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

PRINTED: 05/04/2021
FORM APPROVED
OMB NO. 0938-0391

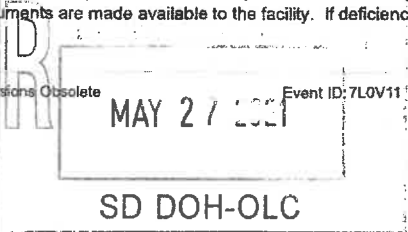
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A075	A. BUILDING ______ B. WING ______	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 40053 An initial certification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/19/21 through 4/21/21. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: F584, F585, F661, F677, F679, F755, F812, F837, F842, and F880.	F 000	Submission of this Response and Plan of Correction (POC) is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute and should not be interpreted as an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the statement of deficiencies .	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	Accordingly, the Facility has prepared and submitted this Plan of Correction for these deficiencies prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law hat mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Without waving the foregoing statement, the facility states that with respect to: F 584- 1, 3, 4, 5 : Wheel chairs for residents # 7,13, 15,32,188 were deep cleaned on 4/23/2021 and repairs were made on all wheel chairs as needed to allow for proper cleaning and removal of dirt or food particles. Housekeeping carts and equipment will be cleaned each day by housekeeper using the cart or equipment. Environmental Services manager or designee will do daily walk through inspections to ensure cartsand equipment are clean at the end of each day.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michael Christensen
TITLE Administrator AMENDED
(X6) DATE 5/14/2021 5/25/2021

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 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Surveyor: 40053 Based on observation, interview, and policy review, the provider failed to ensure: *Routine cleaning and maintenance for five of five observed resident wheelchairs (7, 13, 15, 32, and 188). *A clean and homelike environment in three of twelve sampled resident rooms (2, 15, and 25). *One of one observed housekeeping cart had been cleaned. *Secure personal storage was available to one of one sampled resident (2). Findings include: 1. Observation on 4/20/21 at 9:24 a.m. of resident 15 in his room revealed: *The covers of both armrests on his wheelchair (w/c) were covered with cracks. *Food remnants were stuck to the wheelchair seat cushion and it was stained. *There were six empty pop cans and two empty	F 584	2.Wheel chairs for some other residents were deepcleaned and repairs were made on wheel chairs including arm rests, seat cushions, and other repairs as needed to allow for proper cleaning and removal of dirt or food particles. DON will do weekly review of wheel chairs for cleanliness and repair needs with Environmental Services Manager Physical Therapist (PT) will complete weekly inspection of wheel chairs and walkers to identify needed repairs or replacement parts on arms rests, cushions, brakes, and wheels and to ensure that chairs remain clean and free of soil, debris or stains. PT will report what wheel chair needs cleaning or repair to environmental services and findings will be reported to the QAPI committee by the PT at the monthly QAPI meeting. 6. Resident 25 room and bed frame was deep cleaned and food remnants, floor and bedside table were cleaned. All other patients may be at risk so all other resident bed frames, bedside tables and rooms were thoroughly cleaned Staff will make sure that there are no food trays left in the rooms and that spills are cleaned up.Nurses will report spills to the housekeepers so they can clean any spills or food on the floor and the metal bed frames. Staff will make sure that the bedding will be changed on every resident on days specified as resident bath days or when they become soiled so residents are not laying on dirty bedding that have dried food on them	4/23/2021 4/23/2021 4/27/2021 4/27/2021 4/27/2021

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F 584	Continued From page 2	F 584		

vienna sausage cans on the television stand.

Observation and interview on 4/20/21 at 9:46 a.m. with housekeepers K and M revealed:
*The entire black plastic bottom base of the housekeeping cart was dark gray with dust and dirt.
*They stated resident rooms were cleaned daily.
-That included sweeping, damp mopping, dusting, cleaning the bathroom, removing garbage, and cleaning over the bed tables.

Observation on 4/20/21 at 10:00 a.m. of resident 15's room after it had been cleaned revealed six empty pop cans and two empty Vienna sausage cans remained on the television stand.

2. Observation on 4/20/21 at 10:10 a.m. of resident 188's wheelchair revealed there were areas of dark colored, dried looking dust, dirt, and food all over the metal frame of that wheelchair.
Surveyor: 40788

3. Observation on 4/19/21 at 6:15 p.m. of resident 7's w/c revealed:
*The side panels below the arm rests were broken bilaterally.
*Where the side panels had screwed into the arms of the chair there was still plastic present with sharp edges.
*Dried liquid and food debris, and dust all over the w/c.
*W/c cushion had some dried white areas which appeared to be a dried liquid or food substance.

4. Observation on 4/20/21 at 8:56 a.m. of resident 13 sitting in his w/c revealed
*The arm pads on the w/c were cracked and peeling. They were no longer a cleanable surface.

Provider's Plan of Correction (F 584):

~~Staff will report this to the DON when needed and the DON and Environmental Services Manager will monitor to ensure sheets are changed appropriately. Results will be reported to QAPI meeting monthly by DON.~~ — 4/27/2021

NURSING STAFF WILL REPORT WHEN SOILED LINENS HAVE BEEN CHANGED TO THE DIRECTOR OF NURSING
DIRECTOR OF NURSING WILL AUDIT EVERY ROOM FOR CLEAN SHEETS WEEKLY AND REPORT TO QAPI MEETING MONTHLY FOR 3 MONTHS — **5/25/2021** ***MHC***

ENVIRONMENTAL SERVICES MANAGER WILL AUDIT CLEANING OF ALL RESIDENT ROOMS , BEDS AND FURNITURE EVERY WEEK AND WILL REPORT RESULTS TO QAPI MEETING MONTHLY FOR SIX MONTHS — **5/25/2021** ***MHC***

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F 584	Continued From page 3 *The metal parts on the w/c were covered with dust and dried food particles. 5. Observation on 4/20/21 at 9:05 a.m. of resident 32's w/c sitting in the hallway revealed: *Coban was wrapped around the arm pads on the w/c. -The Coban was worn, dirty, and not a cleanable surface. *Appeared the part of the arm rest pads that could be seen were cracked and peeling. *The seatbelt was covered in dried food. *W/c cushion was covered with dried food particles. 6. Observation on 4/20/21 of resident 25 while he was sleeping in his bed revealed at: *9:01 a.m.: -He was laying on top of a fitted sheet and a absorbent pad covered with another absorbent pad. -There was a food tray on his bedside stand with a half empty plate. -There was food spilled on the floor and bed frame. *9:08 a.m. certified nursing assistant L entered the room and removed the food tray. She had not cleaned up the food on the floor or the bed frame. *9:47 a.m. housekeeper K was in the room cleaning. -She had cleaned the food of the floor but not the bed frame. *10:42 a.m.: -The fitted sheet he was laying on had dried food and liquid on it. -The top of bedside stand was partially covered with a dried sticky liquid and also contained: --An uncovered bowl of what appeared to be chocolate cake or a brownie.	F 584		

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F 584	Continued From page 4 --An uncovered frosted cupcake. --Small snack size chocolate bars. Some wrapped and some unwrapped. --Unopened bag of chips and bag of Ritz cracker snacks. --Opened can of Coke. --Bottle of hand sanitizer. --Water cup with straw. --Opened package of personal care wipes. -There had been dried food and liquid all over the tops and bottoms on his shoes that he was wearing in the bed. -There was tissues, food particles, dirt, and dust on the floor under his bed. -There was an empty plastic cup, a lid to a water cup, food particles, and a newspaper on the floor under and behind the bedside stand. -Between the bed and bedside stand there had been two plastic sacks, one on top of the other, they contained bottles of water, chips, and other miscellaneous food items. 7. Observation and interview on 4/20/21 at 10:23 a.m. with resident 2 regarding the cleaning of his room revealed: *The room was cluttered with several open and new food items sitting on the bedside stands, dresser, and over bed table. *The surfaces of both of his bedside stands and his over bed table had area that had been sticky, dusty, and covered with dried food particles. *The floor appeared to have dirt and dust on it. There had been a sticky area next to the bed. Under the bed there was visible food particles and dirt. *The dresser and bedside stand had some cracks and chips on the surface making them uncleanable surfaces. *The wall by the bathroom had some holes and	F 584		

