 686		

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F 686	Continued From page 10 Treatment Team of pressure relieving devices being used to promote skin integrity and for adding the devices to the resident's Treatment Plan. *Follow-up Activities for Decubitus Ulcer: -The resident may require an alternating air mattress. -Nursing directive to institute repositioning schedule for turning may be required. -The dietitian was to have been notified of pressure ulcer concerns. -Inspect the bed linen and bed clothes to ensure they were clean, dry, and wrinkle-free. *Documentation and reporting: -The pressure ulcer was to have been assessed and documented for the size, appearance, any edema, inflammation or tenderness surrounding the ulcer, any type of drainage, any topical agent used daily or at the nurse's discretion. -Any worsening of the ulcer's condition was to have been reported to the charge nurse or physician/PA-C. Review of the provider's revised 9/4/18 Treatment Plan policy revealed: *A comprehensive Individualized Treatment Plan was to have been based on patient's strength, needs, input, and prepared with the participation of the resident, family or legal appointed decision maker, when possible. *The Geriatric Treatment Plan was to have shown all active treatment methods and interventions used to treat and care for the resident. *The physician provided the final approval for the treatment plan. *Problems/needs were to have been identified fro the psychiatric and psychological evaluations,	F 686		

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F 686	Continued From page 11 nursing assessments, or psychosocial assessment for the Treatment Plan. *All problems were to have been written in observable, behavioral, descriptive terms to facilitate measurable goals. *Ask for the resident's input to incorporate into the Treatment Plan. *Goals were written based on identified problems. *The plan was to have included methods and interventions, specific treatment approaches utilized, responsibilities of each member of the treatment team. *Progress notes were to have reflected progress/performance/status/and condition of the resident. -They should describe changes in the resident's status related to physical, medical, emotional or behavioral issues/concerns. -The frequency of the progress note depended on the condition of the resident.	F 686		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761	F761: Locks to medication rooms will be changed. One key will be provided to each unit; the key will be handed off nurse-to-nurse and counted with the sharps count at shift change. Two additional keys will be stored in each Omnicell and available to be signed in and out by authorized and licensed personnel. All authorized and licensed personnel will be educated on the new process through a mandatory meeting where staff will sign for thier attendance. QAPI nurse or designee will audit all med room door locks daily to ensure they can only be accessed with the new key every day until 100% compliance has been met.	8/23/21

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F 761	Continued From page 12 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Three of three medication rooms were kept secured from access of unauthorized and unlicensed staff. *Medication room keys were kept secure. Findings include: 1. Observation on 7/13/21 at 10:00 a.m. on the Spruce 2 resident unit of maintenance supervisor A revealed he opened the medication room with a key. He was showing the life safety surveyor around the building. Surveyor: 32332 2. Interview on 7/14/21 at 2:30 p.m. with RN charge nurse J regarding the medication room keys revealed: *All nurses and med aides have their own medication room keys. *They took the medication room keys home with them at the end of their shift. *The medication rooms had secured automated medication machines, but there were also medications in the medication room that were not	F 761	QAPI nurse or designee will audit for 100% compliance at a minimum of weekly for 4 weeks. After 4 weeks of monitoring demonstrating expectations are being met, monitoring will be reduced to twice monthly for one month. After one month of twice weekly monitoring demonstrating expectations are being met, monitoring will be reduced to monthly. After two months of monitoring demonstrating expectations are being met, auditing frequency will be reviewed and determined by the QAPI committee and Medical Director: *The sharps count for the med room key and *a report from Pharmacy that indicates what times the extra keys were dispensed from the Omnicell, who dispensed the key, and when the key was returned to the Omnicell to ensure the spare keys are being used as intended by med aides and charge nurses for no longer than the duration of their shift.	

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	43A067	A. BUILDING _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SD HUMAN SERVICES CENTER - GERIATRIC PROGRAM	3515 BROADWAY AVE YANKTON, SD 57078

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F 761	Continued From page 13 locked in a drawer. *She confirmed maintenance supervisor A should not have had the authority to enter the medication room alone. Surveyor: 26632 3. Interview on 7/14/21 at 6:45 p.m. with administrator B and director of nursing C confirmed: *All nurses and medication aides have a key to the medication rooms. *The maintenance department also had access to the medication rooms. *Those keys were kept by each nurse, medication aide, and maintenance person unless they terminated their employment. *The nurses and medication aides took the medication keys home with them after their shifts. Surveyor: 32332 4. Review of the provider's revised January 2017 Issuing of Employee Keys policy revealed: *It was the policy that the control of keys would be maintained for safety and security of patients, staff, and property. *Keys were issued by the Physical Plant Manager or designee. *Employees were to have been issued only those keys necessary to complete job responsibilities.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880	F880: 1. Administrator, Director of Nursing (DON), and Infection Control nurse (ICN) were provided education/re-education by SD QIN QI Advisor on 8/2/21. Administrator, DON, and Medical Director reviewed policies for hand hygiene, equipment cleaning and glucometer cleaning, and policy on infection control, prevention and surveillance. Policy on cleaning multi-patient use equipment was revised to be more specific on when and how to clean and disinfect equipment. Policy on hand hygiene was revised to include hand hygiene prior to donning gloves.	8/2/21 8/6/21

