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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTCHMAN LIVING CENTER	503 WEST PINE PHILIP, SD 57567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/25/22 through 10/27/22. Scotchman Living Center was found not in compliance with the following requirements: F609 and F880.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 11/18/2022

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 609	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (2) with a fall resulting in an injury had: *Completed a thorough investigation of the fall with injury. *Notified the South Dakota Department of Health (SD DOH) of a reportable incident. Findings included: 1. Observation and interview on 10/25/22 at 12:04 p.m. in resident 2's room revealed she: *Was sitting in her wheelchair leaning to the right side. *Had a soft wrist splint on her right wrist. *She had asked the certified nursing assistant (CNA) to put her earrings on. *She stated: -Her arthritis made it difficult for her to put her earrings in. -She had numerous falls. --One of the falls caused her to end up in the hospital with a broken hip. -She was unable to stand or walk because of her broken hip and right knee. --They were using a mechanical lift to transfer her. -She had fallen and broken her right wrist which was why she was wearing a wrist splint. Review of resident 2's medical record revealed: *An admission date of 10/10/17. *She had diagnoses of arthritis, back pain, degenerative joint disease, osteoarthritis, osteoporosis, and right knee pain. *She had falls documented on 4/4/22, 6/2/22, and on 6/24/22.	F 609	The Administrator or designee will ensure all incidents will be investigated and reported according to regulation. The Administrator or designee will communicate resident 2's right wrist injury to the Department of Health. The Director of Nursing or designee will educate nursing staff to ensure they understand the policy to report and investigate all resident incidents. The Director of Nursing or designee will monitor incident reports for three months to ensure incidents are properly investigated and reported according to regulation. This includes incident reporting as required to the department of health. The Director of Nursing or designee will report findings to the Quality Assurance Team for three months for further recommendation.	11-23-22

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F 609	Continued From page 2 -The 4/4/22 fall resulted in a hospitalization with a distal femur [thigh bone] fracture with a fracture extending to the previous knee replacement. *There were no further falls documented since 6/24/22. *There was a 10/20/22 physician's order for a right wrist brace for two weeks. Review of resident 2's 10/17/22 quarterly Minimum Data Set (MDS) assessment revealed: *A Brief Interview for Mental Status examination score of fifteen indicating she was cognitive. *She required extensive assistance of two staff for bed mobility, transfer, and toilet use. *She: -Used a wheelchair for locomotion. -Had fallen in the past month and the past two to six months. -Had a fracture in the past six months from a fall. -Was on a restorative nursing program. Review of resident 2's 8/10/22 care plan revealed: *She had a high risk for falls "related to limited mobility and desire for independence." *The goal was to have no major injuries from falls. *Interventions included: -"Call light within reach and encourage the resident to use it." -"Fall risk evaluation completed upon admission and then quarterly or with any significant change in Status." -"PT (physical therapy)/OT (occupational therapy) screen will be sent after any fall." --"Staff to conduct hourly rounds monitoring the 4Ps-Pain-Potty-Position-Possessions." *There were no interventions on the care plan related to her right wrist splint.	F 609		

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F 609	Continued From page 3 *"Staff to use Hoyer lift with all transfers. If resident refuses, she may self-transfer with no staff assist." Review of resident 2's 10/19/22 Fall Risk Evaluation revealed she had not been coded as having any falls in the past 90 days. Interview on 10/26/22 at 2:20 p.m. with MDS nurse K regarding resident 2's falls and right wrist injury revealed: *They didn't know if or when resident 2 had fallen because she could not have gotten up by herself. *There was no documentation or staff reports she had fallen. *They were surprised she had a ligament tear on her right wrist. Interview on 10/27/22 at 2:00 p.m. with director of nursing B regarding resident 2's falls and right wrist injury revealed: *They were unaware of how the injury occurred to her right wrist. *There was no documentation of what had happened. *After she had read the physician's report, she was surprised about resident 2's right wrist injury. *She confirmed resident 2's right wrist injury: -Was an injury of unknown origin. -Had not been reported to the SD DOH. -Should have been reported to the SD DOH. Interview on 10/27/22 at 3:00 p.m. with physician L regarding resident 2's right wrist injury revealed due to her multiple falls and arthritis the right wrist injury had arthritis with progressive deformity with a tear. Review of the provider's July 2021 Accidents and	F 609		