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F 584	Continued From page 5 sheet rock was damaged making it uncleanable. *The fan on his bedside stand was filthy with dirt and could see the dust particles blowing in the wind. *He was told if he had a fan he was responsible to clean it him self and if he did not keep it clean it would be taken away. *He said housekeeping came in and took out the garbage daily. *Staff did not come in to assist him with organizing or cleaning the tops of dressers, bedside stands, or over bed tables. *He was not able to see well so it had been hard for him to keep his room organized. *At times housekeeping would mop the floor without sweeping it first. *Housekeeping did mop the floors a few times a week. *Housekeeping cleaned his bathroom daily. Surveyor 40053 8. Interview on 4/21/21 at 8:25 a.m. with DON B concerning w/c cleaning revealed: *Wheelchairs were cleaned on Wednesday and Saturday nights. -Even numbered rooms one night and odd the other. *All w/c's were cleaned once a week. *She did not have: -A w/c cleaning schedule or check list. -Documentation that w/c cleaning had been completed. -A w/c cleaning policy. *She stated "I know they are cleaning the wheelchairs." Surveyor 40788 Interview on 4/21/21 at 1:35 p.m. environmental services manager J regarding w/c cleaning and	F 584	7. Rooms for residents # 2,15 and 25 were deep cleaned All other residents were at risk so all rooms were cleaned The wall in Resident 2 room was patched and painted so it can be cleaned the fan in his room was cleaned and washed to remove dirt The environmental services manager will inspect the rooms for cleanliness weekly and Administrator and environmental services manager will do weekly walk though inspection of rooms. DON and Environmental Services manager will also do weekly walk through to inspect room cleanliness. Environmental services manager will report results of monitoring to QAPI committee monthly. **ENVIRONMENTAL SERVICES MANAGER WILL AUDIT CLEANING OF ROOMS WEEKLY AND WILL REPORT TO QAPI MEETING MONTHLY FOR 3 MONTHS** 8. Wheel chairs will be pressure washed and pads, cushions and armrests deep cleaned ~~at least~~ every two months starting 5/17/2021. All chairs will be pressure washed by 5/21/2021 Resident 2 is gone so we cannot ensure personal storage is available to resident 2 . All other residents are at risk so Environmental Services manager will make sure all residents have personal storage available Environmental services manager will check monthly to ensure personal storage remains available for every resident. **WHEELCHAIRS WILL BE PRESSURE WASHED EVERY TWO MONTHS FOR ONE YEAR**	4/27/2021 4/28/2021 5/14/2021 4/25/2021 **5/25/2021 *MHC*** 5/3/2021 **5/25/2021 *MHC***

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F 584 Continued From page 6

maintenance revealed:
*There were written and computerized work orders that any staff was able to complete for w/c maintenance.
-He reviewed those work orders daily.
*All w/cs were inspected monthly by him and a physical therapist.
*He was unaware of the w/c needs of residents 7, 15 and 188.
*The facility had a full inventory of w/c parts including cushions, cushion covers, and armrests.
*W/cs had been pressure washed once every couple months, but that had not occurred during the current pandemic.

9. Continued interview on 4/21/21 at 1:45 p.m. with environmental services manager J regarding housekeeping revealed he:
*Expected housekeeping staff to follow and complete a daily computerized cleaning checklist.
-Individual task frequency varied.
*He was responsible for the oversight of the housekeeping department.
*Knew the housekeeping carts were dirty.
-Cleaning of those carts was not listed on the cleaning checklist.
*Expected all trash including empty food and drink containers were removed when a resident's room was cleaned.
*Stated failure to discard those items had the potential of creating a pest problem.

Review of the provider's May 2018 Housekeeping Job Description revealed:
*"Equipment and Supply Functions:"
-"2. Assure equipment is cleaned and properly stored at the end of the day."
-"4. Report all maintenance issues in a timely

F 584 (Plan of Correction)

ENVIRONMENTAL SERVICES MANAGER WILL AUDIT HOUSEKEEPERS DAILY REPORT FORM WEEKLY FOR SIX WEEKS AND BI-WEEKLY FOR SIX ADDITIONAL WEEKS AND WILL REPORT TO QAPI COMMITTEE — 5/25/2021 *MHC*

ALL RESIDENT ROOMS WILL BE INSPECTED DURING THESE AUDITS — 5/25/2021 *MHC*

9. Environmental services workers will make sure that the resident rooms are clean and the trash is thrown away, that bed rails, night stands and dressers are all wiped down and resident room floors are swept and mopped, and the bathrooms cleaned, stools wiped down, sink wiped down and bathroom floors swept and mopped . Environmental Services manager will ensure that housekeepers complete daily report forms , which they will sign and date when they get done each day. Resident rooms will be inspected weekly by the Environmental Services Manager. Results of these reviews will be provided at the monthly QAPI meeting.

A work order box has been installed by the DON office and a reporting form that people can fill out to report cleaning or equipment repair needs is available near the box. This box is checked every day and the electronic SQSS system is also checked every day for work needing to be completed. The environmental services manager gives the work orders to his maintenance team to perform the work and the work order tickets when completed are placed in a book for retention. The environmental services manager will check this book weekly and will report results monthly to the QAPI committee — 5/10/2021

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F 584	Continued From page 7 manner, make out a work order request for maintenance as directed by supervisor." "Specific Requirements." -"3. Clean/Polish furnishings, fixtures, ledges, room heating/cooling units etc., in resident's and or patients rooms, recreational area, public areas etc. daily and as instructed. -4. Clean, wash, sanitize and/or polish bathroom fixtures. Assure that water marks are removed from fixtures. -5. Clean windows/mirrors in resident's and or patient's rooms, recreational areas, bathrooms and entrance/exit ways. -6. Clean floors, to include sweeping, dusting, damp/west [wet] mopping, disinfecting, etc. Assure appropriate caution/safety signs are properly set up prior to performing duties."	F 584	**ENVIRONMENTAL SERVICES MANAGER WILL BE CHECKING BOOK TO ENSURE THAT ALL WORK IS COMPLETED. AUDIT WILL BE PERFORMED BY ENVIRONMENTAL SERVICES MANAGER WEEKLY FOR SIX WEEKS THEN BIWEEKLY FOR SIX MORE WEEKS AND REPORTED TO QAPI MONTHLY** **ENVIRONMENTAL SERVICES MANAGER WILL EDUCATE NURSING STAFF, RESIDENTS AND HOUSEKEEPING STAFF ON THE USE OF WORK ORDER FORMS AND BOX FOR REPORTING FACILITY OR EQUIPMENT REPAIR NEEDS**	**5/25/2021** ***MHC*** **5/25/2021** ***MHC***
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585	1.Resident 2 was interviewed about missing phone card and a phone card replacement was offered by facility. Resident declined the card and is no longer a resident in the facility as he was discharged to his home. 2.Social Service Designee and DON provided an in-service 05/10/2021 to nursing home staff on how and when to notify Social Service Designee of a grievance. A binder with grievance forms is available at the nurse's station for staff, family or residents to fill out as they desire. This binder will be checked frequently by Social Service Designee.Grievance forms are also available outside DON and Social Service Designee offices. Residents, staff and family may come talk to SSD in person any time they choose, to file a grievance. Residents or their POA will receive a copy of our facility grievance policy and a letter by 05/19/2021 informing them of their right to file a grievance without fear of discrimination or reprisal and instruction on how to file a grievance. Grievance policy and letter will be added into the admit packet for all new residents	5/19/2021

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F 585	Continued From page 8 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585	Grievance policy will be updated to contain an expected time that grievances will be completed. Policy will also be updated with contact information for independent entities whom grievances may be filed with (Local Long-Term Care Ombudsman 1-866-854-5465 and Complaint Coordinator Office of Health Care Facilities Licensure & Certification 605-367-7499). SSD will keep a copy of all grievances filed, steps taken to investigate grievance and the conclusion of the grievance. To ensure grievances are being reported to SSD, two residents and one nursing home staff member per week X 4 weeks, will be asked if they have, received or heard of any grievances and if those grievances have been passed along to SSD (starting the week of 05/10/2021). Then two residents and one staff will be asked every other week X three months, then monthly for three months, and then quarterly thereafter. Different residents and staff will be asked every audit. Monitoring will be completed by SSD and will be reported in QAPI meeting monthly and to CEO monthly X 4 months, then reported quarterly.	5/14/2021 5/14/2021

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F 585	Continued From page 9 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure an investigation and resolution had been completed	F 585		

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for a grievance verbalized by one of one sampled resident (2). Findings include:

1. Observation on 4/19/21 at 3:47 p.m. of resident 2 propelling himself in his wheelchair down the hallway to the shower room with an unidentified staff person revealed he was overheard telling her about his missing phone card.

Interview on 4/19/21 at 4:50 p.m. with resident 2 about his missing phone card revealed:
*He is almost blind so the staff help him load minutes on his cell phone with a phone card.
*He had a phone card that was in his top drawer of his night stand.
*The phone card had been missing for about one to two weeks.
*He had emptied the dresser drawers in his room and could not find it.
*Director of nursing (DON) B had told him a staff person would come help him look for it but no one had come in yet.
*He thought another resident had taken the phone card.
*There is a small safe on the wall in his room for personal items but he did not have access to it.
*He had asked several times for access to the safe and no one had helped him.