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F 880	Continued From page 14 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under	F 880	All staff who provided above care and services to residents will be educated/re-educated by 8/23/21 by Administrator, DON, and Staff Development at a mandatory meeting where they will sign for thier attendance. 2. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by 8/23/21 by Administrator and DON at a mandatory meeting where they will sign for thier attendance. 3. Root Cause Analysis was completed on 7/29/21. Hand hygiene and gloving during resident care was missed because policy was not followed, new staff, new staff with an existing CNA license had not demonstrated competency to SDHSC, staff were distracted, no recent auditing was completed, and hand sanitizer stations are not conveniently located. Appropriate cleaning and maintenance of mechanical lifts was missed because policy was not followed, new staff, staff were distracted, it was not being audited, and disinfectant was not readily available. Appropriate cleaning and maintenance of multi-resident use glucometer was missed because policy was not followed, established process was inefficient, staff was distracted, it was not being audited, and disinfectant was not readily available. Administrator, DON, ICN, and Medical Director will ensure All facility staff responsible for the assigned tasks(s) have received education/ training through a mandatory meeting where they will sign for thier attendance and demonstrate competency. Administrator, DON, and ICN contacted the South Dakota Quality Improvement Organization (QIN) on 8/2/21 and discussed root cause analysis findings, infection control re-education for all staff; utilizing real-time audits; auditing tools; making hand sanitizer and disinfecting wipes more convenient to avoid staff interruption by attaching disinfecting wipes to mechanical lifts, adding disinfecting wipes to glucometer caddies, and having hand sanitizer stations outside each resident's room; using a disposable barrier to set glucometer caddies on; and communication tools.	8/23/21 8/23/21 7/29/21 8/23/21 8/2/21

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F 880	Continued From page 15 the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Two of five observed certified nursing assistant (CNA) (D and E) had performed hand hygiene and glove changes during one of five observed sampled residents (47) personal care. *Sanitizing of the total body lift between resident use by one of one observed CNA (D). *Sanitizing of the glucometer between each resident use by one of one observed registered nurse (RN) (H) to monitor blood sugar levels. Findings include: 1. Observation on 7/13/21 at 2:48 p.m. of CNA D and E while they provided personal care to	F 880	4. Administrator, DON, ICN, and designees will conduct auditing and monitoring for appropriate hand hygiene and glove use during provision of personal care, appropriate cleaning and maintenance of mechanical lifts, and appropriate cleaning and maintenance of multi-resident use glucometer(s) at a minimum of weekly for 4 weeks. After 4 weeks of monitoring demonstrating expectations are being met, monitoring will be reduced to twice monthly for one month. After one month of twice monthly monitoring demonstrating expectations being met, monitoring will be reduced to monthly. After two months of monitoring demonstrating expectations are being met, auditing frequency will be reviewed and determined by the QAPI committee and Medical Director. Any staff that is unable to attend mandatory trainings, complete required readings, and demonstrate competencies as assigned by 8/23/21 will be required to complete them before thier next working shift. Corrective Action: 1. Time cannot be turned back to a time prior to the identification of lack of: *Appropriate hand hygiene and glove use during provision of personal care. *Appropriate cleaning and maintenance of mechanical lifts. *Appropriate cleaning and maintenance of multi-resident use glucometer(s). Administrator, Director of Nursing (DON), and Infection control nurse (ICN) were provided education/re-education by [whomever determined as outside facility by title not name] on date.	