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F 609	Continued From page 4 Incidents Investigation and Reporting policy and procedure revealed: *Policy: -"All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator." *"Procedure: -"1. The Nurse Supervisor/Charge Nurse and/or the department director or shift supervisor shall promptly initiate and document the investigation of accident." *It had not included the process on reporting to the SD DOH. Review of the provider's September 2019 Fall Prevention and Management policy revealed "If resident has a significant injury notify the SD DOH."	F 609		
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 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	F 880	The administrator, Director of Nursing, or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for wound care, protective barrier, and change of an incontinence brief. The Director of Nursing, or designee will educate nursing staff regarding appropriate procedural wound care, protective barriers and changing an incontinence brief.	11-23-22

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F 880	Continued From page 5 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 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.	F 880	All residents have the potential to be affected by appropriate procedural techniques during dressing changes. Root cause analysis is completed for the dressing change noted. The root cause identified the barrier was not included in the dressing change "kit" or supplies. The Director of Nursing or designee will add the barrier to the "kit". The Director of Nursing or designee will educate nursing staff regarding the system change and ensure nursing team members demonstrate competency. The Administrator contacted the QIO. Lori Hintz, discussed the infection control process and root cause analysis. Lori Hintz will provide additional infection control resources. The Director of Nursing or designee will utilize these resources to educate nursing team members. The Director of Nursing or designee will monitor one resident dressing change weekly for a month, then monitor one dressing change monthly for three months to ensure proper technique. The Director of Nursing or designee will report results to the quality assurance team monthly for three months for further recommendation.	11-23-22

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F 880	Continued From page 6 §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, and policy review the provider failed to ensure: *A protective barrier was placed under a wound prior to a dressing change for one of two sampled residents (15). *A clean brief had been applied after dressing change for one of two sampled residents (12). 1. Observation and interview on 10/26/22 at 10:45 a.m. of resident 15's dressing change with registered nurse (RN) E revealed: *The resident laid on top of his bedspread. *Registered nurse E had not placed a barrier between the bedspread and his legs. *RN E confirmed after the dressing change she should have placed a barrier between resident 15's legs and the bedspread. 2. Observation and interview on 10/26/22 at noon of resident 12's dressing change with RN E revealed: *The resident was laying on her right side with a brief on. *RN E opened the left side of residents brief and lowered it below the coccyx area and folded the brief over onto itself and exposed an open wound with no dressing on it. -She applied a clean dressing to the wound,	F 880		

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F 880	Continued From page 7 unfolded the brief and reapplied it. -She confirmed she should have changed resident 12's brief. Interview on 10/26/22 at 12:30 p.m. with RN E revealed she should have changed resident 12's brief. Interview on 10/27/22 at 10:30 a.m. with director of nursing B regarding the above dressing change she confirmed: *Resident 15 should have had a barrier placed between his legs and the bedspread. *Resident 12 should have had a clean brief placed on after the dressing change. Review of the revised December 2019 Wound Care Protocol revealed "All wound care will be performed, at a minimum, using clean technique to prevent cross-contamination."	F 880		

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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 10/25/22 through 10/27/22. Scotchman Living Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 11-15-2022

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	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**10/26/2022**

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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 10/26/22. Scotchman Living Center 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: CEO — (X6) DATE: 11-15-2022

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South Dakota Department of Health

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	10661	A. BUILDING: _____ B. WING _____	10/27/2022

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SCOTCHMAN LIVING CENTER	503 W PINE POST OFFICE BOX 790 PHILIP, SD 57567

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/25/22 through 10/27/22. Scotchman Living Center was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview the provider failed to ensure nine of nine required dietary trainings (food safety, handwashing, food handling and preparation, food-borne illnesses, serving and distribution policies, leftover food handling, time and temperature controls, nutrition and hydration, and sanitation) were completed by five of five dietary staff (F, G, H, J, and M) for calendar year from 10/1/21 through 10/27/22. Findings include: 1. Interview on 10/26/22 at 11:59 a.m. with dining director D regarding training for dietary employees revealed they used a online based training program. Interview on 10/27/22 at 3:07 p.m. with administrator A revealed: *Dining director D was responsible to ensure the	S 301	The Dining Services Director or designee will assign the required education to staff ensuring all required food handling education is completed. The Dining Services Director or designee will monitor staff education records for three months to ensure the required education is complete. The Dining Services Director or designee will report audit findings to the quality assurance team monthly for three months for further recommendation.	12-16-22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 11-15-2022

South Dakota Department of Health

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S 301	Continued From page 1 training had been completed. *They used an online based training program and in-person training. *He, previous to this interview, had not been aware the training had not been completed. *He was aware they should have provided the ongoing required training. *He confirmed the training had not been completed. 10/27/22 Dining director D was not available for a follow-up interview. Review of provider's June 2018 food handling policy revealed, "3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents."	S 301		
S 000	Compliance/Noncompliance Statement 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 10/25/22 through 10/27/22. Scotchman Living Center was found in compliance.	S 000		