Review of resident 2's progress notes had not revealed any notes about his missing phone card.

Interview on 4/21/20 at 10:45 a.m. with DON B regarding resident 2's missing phone card revealed:
*He had told her last week he was missing his phone card, she hadn't heard anymore about it since.
*A grievance form had not been filled out for the

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missing phone card.
*When a resident had a missing item she or staff person D would look for it but usually did not fill out a grievance form.
*The facility only replaced missing clothing items, so would not have replaced his missing phone card.
*Environmental services manager J had helped resident 2 set up access to the safe in his room several times.

Interview on 4/21/21 at 1:40 p.m. with environmental service manager J revealed he:
*No longer had a book to program the safes in the facility so he was not able to get resident 2 access to the safe in his room.
*Had a key to the safe but had not looked into making a copy of the key for resident 2 to use.
*Was aware resident 2 had wanted to use the safe.

Review of the provider's undated Rights and Responsibilities of the Facility form included in the admission packet revealed:
*"While residents are [at] the Facility Bennett County Hospital, Nursing Home & Rural Health Clinic has the duty to and will exercise reasonable care for the protection of Resident property from loss or theft.
*In addition, Facility Resident should also make their best effort within reason to ensure the safety and security of their personal belongings.
-For example, it is not wise to leave large sums of money or other valuables out in the open when the Resident is not in his or her room."

Review of the provider's revised November 2016 Grievance policy revealed:
*"Procedure for registering and resolving

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F 585	Continued From page 12 grievances: a. Register grievance with facility Grievance Officer: [staff person D] b. Grievance officer will discuss problem with patient/resident and anyone else involved to determine validity. Discussion will be individually and collectively. c. If the patient/resident and family are still unsatisfied they will be invited to appear at a Board meeting."	F 585		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements	F 661	1.Nursing home modified it's Policy on Dispensing Pharmaceuticals, #9, to include a clarification on accounting for medications once removed from medication cart and awaiting disposal. This is pertaining to non-narcotic medications. 2.Facility was unable to correct documentation for resident 33 and resident 38 as they were both discharged from facility. All current residents are at risk. Moving forward, the process for medication accountability has been changed in accordance with the new policy. 3.Facility policy was reviewed and updated, to include, "The nurse removing the discontinued/ expired medication from the medication cart shall fill out the "Medication Destruction Form" in the medication cupboard prior to placing the medications in the cupboard. Nurse must fill in the date, patient name, RX number, quantity, medication name, reason for discontinuation, and nurse signature for each medication placed in the medication cupboard." Medication destruction forms were placed in a binder in the medication cupboard with expectations for compliance outlined. Education was provided to nursing staff	4/22/2021

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F 661	Continued From page 13 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on closed record review and interview, the provider failed to document the disposition of discharge medications for two of two sampled residents (33 and 38). Findings include: 1. Review of resident 33's closed record revealed: *She was discharged from the facility on 2/17/21. *There was no documentation to support an accounting of her medications that were returned to the pharmacy. 2. Review of resident 38's closed record revealed: *He was discharged from the facility on 1/31/21. *There was no documentation to support an accounting of his medications that were returned to the pharmacy. Interview on 4/21/21 at 3:45 p.m. with director of nursing B regarding the discharge medication documentation and accounting process revealed: *Non-narcotic discharge medications were placed in a designated cupboard in the medication storage room by nursing staff. -There was no documentation expectation of nursing staff for those medications. *Pharmacy staff retrieved those discharge medications, documented identifying information about them, and destroyed them. *She agreed there was no way to reconcile any discrepancies between those discharge medications placed in the storage room by nursing staff and the same medications accounted for by the pharmacist.	F 661	4.Consultant pharmacist and Director of Nursing will monitor its performance auditing the medication destruction forms for completion at least monthly and report findings to the Quality Assurance and Performance Improvement (QAPI) meetings. 5. The policy and form were implemented	4/22/2021

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F 661	Continued From page 14 -For example, the pharmacist was unable to account for a blister pack of gabapentin that resident 33 should have had. -Without documentation there was no way to support if a blister pack of gabapentin had even been put in the storage room by nursing staff. *She stated there was no discharge medication documentation and accountability policy, but agreed there should have been to protect and hold accountable the nursing staff who had placed discharge medications there.	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on observation, interview, record review, review of documentation survey reports, and policy review, the provider failed to ensure activities of daily living (ADL) which included grooming of hair and fingernails, oral care, bathing, and changing of soiled residents clothes had been provided for nine of twelve sampled residents (2, 3, 18, 25, 28, 32, 37, 138, and 188). Findings include: 1. Admission record review of resident 138 revealed an admittance date of 4/8/21 with diagnoses of carcinoma in situ of rectum, chronic obstructive pulmonary disease, mild persistent asthma, and history of urinary tract infections Observation, interview, and record review on	F 677	1.Resident 138 is no longer in quarantine and has been bathed and groomed including hair care, personal oral care, shaving and nail care. Toiletries have been placed near him so he can reach them and perform personal grooming if desired. 2.Resident 28 personal cares were completed 3.Resident 37 personal cares were completed 4.Resident 3 personal cares were completed 5.Resident 188 personal cares were completed.His clothes were changed to clean clothing. 6.Resident 18 personal cares were completed. His clothes were changed to clean clothing. 7.Resident 32 personal cares were completed.His clothes were changed to clean clothing. 8.Resident 25 personal cares were completed and he was given access topersonal grooming toiletries so he could perform appropriate ADLs. 9.Resident 2 was personal cares were completed and he was given access to personal grooming toiletries so he could perform appropriate ADLs	

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4/20/21 at 9:22 a.m. of resident 138 while in his room revealed:
*An admittance date of 4/8/21.
*He was currently living in the Covid quarantine unit of the facility.
-He would be in that room till his 14 day quarantine period was completed.
--Two days were remaining.
*He was sitting on his bed with a gray sweatsuit on.
-His hair looked disheveled, his face had a considerable amount of gray stubble, and his glasses were smudged.
*He stated he had been unable to find a comb to comb his hair and he had not had a shower or brushed his teeth since he arrived at the facility.
*He thought they were going to give him a shower and shave him when he arrived at the facility but that had not happened.
*He felt he needed assistance with daily personal care.

Continued interview and observation of resident 138's room revealed:
*There were no toiletries available in his bathroom.
*He stated his shaving kit may be in his closet.
*In the closet on the floor was a large cardboard box.
-That box had contained numerous personal items including a blue zipped toiletry bag.
*He stated there were items in the bag that he needed but was unable to get those items out of it.
*He stated, "I need help."

Record review of the bath schedule indicated his bath days were to have been Wednesday's and Saturday's.

F 677

Facility has revised weekly skin assessment to include nail trimming and care, hair grooming, oral care, bathing, charting and shaving on residents 2,3,18,25,28,32,37,138,and188.

All residents are at risk so facility has re-educated nursing on weekly skin assessment to include nail trimming and care,hair grooming, oral care, bathing, charting andshaving on all residents. The facility will ensure that each resident has quality daily ADL for good nutrition, good personal grooming, good personal oral hygiene and personal care through this process

Monitoring will be performed by DON or designee

5/10/2021

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2. Review of resident 28's medical record revealed he:
*Was legally blind, had deafness in both ears, had a history of a brain tumor with radiation, had right arm paralysis and little or no mobility in his lower extremities.
*Needed extensive assistance with one person physical assistance for personal hygiene.

Observations throughout the survey from 4/19/21 from 2:54 p.m. till 7:00 p.m, 4/20/21 from 8:30 a.m. till 6:30 p.m., and 4/21/21 from 11:50 a.m. to 1:30 p.m. of resident 28 revealed his hair was unkempt and greasy and his face remained unshaven.

Record review of the bath schedule indicated his bath days were to have been Monday's and Thursday's.

3. Review of resident 37's medical record revealed he:
*Needed extensive assistance with one person physical assistance for personal hygiene.
*Was totally dependent with two plus person physical assistance for bathing.

Observations throughout the survey from 4/19/21 at 3:09 p.m. till 7:00 p.m., 4/20/21 from 8:30 a.m. till 6:30 p.m., and 4/21/21 from 11:50 a.m. to 1:30 p.m. of resident 37 revealed his hair was unkempt, skin on his arms was dry and flaky, and his fingernails needed to be trimmed due to hanging over his fingertips.

Interview on 4/21/21 at 11:50 a.m. with resident 37 in his room revealed he had his face washed that morning but had not had his teeth brushed or

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had been offered assistance.

Record review of the bathing schedule indicated his bath days were to have been Monday's and Thursday's.

4. Record review of resident 3's medical record revealed he:
*Needed limited assistance with one person physical assistance for personal hygiene.
*Was totally dependent with one person physical assistance for bathing.