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F 880	Continued From page 16 resident 47 revealed: *CNAs D and E entered the room with the full body lift. *With no hand hygiene they put on gloves. *They used the full body lift to transfer him from his wheelchair to his bed. *Without changing their gloves CNA D and E: -Removed his pants and unfastened his incontinence brief. -CNA D then provided perineal care. -Resident 47 had been incontinent of a large amount of stool. -They then repositioned him onto his right side. -While CNA E held onto the resident CNA D continued to clean him and then removed his incontinence brief. -CNA E then went to the residents closet and took a disposable underpad. -CNA D placed this on the end of the bed and placed the soiled incontinence brief and soiled cleansing wipes on top of it. -CNA D continued to provide perineal care. -CNA D removed her gloves, took the disposable underpad she had set the soiled incontinence brief and wipes on, and placed it in the garbage can. There was no garbage bag in the garbage can. -Without any hand hygiene or putting on a new pair of gloves CNA D assisted to put on a new incontinence brief and pull his pants up. -CNA E removed his gloves and did not do any hand hygiene. -CNA E moved the residents wheelchair into the bathroom. -CNA D took the full body lift to the shower room. She did not sanitize the lift. -Upon returning to the resident's room CNA E had placed the garbage into a garbage bag. He	F 880	The Administrator and DON in consultation with the Medical Director and ICN and whomever else identified will review, revise, create as necessary policies and procedures about: *Appropriate hand hygiene and glove use during provision of personal care. *Appropriate cleaning and maintenance of mechanical lifts. *Appropriate cleaning and maintenance of multi-resident use glucometer(s). *Necessary infection control and prevention plan that includes effective compliance. All staff who provided above care and services to residents will be educated/re-educated by date by whomever [title, not name]. Identification of Others: 2. All residents have the potential to be affected if staff do not adhere to: *Appropriate hand hygiene and glove use. *Appropriate cleaning and maintenance of multi-resident use equipment. All staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by date by whomever [title, not name]. System Changes: 3. Root Cause Analysis conducted answered the 5 Whys: [Do include what	

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F 880	Continued From page 17 then washed his hands and picked up the garbage bag and carried it to the shower room. He did not sanitize his hands after. -CNA D then washed her hands. Interview on 7/14/21 at 10:04 a.m. with registered nurse (RN)/clinical support manager F and RN/infection control preventionist G revealed: *Both CNAs D and E had missed opportunities for hand hygiene and glove changes. *Were not sure if they had a policy and procedure for sanitizing the lifts between residents. Review of the provider's 3/23/21 Handwashing Technique and Use of Hand Sanitizers policy revealed hands were to have been cleansed: *Before caring for a resident. *After: -Giving care to a resident or handling the residents equipment. -Following the removal of gloves. -Handling body secretions. Review of the provider's 1/26/21 Mechanical Lifts policy revealed all surfaces should have been wiped with human services center (HSC) approved germicidal solution per HSC policy. 2. Observation on 7/13/21 at 4:50 p.m. of RN H obtaining blood sugar tests revealed she: *Entered resident 44's room and obtained the test results. *Picked up the glucometer and exited the room. *Entered resident 50's room with the same glucometer without disinfecting the glucometer obtained his test results. *Picked up the glucometer and exited the room.	F 880	you learned from the Root Cause Analysis] Administrator, DON, ICN, Medical Director and any others identified as necessary will ensure All facility staff responsible for the assigned task(s) have received education/training with demonstrated competency. Whomever [title, not name] contacted the South Dakota Quality Improvement Organization (QIN) on date and include brief detail of discussion. Monitoring: 4. Administrator, DON, ICN, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 4 weeks, Administrator, DON, and/or ICN making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for two months. Monitoring results will be reported by	

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F 880	Continued From page 18 *Entered the medication room and disinfected the glucometer with a Sanicloth disinfectant wipe. Interview at the above time with RN H regarding the glucometer disinfection revealed: *The above glucometer was used for all residents who required blood sugar testing. *RN H normally disinfected the glucometer one time, after all the residents' blood sugar testing had been completed. *She confirmed she should have disinfected the glucometer after each resident had been tested. Interview on 7/20/21 at 9:30 a.m. with the director of nursing confirmed the glucometer was to have been disinfected between each resident use. Review of the provider's revised May 2021 Blood Sugar Testing/Accu-chek policy regarding cleaning the Accu-chek glucometer revealed the nurse was to have: *Put on gloves. *Used an approved germicidal disinfecting wipe to thoroughly clean the glucometer after each resident use. *Disposed of the wipe after one use. *Allowed the glucometer to air dry after the approved disinfectant contact time. *Remove gloves and wash hands.	F 880	Administrator, DON, and/or ICN to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and Medical Director. Corrective Action Date: 8/11/21	

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/13/21. South Dakota Human Services Center - Geriatric Program was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/13/21. South Dakota Human Services Center - Geriatric Program was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Amelia Henderson, NHA | Program Director | 08/06/2021

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.

South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/13/21 through 7/14/21. SD Human Services Center - Geriatric Program was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/13/21 through 7/14/21. SD Human Services Center - Geriatric Program was found in compliance.	S 000		

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

Amelia Henderson

TITLE: Program Director

(X6) DATE: 07/26/2021

STATE FORM 6899 U5RD11 If continuation sheet 1 of 1