Observations throughout the survey from 4/19/21 at 3:59 p.m. till 7:00 p.m, 4/20/21 from 8:30 a.m. till 6:30 p.m. and 4/21/21from 11:50 a.m. to 1:00 p.m of resident 3 revealed his hair was unkempt, his face was unshaven, and his hands had a brown color on his palms and fingertips.

Observation and interview on 4/21/21 at 8:37 a.m. revealed:
*Resident 3 was in the dining room eating breakfast.
-Interim dietary manager (DM) E was sitting at the table with him and stated "he needs a shave."

Record review of the bathing schedule indicated his bath days were to have been Monday's and Thursday's.

Review of the undated bath schedule for residents 3, 28, 37, and 138 revealed no documentation that any of their baths or showers had been given.
Surveyor: 40788
5. Observation on 4/19/21 at 3:54 p.m. of resident 188 in his room revealed he:
*Laid in bed wearing a light blue t-shirt that had

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light brown stains on it.
*The underneath of his nails were rust colored and nail beds had dried material under them.
*His left thumb nail had been partially broken and was jagged.
*He was unshaved.

Observation and interview on 4/20/21 at 10:10 a.m. with resident 188 in his room revealed he:
*Was wearing that same light blue stained t-shirt.
-Stated he had slept in that shirt the night before.
-Said he had clean shirts in his closet and wanted to change into one of them.
-Was provided a clean t-shirt to wear by the surveyor.
*Said he tore his nails if they were jagged.
*Had no razor to shave himself.
-Said staff helped him with that sometimes.

Observation on 04/21/21 at 12:23 p.m. of resident 188 revealed the status of his facial hair and fingernails remained unchanged from the first observation.

Review of resident 188's 4/1/21 through 4/21/21 documentation survey report that had recorded when the resident's activities of daily living had occurred revealed he:
*Had received dressing assistance on 4/9/21, 4/13/21, and 4/15/21.
*Had received personal hygiene assistance including shaving 4/2/21, 4/4/21, 4/9/21, 4/13/21, and 4/15/21.
*Had been bathed on 4/2/21 and 4/4/21.
Surveyor: 41895

6. Review of resident 18's medical record revealed he:
*Was in a wheelchair (w/c) and unable to

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F 677	Continued From page 19 ambulate. *Had functional limitations on one side of his body to upper and lower extremity. *Required limited assistance from staff with dressing and supervision with toilet use, personal hygiene, transfers, and bed mobility. *Required physical help in part of bathing activity. *Was scheduled for a bath on Sundays, Tuesdays, and Fridays. Interview on 4/19/21 at 3:55 p.m. with resident 18 revealed: *The certified nursing assistants (CNA) will skip his bath days and won't tell him they are not going to give him a bath so he waits all day. *His bath days are Sundays, Tuesdays, and Fridays. *He did not get his bath on 4/18/21. *On 4/19/21 he had went to administrator A about missing his bath and then the staff gave him a bath on 4/19/21. *He felt like he misses a bath every week. *He thought that sometimes it was because the provider did not have enough help and at other times the staff just did not want to give him a bath. *He preferred to have a bath three times a week. *He had complained to director of nursing B about it in the past but felt like she did not do anything about it. Review of resident 18's bathing documentation over the last 21 days revealed he had a bath on 4/12/21, 4/16/21, and 4/20/21. 7. Observation on 4/20/21 at 11:33 a.m. of resident 32 revealed he was up in w/c at nurses station, his hair was not combed and his face was not shaved.	F 677		

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F 677	Continued From page 20 Review of resident 32's medical record revealed he: *Was in a w/c and unable to ambulate. *Had functional limitations to bilateral upper and lower extremity. *Was dependent on staff for all of his activities of daily living (ADL). *Was scheduled for a bath on Wednesdays and Sundays. Review of resident 32's bathing documentation over the last 21 days revealed no documentation that he had received a bath. Review of resident 32's ADL documentation over the last 21 days revealed he had only received personal hygiene on 4/2/21, 4/4/21, 4/9/21, 4/12/21, 4/13/21, 4/15/21, and 4/20/21. 8. Review of resident 25's medical record revealed he: *Was independent with all ADLs with the exception of needing physical help in part of his bathing activity. *Was scheduled for a bath on Wednesdays and Sundays. Review of resident 25's bathing documentation over the last 21 days revealed no documentation that he had received a bath. 9. Review of resident 2's medical record revealed he: *Was independent with all ADLs with the exception of needing physical help in part of his bathing activity. *Was scheduled for a bath on Mondays and Thursdays.	F 677		

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Review of resident 2's bathing documentation over the last 21 days revealed no documentation that he had received a bath.

Surveyor: 40053
Interview on 4/20/21 at 11:28 a.m. with staff person D revealed ADL's were completed throughout the afternoons due to it being too busy in the mornings.

Interview with Interim dietary manager E revealed ADL's were completed in the mornings.

Surveyor: 41895
Interview on 4/21/21 at 10:30 a.m. and at 2:26 p.m. with director of nursing B regarding residents' personal care revealed:
*The days residents get a bath are list on the CNA assignment sheets.
*Resident baths are not documented or part of the medical record.
*Expectation was that staff gave the baths as listed on the assignment sheet.
*The provider did have a Point of Care application to document the bathing but she did not have access to add it until recently.
*There had been no way for her to audit that baths had been done as scheduled.
*Shaving and nail care was expected to occur with baths.

Review of the provider's revised August 2002 Bathing policy revealed:
*"It is the policy of this facility that all residents receive a bath at least one time per week.
*Purpose:
-To promote cleanliness and general hygiene.
-To stimulate circulation of the skin.

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F 677	Continued From page 22 -To promote comfort and relaxation. -To observe resident's skin condition. -To assist the resident with personal care." Review of the provider's revised August 2002 Dressing and Undressing Assistance policy revealed: *Purpose: -"To increase self esteem." Review of the provider's January 2019 "Documentation: Assessment, Treatments & Completion of Provider(s) Orders" policy revealed: *"It is the policy of this facility that documentation of all nursing care, observations, assessments, treatments, and effects will be written by an authorized professional. *All documentation is expected to be legible, accurate, understandable, timely, pertinent, and held in confidence."	F 677	The DON re-educated RNs, LPNs, and CNAs on daily and weekly assessment and charting ADL in an in-service training DON or Designee will perform 6 audits weekly for 4 weeks, then monthly X 4 months to ensure daily ADLs, grooming, personal cares, hair grooming, clean clothing and oral care is completed. Results of audits will be reported by DON or designee and discussed at monthly QAPI meeting who will complete further review and continuation or evaluation of auditprocess.	5/10/2021
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Surveyor: 40788	F 679	1.Facility Protocols/ Activity Guidelines were reviewed and revised 5/12/2021 to provide an activity program based on comprehensive assessment and care plan with the preferences of each resident to help meet the interest of and support the physical, mental, and psychosocial wellbeing of each resident. 2. Resident 188, will have his individual needs met by offering him the opportunity for playing horse shoes, watching other resident playing cards, and listening to pow wow music. 3, 4. Resident 8,29,138 were offered activities on a weekly bases that will be shown on the board or calendar weekly by assigning a CNA to complete activities and/orPsychiatric and mental health nurse practitioner asmental health group activities.	

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F 679	Continued From page 23 Based on observation, interview, record review, and policy review, the provider failed to provide an individualized activity program for all thirty-six residents. Findings include: 1. Observation on 4/19/21 at 4:25 p.m. outside the main dining room revealed: *A digital board that identified the following activities scheduled for that day: -9:00 a.m. Coffee -10:00 a.m. Stretch -10:30 a.m. Weights balance -11:30 a.m. Music and reminising at nurse station, coloring -3:00 p.m. Coffee/snack social Review of the activity calendar for that day identified those same activities. 2. Random observations on 4/19/21 from 2:47 p.m. through 6:00 p.m. and on 4/20/21 from 9:00 a.m. through 3:00 p.m. of resident 188 revealed he: *Had not attended an activity. *Watched a television in his room. Review of resident 188's care plan revised on 4/14/21 revealed he had no activity care plan. Interview on 4/21/21 at 12:21 p.m. with resident 188 regarding activities revealed he: *Stated (the facility) "don't have much activities." *Was interested in horses, horseshoes, watching sports, cowboy movies, looking at magazines, pow wows, and watching others play cards. *Disliked bingo and puzzles. 3. Other random resident interviews on 4/19/21 at 4:30 p.m. with resident 29 and on 4/20/21 with	F 679	5.Resident 26 will be offered puzzles and one on one card playing up to several times weekly. 6. Resident 32 will be offered music several times daily and/or visit about his life at mealtimes. These activities will be offered beginning 5/17/2021 7. An In-service will be conducted by the DON and SSD on the new activity program for following staff: Administrator, DON, and activityStaff, and rest of interdisciplinary team All Staff will be educated to start documenting on activities performed with residents Care Plans and Assessments will be reviewed and revised for activities on residents #8, 26, 29, 32 & 38 & 188 All residents are at risk so Facility will review and revise all resident's care plans, quarterly and/or at care team meetings. DON and SSD will educate the CNA's and nurses on where and how to look up resident likes and dislikes and will provide education on individual resident activity charting Monitoring of the activity program will be done by DON or designee performing 6 random audits weekly x4, then 6 audits q 2 weeks then 6 audits monthly. Results of the audits will be reported by DON or designee and discussed at monthly QAPI for further review and recommendation and/or continuation/discontinuation of audits.	 5/16/2021 5/16/2021 5/14/2021

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F 679	Continued From page 24 resident 8 regarding activities revealed: *Resident 29 stated the activity information on the digital board was not correct. *She said "we sit here [outside the main dining room across from the nurses' station] and visit with each other" for activity. *Resident 8 stated "it's depressing" and the lack of activities "can go on for days." Surveyor: 40053 4. Interview on 4/20/21 at 9:19 a.m. with resident 138 revealed: *He was admitted on 4/8/21. -He was isolated due to being on a 14 day new admit Covid quarantine. *The facility had no activities for the residents. *He stated "This is just like jail." 5. Interview on 4/20/21 at 4:42 p.m. with resident 26 in her room regarding activities revealed she: *Mostly stayed in her room. *Spent a lot of her time coloring pictures and watching television. *Felt there were not enough activities available at the facility. *Did not have one on one activities on a regular bases. -Stated "Hardly ever." *Felt they were to short of staff for someone to spend time with her. *Would have liked to have a staff member to do activities with her. *Was interested in playing cards or putting together puzzles. *Stated she would have enjoyed the company. Surveyor: 41895 6. Record review of resident 32 revealed he: *Has short and long term memory impairment with severely impaired decision making skills. *Had diagnosis including: epilepsy, legal	F 679		

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F 679	Continued From page 25	F 679		

blindness, unspecified dementia with behavioral disturbance, unspecified mental disorder due to known physiological condition, chronic obstructive pulmonary disease.
*Was in a wheelchair (w/c) and unable to ambulate.
*Had functional limitations to bilateral upper and lower extremity.
*Was dependent on staff for all of his activities of daily living (ADL).
*Was to participate in musical events such as kids coming to sign, local drum groups when available, offering the radio, 1:1 visits 7 days a week for 15 minutes a day.
-This was documented as not applicable on 3/29/21, 4/13/21, and 4/15/21.
-There was no other documentation noted for activities.

Random observations on 4/19/21 from 2:47 p.m. through 6:00 p.m. and on 4/20/21 from 9:00 a.m. through 3:00 p.m. of resident 32 revealed:
*The resident had not attended an activity.
*There had not been a television or radio turned on when he was in his room or sitting in his w/c by the nurses station.
*Had not seen staff interacting with him.

Review of resident 32's revised 3/5/20 activities care plan revealed:
*"[Resident name] is involved in little or no scheduled activities."
*"Resident is blind which may be a contributing factor."
*"1:1 visits are offered, which he refuses often."
*"He has expressed little interest in any type of scheduled group activities or self initiated or personal activities."
*"[Resident name] will participate in activities of

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F 679	Continued From page 26 choice such sitting by nurse's station, during which he visits with staff every day." *"When [resident name] is sitting by nurse's station, staff to attempt to visit with resident 1:1 during the day to avoid isolation." 7. Interview on 4/21/21 at 2:51 p.m. with activity assistant H revealed: *She had worked at the facility since 4/1/21. *She has not worked with resident 32 because he does not like to participate. *She comes in and does activities with residents Monday through Friday from 1:00 p.m. to 5:00 p.m. and for eight hours on Saturday and Sunday. *When she does an activity with a resident she charts it in the residents progress notes. *Her training included a tour of the facility, introduction to residents, and how to complete her documentation. *She was not required to follow any type of activity calendar. *She could do what ever activity she wanted to do. *Most residents did not participate or did not like the activity she provided so she was thinking of new ideas. *She would often ask residents what they liked to do. *Had a closet of items to use for activities. *She did not know where in the resident medical record to look for residents interests and was unfamiliar with care plans. Interview on 4/21/21 at 1030 a.m. with DON B revealed: *Music is played some times at the nurses station but some residents don't like it. *She was not aware resident 32 liked to listen to music.	F 679		

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F 679	Continued From page 27 *She thought they could probably get a radio to put in resident 32's room. *There was an occupational therapist who helps oversee with staff person D to do some activities with residents. *The occupational therapist comes two to three times a week. *An activity assistant comes and does bingo on Wednesday nights and one day on the weekend. On the weekend she stays longer and also does some 1:1 activities with residents. *They recently hired activity assistant H to help increase activities through out the building. *She had agreed the activities that were posted on the activity calendar were not being offered.	F 679		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755	483.45(b)(3) Requires that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 1.All residents on narcotics were/are at risk. Consultant pharmacist in conjunction with Director of Nursing and nursing staff will audit narcotic count form to ensure documentation of shift narcotic counts are being documented. Nursing staff will be educated on policy and importance of completing documentation. 2.Consultant pharmacist combined narcotic binder with refrigerator temperature check binder so that the process of checking each should be congruent. (Less binders less chances to forget). 3.Consultant pharmacist in conjunction with Director of Nursing will monitor form for completeness. The forms will be evaluated at least monthly for completeness and this will be reported to quality. A quality assessment has been created and will be the joint responsibility of the consultant pharmacist and Director of Nursing. 4.Quality assessment form process was Implemented	5/5/2021

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F 755	Continued From page 28 aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on interview, record review, and policy review the provider failed to ensure all controlled medications had been accounted for at shift changes. Findings include: Review of the March 2021 Narcotic Count Sheet revealed on: *3/1/21 and 3/2/21 there were no signatures indicating the medications had not been accounted for either shift on those days. *The off going staff person for 7:00 a.m. had not signed on 3/3/21 and 3/15/21. *The off going staff person for 7:00 p.m. had not signed on 3/19/21, 3/30/21, and 4/6/21. *The coming staff person for 7:00 p.m. had not signed on 3/14/21, 3/24/21, and 4/10/21. Interview on 4/21/21 at 11:00 a.m. with licensed practical nurse I revealed: *All controlled medications where counted at shift change with the on coming staff person and off going staff person. *After all controlled medications had been counted and accounted for they would both sign the "Narcotic Count Sheet".	F 755	DIRECTOR OF NURSING WILL AUDIT NARCOTIC COUNT FORM TO ENSURE SHIFT NARCOTIC COUNTS ARE DOCUMENTED WEEKLY FOR FOUR WEEKS THEN BIWEEKLY FOR FOUR WEEKS THEN MONTHLY IF NO MORE ERRORS OCCUR AND WILL REPORT TO QAPI COMMITTEE MONTHLY	5/25/2021 *MHC*

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F 755	Continued From page 29 *If the count had been incorrect and all controlled medications could not be accounted for director of nursing (DON) B was to be notified. *He had agreed the Narcotic Count Sheet should have two signatures for each shift. Interview on 4/21/21 at 11: 15 a.m. with DON B regarding controlled medication counts revealed she: *Had expected the controlled medications to be counted at each shift change. *She did not time to audit staff compliance with ensuring they had counted the controlled drugs at shift change. Review of the provider's reviewed April 2021 Dispensing Pharmaceutical policy revealed "Controlled substances will be counted daily by 2 licensed nurses (one nurse from the oncoming shift and one from the off going shift)."	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812	A new Policy has been developed for proper glove use and hand washing in the dietary area. Training on the new policy for all dietary staff was completed Dietary staff and dietary manager completed ServSafe Food Handler course Dietary Manager educated Cook G and all dietary staff on proper hand washing and the proper usage of gloves 5/12/2021 Dietary Manager will follow up with weekly observation X 3 weeks, and observe each staff member 3 X @ week, then 2X @ Week for 2 additional weeks and will continue to educate to ensure glove use is properly performed if errors are observed. Dietary manager will educate dietary staff on proper food handling and will audit weekly X 3 weeks, and observe each staff member 3 X @ week, then 2X @ Week for 2 additional weeks	5/12/2021 5/12/2021

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F 812	Continued From page 30 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Surveyor: 41895 Observation on 4/20/21 at 11:38 a.m. through 12:51 p.m. of cook G serving lunch from the kitchen revealed: *She was wearing gloves and those gloves she had touched multiple surfaces including the serving trays, resident diet cards, freezer door, ice cream bar box, and drawers. *With those same contaminated gloves on she: -Checked the temperature of the food on the steam table. -Dished food onto a plate, touched the minced ham and pushed it to the side of the plate. -Touched the green beans while dishing them into a bowl. -Touched a piece of ham while placing it on another plate. -Touch her face mask four times while dishing up plates. *She removed the gloves and put on a new pair of gloves without washing her hands. *With those gloves on she went into the freezer touching the handle on the door and a box of ice cream bars. *With those now contaminated gloves she went back to dishing food on to plates and: -Touched her mask. -Took a prepackaged meal from an unidentified staff person for an unidentified resident and set in on the counter.	F 812	Results of observation audits will be reported to monthly QAPI committee meeting for further review and recommendation and/or continuation/ discontinuation of audits.	

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F 812	Continued From page 31	F 812		

-Continued to dish food on to plates.
-Touched her mask.
-Touched green beans while dishing them into a bowl.
-Touched her mask.
*She then removed her gloves and walked into the freezer to put ice cream bars away.
*Without washing her hands she had put on a new pair of gloves and:
-Touched her mask.
-Prepared the prepackaged meal for the unidentified resident by adding some water and putting it into the microwave.
-Continued to dish food on to plates.
-Touched her mask.
*She then removed those gloves, washed her hands, and put on a new pair of gloves.
*With that pair of gloves she:
-Continued to dish food onto plates.
-Went to the microwave twice to check on food she was warming.

Interview on 4/20/21 at 4:45 p.m. with cook G regarding the above observation revealed:
*She thought she was required to wear gloves with all her duties in the kitchen.
*She should have washed her hands with each glove change.
*Moving from one task to another in the kitchen would have contaminated her gloves.
*She should not touch ready to eat food with contaminated gloves.

Surveyor 40053
Interview on 4/21/21 at 4:37 p.m. with director of nursing (DON) B regarding expectations of kitchen staff's hand hygiene revealed if gloves were not used hand hygiene should have been completed after touching a dirty surface. If

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F 812	Continued From page 32	F 812		

wearing gloves and a dirty surface had been touched, gloves should have been removed, hand hygiene performed, and a new pair of clean gloves donned.

Surveyor: 41895
Interview on 4/20/21 at 11:15 a.m. and at 4:43 p.m. with interim dietary manager E regarding the above observation revealed she:
*Had started in the kitchen the beginning of January.
*Had done training with all kitchen staff on food safety, food handling, food preparation techniques, food borne illnesses, food time and temperature controls, leftover food policies, nutrition and hydration, and sanitation.
*Agreed cook G should have washed her hands before and after glove use.
*Agreed cook G could have contaminated her gloves by moving from one task to another without washing her hands and changing her gloves.
*Thought the kitchen staff was required to wear gloves at all times.
*She did not have a policy for hand washing and glove use for food handling.

Review of the provider's revised December 2016 Handwashing & Use of Personal Protective Equipment (PPE) policy revealed:
*"Excellent hand hygiene and use of PPE are included in a group of infection prevention practices that apply to all patients, in any setting."
*"Policy Guidelines:
-A. Handwashing"
--"f. After removing gloves/between glove changes."
*This policy had not addressed hand washing or glove use in the kitchen.

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F 837 SS=D

Governing Body
CFR(s): 483.70(d)(1)(2)

§483.70(d) Governing body.
§483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and

§483.70(d)(2) The governing body appoints the administrator who is-
(i) Licensed by the State, where licensing is required;
(ii) Responsible for management of the facility; and
(iii) Reports to and is accountable to the governing body.
This REQUIREMENT is not met as evidenced by:
Surveyor: 41895
Based on observation, interview, record review, job description review, and policy review, the governing body failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being for all residents in the facility. Those areas included:
*Evaluation of their resident population and identification of staffing and other resources needed to ensure the quality of care and quality of life for all thirty-six residents.
*Infection control practices for hand hygiene, personal protective equipment use, wound care, blood sugar monitoring, care of a quarantined resident, COVID-19 vaccine administration, cleaning and disinfection of re-usable resident equipment.
*Staff assistance for the residents activities of daily living (bathing, grooming, nail care, oral care, dressing) and documentation for those

F 837

1.Persuant to CFR 483.70(d) (2) (iii) The facility must determine a process and frequency by which the administrator reports to the governing body, the method of communication between the administrator and the governing body including, how the governing body responds back to the administrator.

The Administrator and the governing body established a reporting communication process which includes a written weekly report from the Administrator to the governing body which includes a balanced scorecard reporting structure consisting of six critical area or 'pillars'. These areas include : Community Perspective, Financial /Stewardship Perspective, Growth, Innovation and Learning Perspective, People Perspective, Quality Perspective and Service Perspective.

Through this weekly report the Administrator informs the governing body on the management and operation of the organization including reports on critical information. This process was implemented — 4/23/2021

The Facility governing body was appraised of the potential deficiencies discussed between the State Surveyors and facility staff, including the Administrator during the exit conference, which was held 4/21/2021 in a formal weekly report to each Board member that they received on 4/23/2021. This weekly report included a summary of the written notes taken by facility staff during the exit conference and included each Federal and State tag which was anticipated.

On 4/29/2021 an in person monthly governing board meeting was held and a written monthly report was provided to the governing body from the Administrator which included greater detail of the anticipated deficiencies as well as information about the scope and severity matrix.

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	43A075	A. BUILDING ____ B. WING ____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 837	Continued From page 34 cares. *Implementation of individualized activity programming for all residents. *Accountability of controlled medication. *Documentation and accountability of discharge medications. *Complete medical record documentation. *Cleaning of residents' rooms. *Cleaning and maintenance of resident wheelchairs. Findings include: 1. Interview on 4/2/21 at 5:34 p.m. with administrator A revealed he: *Had been in his current role less than one month (one week). *Had identified the need to fill management positions as one of his concerns. -Current managers were unable to juggle responsibilities for their primary roles as well as the responsibilities of other unfilled positions. *Had also identified staff turnover as a concern. *Had communicated those needs with the governing body who "had no idea of the extent of [the facility's] problems." Surveyor 41895 Interview on 4/21/21 at 10:30 a.m. with director of nursing (DON) B regarding her duties revealed: *At times she worked twenty-four to twenty-eight hours straight due to short staffing or a night nurse calling off. *She usually worked seventy to eighty hours a week. *Her roles included being the DON, minimum data set (MDS) coordinator, restorative nurse, and discharge planner. *She had tried to get an MDS nurse from a staffing agency. When administrator A found out	F 837	When the final written deficiencies were received on 5/4/2021 on form 2567, the Administrator provided the board with a summary of the deficiencies noted and their tag level. In a written weekly Administrator's report to the governing body on 5/8/2021 each F tag was explained and the details were provided as well as a summary of the process that would be undertaken to respond to the deficiencies. A copy of the completed Plan of Correction and completed form 2567 will be provided to the governing body by the administrator on 5/14/2021. The 5/15/2021 weekly report to the board from the administrator will include the final corrective actions identified as well as information about the operation of the organization not included in the deficiency statements. Through this process, the governing body will ensure the facility is being operated and administered in a manner that ensures the safety and overall well-being of all residents in the facility. This weekly reporting, including back and forth open communication between the board and the administrator combined with a written monthly report, which is reviewed and discussed in a monthly governing body meeting, will ensure that the governing body provides proper oversight of the management and operation of the organization. Further reporting on operation and management of the organization will include a written QAPI committee report given to the governing body each month in the monthly board meeting 2.A new interim Director of Nursing who is a Certified Nurse Practitioner has been appointed 5/13/2021 to lead the nursing home staff and to ensure that the Plan of correction outlined in this 2567 is completed. This allows DON B to step down from role as Director of Nursing and focus on updating MDS and Care plans for all residents. This separation of duties will also provide enhanced oversight of direct care staff and training as described in this document.	4/29/2021 5/13/2021

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F 837	Continued From page 35	F 837		

the cost he said it was too expensive and had not approved it.

Review of the provider's May 2018 Nursing Home Director of Nursing Job Description revealed:
*"Perform day to day activities that will assist the Administrator of the facility in accordance with current federal, state and local standards, guidelines and regulations governing our facility and as may be directed by the Administrator to assure that our facility is maintained in an orderly manner."
*"Has accountability and provides departmental leadership for all Nursing Home department employees."
*"The incumbent manages the overall operations of the nursing department.
*Responsibilities include: Fiscal, clinical and operations management.
*Manages all department staff in their performance of their duties to residents and patients.
*This position partners with other department managers."
*"Interviewing, hiring, developing, training and retaining employees.
*Planning assigning and directing employees."
*"Addressing complaints and solving problems."
*"Make regular rounds of the Nursing Care areas to ensure compliance with policies, procedures and regulations are maintained."
*"Monitors infection control of the facility."
*"Responsible for coordination of medical records. (Assists with Nursing documentation chart audits/reviews)".

Review of the provider's 9/11/19 CEO Job Description revealed:
*"The Administrator provides leadership,

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F 837	Continued From page 36 direction, and administration of all aspects of the hospital, nursing home, and affiliated ventures. *This position ensures that delivery of resident and health care services programs continue to respond to the needs of both resident/patients and the community at large by leading, directing and coordinating all facility functions including physical and human resources." *"Ensure appropriate manpower through effective recruitment and retention programs and policies, and ensure motivation of qualified staff." *"Ensure organizational structure and activities comply with policies as well as licensing and accrediting agencies." *"Ensure the facility meets all regulatory requirements for licensure and certification and maintains JCAHO accreditation if applicable." Surveyor: 40788	F 837		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842	1.Facility will keep confidential all information contained in the resident's records, regardless of the form or storage method of the records. The medical record will contain all sufficient information to identify the resident, by resident assessments, comprehensive plan of care and services, provider's progress notes, Dx: for meds, foley's. For means of communication among the providers and any professionals contributing to the residents cares; by furnishing documentary, evidence of the course of the resident's illness and treatment during their stay. Medical provider notes for Resident 4 were updated in the Nursing Home record on 4/25/2021 to include notes made by the provider on 3/15/21 in the Rural Health Clinic. 2.All residents are at risk. Facility provided discussion and training to all medical staff members on the importance of dual progress notes in the clinic and in the nursing home record during medical staff meeting	5/13/2021

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F 842	Continued From page 37 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842	Facility contacted both the Nursing Home Electronic health record company and the Rural health clinic Electronic health record provider to investigate the potential of an automatic electronic interface that would eliminate the need for duplicate charting. Both companies are evaluating their product to find a solution. 4.Facility will continue to require providers to chart in Nursing Home charts 5.Evaluation and monitoring will be done by DON or designee performing 3 audits weekly x 4 weeks, then 3 audits every 2 weeks, then monthly. DON or designee will report results of audits at the monthly QAPI meeting for further review and recommendation and/or continuation/ discontinuation of audits	5/10/2021

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F 842	Continued From page 38 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, record review, interview, and policy review, the provider failed to have a system in place for obtaining necessary documentation to ensure complete and accurate resident medical records for one of one sampled resident (4) who was followed by 1 of 4 medical service providers. Findings include: 1. Observation on 4/19/21 at 4:02 p.m. of resident 4 revealed he: *Was asleep in his bed. *A urinary catheter bag hung from the side of his bed off the floor. Review of resident 4's 11/6/20 quarterly minimum data set (MDS) revealed he: *Had a urinary catheter. *Had no active genitourinary (related to genital and urinary organs) diagnoses, no history of genitourinary surgeries and no indication a toileting program trial had been initiated. Interview on 4/20/21 4:40 p.m. with director of nursing (DON) B regarding resident 4's catheter revealed she: *Had been unable to find a diagnosis for the catheter or a medical provider justification for continued use of that catheter in his care record.	F 842		

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F 842	Continued From page 39 *Stated that resident's medical provider had not entered progress notes from his resident visits in the electronic medical record like other medical providers had. -Those progress notes had been kept in his clinic office. *Had not contacted that clinic about securing copies of those progress notes. Review on 4/20/21 at 5:00 p.m. of the 3/15/21 medical provider's progress note obtained from the clinic for resident 4 revealed he: *Had a diagnosis of urinary retention. *Had "failed several voiding trials and therefore has foley catheter in place." Interview at that same time with DON B revealed she: *Voiced those reviewed progress notes were beneficial in ensuring the overall continuity in care for resident 4. *Confirmed it would be of benefit to have similar progress notes for the seventeen other residents who received medical care from the same medical provider. Review of the revised January 2019 Documentation Purpose and Procedure policy revealed: *Purpose: -"To symstematically and continuously collect information about the health status of the resident." -"To provide a means of communication among the physicians and any professionals contributing to the resident's care." -"To furnish documentary evidence of the course of the resident's illness and treatment during his or her stay in the facility."	F 842		

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F 880 SS=E	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 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:	F 880	Directed Plan of Correction System Changes: 1.Facility Administrator conducted an Ishikawa diagram (causal diagram) review of several previous facility surveys in which F880 was cited and reviewed previous Plan of Corrections as well as reviewing in detail the 4/21/2021 Survey with Root Cause Analysis participants. The team then developed a problem statement . The team reviewed causal relationships of Measurement/Monitoring, People, Environmental, Machines/Equipment, Methods and Materials utilizing the Ishikawa diagram and then conducted detailed Root cause analysis and the team answered the 5 Whys: Administrator contacted the Quality Improvement Advisor from the Great Plains Quality Innovation Network who are the designated South Dakota Quality Improvement Organization (QIO) on 5/13/2021 and discussed at length the Ishikawa Assessment as well as the root cause Analysis which was performed. The Quality Improvement Advisor provided links to resources for a customizable GPQIN Performance Tracking Tool as an auditing tool, which can be used in aggregating all audit findings into one document, which will be considered as a tool for tracking monitoring activities. The QI Advisor also provided as a resource links to other Infection Control training materials . Root Cause Analysis Meeting 5 Whys Reported as required and directed plan of correction Members present: Administrator RN-Director of Nursing, Nursing Home Human Resources Director Facilities Management Manager RN, QAPI, Infection Control CNP	

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(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.

§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:
Surveyor: 40788
Based on observation, interview, review of the Pfizer-Biotech COVID-19 vaccine fact sheet, and policy review, the provider failed to maintain appropriate infection control practices for:
*Completion of the COVID-19 vaccination series for one of five sampled residents (4).
*Blood glucose monitoring by one of one licensed practical nurse (LPN) I for one of one observed resident (14).
*Hand hygiene and cleaning of shared resident

F 880 Root Cause Answer to 5 Whys

Problem Statement
Infection Control has not been a priority in the Nursing Home which is a direct consequence of reduced and unstable staffing, in addition to inconsistent leadership at all levels.

1-Why?- Staff turnover/lack of adequate staff & contract employees.

2-Why?- Inconsistent or lack of appropriate education, evaluation, reinforcement and continued monitoring of skill.

3-Why?- Inconsistent leadership in all areas.

4- Why?- Infection Control Preventionist position underdeveloped, does not have dedicated time for LTC and is not LTC certified/trained.

5- Why?- Central Supply is off site, increasing time to needed supplies which includes decontamination & cleaning supplies.

Corrective Action (Notes)
•Infection Control needs to become a focus
•Formalized Infection Control Program including a Preventionist (RN)
- will require an annual review
•Consistent leadership including administrator, DONs RN roles
•Vigilant monitoring weekly and continued monitoring
•Infection Control Preventionist Nurse with dedicated time for NH, LTC IC training/certification
•Foil Barriers for cares (wound care)
•New Supply Cart for unit
•Increase Staffing
•Consistent Staffing
•Improve organizational culture
•Quality training, evaluation, monitoring, re-evaluation

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F 880	Continued From page 42 equipment between four of four observed residents (7, 27, 35, and 188) who had vital signs taken by two of two observed nurse aides (NA) (C and L). *Hand hygiene, personal protective equipment (PPE) use, and cleaning of re-usable resident equipment by one of one NA (C) who provided personal care for one of one quarantined resident (138). *Hand hygiene by one of one certified nurse aide (CNA) (D) who provided personal care for one of one sampled resident (28). *Wound care provided by one of one director of nursing (DON)(B) for one of one sampled resident (4). *Wound care provided by one of one LPN (I) for one of one sampled resident (18). Findings include: 1. Review of resident 4's care record revealed: *His immunization record indicated he had received the first of two Pfizer-BioNTech COVID-19 vaccinations on 1/18/21. *A 2/15/21 progress note stated his second scheduled vaccination was not given due to an elevated temperature and possible infection. *There was no documentation a second COVID-19 vaccination had been administered. Interview on 4/20/21 at 4:33 p.m. with DON B regarding COVID-19 vaccinations revealed: *CVS pharmacy had administered resident 4's first COVID-19 vaccination. -They were unable to administer the second scheduled vaccination on 2/15/21. -They had not returned after that date to administer further COVID-19 resident vaccinations. *She confirmed resident 4 had not completed his	F 880	Specific Plan of Corrections 1-Facility made arrangements for resident number 4 to receive second Pfizer-BioNTech COVID-19 vaccination at the FQHC Clinic located in Martin, SD on 5/12/21 to be compliant with CDC vaccination guidance. Vaccination administration will be reflected in the medical record. 2-Facility's blood glucose monitoring procedure will be reviewed with LPN 1 by CNP/DON and will return demonstration of competence performed; also being be monitored by the CNP/DON. 3-(a&b) NA-C is no longer employed at the family. CNP/DON will review proper procedure for hand hygiene, glove changing, and disinfection of reusable equipment with NA-L. Procedure techniques will be monitored, a return demonstration for compliance will be performed by NA-L and documented. 4-Resident #138 is no longer in quarantine. NA-C is no longer employed at the facility. 5-Appropriate procedure for hand hygiene and glove changes during resident personal cares will be reviewed with Social Services Designee D by CNP/DON and demonstration of competence will be performed, monitored and documented 6-a & b- Correct Infection Control Procedure for wound care will be reviewed with DON B & LPN I by CNP/DON. Procedure techniques will be monitored, a return demonstration for compliance will be performed by DON B and LPN I and documented by CNP/DON. 7-QAPI nurse is LTC ICPC certified and will assume role of nursing home infection control nurse. CNP will assist in this role effective 5/11/21 and will complete CDC IC LTC certification course	5/12/2021 5/12/2021 5/19/2021 5/13/2021 5/19/2021 5/19/2021 5/19/2021

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F 880 Continued From page 43
COVID-19 vaccine series.
*She said she should have contacted resident 4's medical provider to determine how to complete that COVID-19 vaccination series.

Review of the revised December 2020 Emergency Use Authorization Of The Pfizer-Biotech COVID-19 Vaccine To Prevent COVID-19 fact sheet the provider referred to for information about that vaccine revealed:
*"2.3 Vaccination Schedule for Individuals 16 Years of Age and Older:"
-The vaccination was administered as a series of two doses three weeks apart.
-"There was no data available on the interchangeability of the Pfizer-BioNTech COVID-19 vaccine with other COVID-19 vaccines to complete the vaccination series."
-Individuals who received one dose of Pfizer-BioNTech COVID-19 vaccine should receive a second dose of the same vaccine to complete the vaccination series.

2. Observation and interview on 4/19/21 at 4:04 p.m. with LPN I taking resident 14's blood sugar reading revealed:
*Without performing hand hygiene, he secured her glucometer supplies, a packaged alcohol pad, and two inch by two inch (2 X 2) clean gauze squares from the medication cart.
*Set his supplies on an uncleaned counter behind the nurses' station, washed his hands, and put on a pair of gloves.
*While clutching the supplies between his arm and body he placed his gloved hands on the unclean handles of the resident's wheelchair and moved her to an unoccupied activity room.
*Set his supplies directly on top of an uncleaned activity table.

F 880 8-Infection Control Policy was reviewed by Medical Staff and Medical Director at meeting 5/13/21. Facility identifies that all residents have the potential to be at risk if staff do not adhere to appropriate infection control and prevention procedural techniques when performing cares and assigned tasks.

Policy and procedure education/re-education of the proper infection control tasks identified will be provided by CNP or designee by 5/19/21 to all nursing home staff who provide care and services to residents.

Identified tasks to include:
•Blood glucose monitoring
•Hand hygiene and cleaning of shared resident equipment
•Hand hygiene, personal protective equipment (PPE) use and cleaning of re-usable resident equipment.
-Hand hygiene during resident personal cares
-Wound care
-CDC guidelines for completion of COVID-19 vaccination series (DON only)

A total of five random opportunities for compliance for each of the tasks identified above will be monitored cooperatively by the infection control nurse and CNP /DON weekly. These leaders will report findings monthly to QAPI Committee for review and plan adjustment related to findings.

9.Time cannot be turned back to a time prior to the identification of *lack of appropriate procedural technique and hand hygiene and glove use during performance of blood glucose monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A075	A. BUILDING ______ B. WING ______	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

(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 880	Continued From page 44 *Used one piece of now unclean 2 X 2 to dry her left thumb after cleaning that thumb with the alcohol pad. *Used a second 2 X 2 to wipe blood off that thumb after puncturing it. *He stated changing the order in which he had prepared and then taken the resident's blood sugar reading would have decreased her risk for infection. -That included first positioning the resident to take her blood sugar, performing hand hygiene, and ensuring a clean barrier existed between the table and his supplies. Interview on 4/20/21 at 9:36 a.m. with DON B confirmed LPN I's understanding of how to mitigate the risk of infection while taking a resident's blood sugar reading. Review of the revised April 2017 Blood Glucose Monitoring policy revealed: *Hand hygiene and glove application was expected to occur immediately before inspecting the resident's fingers for a suitable site puncture. *Drying that selected puncture site with a 2 X 2 was not indicated after cleansing that site with the alcohol pad. *Applying a clean, dry 2 X 2 to the puncture site with pressure was indicated if appropriate. 3.a. Observation on 4/19/21 at 4:51 p.m. of NA L taking resident vital signs revealed she had not performed hand hygiene, cleaned or disinfected the thermometer, pulse oximeter, or blood pressure cuff between cares for residents 7, 27, and 188. Interview on 4/19/21 at 6:00 p.m. with NA L regarding the above observations revealed she:	F 880	*lack of appropriate cleaning and disinfection of multi-resident re-usable equipment and procedural technique for transport and maintenance of equipment, including having dedicated equipment for those residents in quarantine or isolation. *lack of appropriate attention to detail to wear necessary personal protective equipment (PPE) when entering and performing care tasks for residents in quarantine or isolation. *lack of appropriate hand hygiene and glove use during performance of resident personal care. *lack of appropriate procedural technique and hand hygiene and glove use during the performance of a dressing change. *lack of documentation of a plan for completion of COVID-19 second vaccination when resident developed temperature and symptomatic of infection. Administrator, DON, and infection control person will be provided education/re-education about: *appropriate procedural technique and hand hygiene and glove use during performance of blood glucose monitoring. *appropriate cleaning and disinfection of multi-resident re-usable equipment, including dedicated equipment for those residents in quarantine or isolation. *appropriate attention to detail to wear necessary PPE when posted to do so. *appropriate hand hygiene and glove use during the performance of resident personal care. *appropriate procedural technique and hand hygiene and glove use during the performance of dressing change. The facility in consultation with the medical director and infection control nurse will review, revise, and create as necessary policies and procedures to be in line with CDC and CMS recommendations about: *Procedural technique and hand hygiene and glove use during performance of blood glucose monitoring. *Cleaning and disinfection of multi-resident re-usable equipment. *Attention to detail to wear necessary PPE when posted to do so. *Hand hygiene and glove use during resident personal cares.	5/19/2021 5/19/2021

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F 880	Continued From page 45 *Stated she normally had not performed hand hygiene, cleaned or disinfected re-usable resident equipment between resident use. *Understood how that practice had increased the risk of transferring an infection between residents. Surveyor 41895 3.b. Observation on 4/20/21 at 10:25 a.m. of NA C taking resident 7 and 35's vital signs revealed he had: *Used and alcohol wipe to clean the probe on the thermometer and the inside of the pulse oximeter. *Not cleaned or disinfected all surfaces of the thermometer or the pulse oximeter. *Not cleaned or disinfected the blood pressure cuff. *Laid the thermometer, pulse oximeter, and blood pressure cuff on possibly contaminated surfaces in the resident's rooms. *Carried the pulse oximeter in his pocket. Interview on 4/20/21 at 10:34 a.m. with NA C regarding the above observations revealed he: *Was currently training to become a CNA. *He had always just cleaned the thermometer probe and inside of the pulse oximeter. *No one had shown him to clean the entire surface of the equipment between residents. *Agreed the thermometer, pulse oximeter, and blood pressure cuff could have been contaminated and should have been cleaned and disinfected between residents. *Agreed his pocket was not clean and he should not have carried reusable medical equipment in his pockets. Surveyor: 40053 4. Observation and interview on 4/20/21 at 9:40	F 880	*Procedural technique and hand hygiene and glove use during performance of dressing change. *Necessary infection control and prevention plan that includes effective compliance. All staff licensed and unlicensed who provide care and services to residents will be educated/ re-educated by CNP/DON 10.*ALL residents have the potential to be affected if staff do not adhere to procedural techniques and appropriate hand hygiene and glove use when performing cares and assigned tasks. *ALL staff completing the care and 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 by CNP/DON Monitoring: Administrator, DON, and infection control person will conduct auditing and monitoring for areas identified as well as any items identified through Root Cause Analysis. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 8 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Appropriate procedural technique and hand hygiene and glove use during performance of assigned task(s). *Appropriate cleaning and disinfection of multi-resident re-usable equipment. *Appropriate documentation of plan should a resident not be able to complete a COVID-19 v accination set. *Necessary infection control and prevention plan that includes compliance. *Any other areas identified thru the Root Cause Analysis and review of facility assessment. 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 and additional 2 months.	5/19/2021 5/19/2021

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F 880	Continued From page 46 a.m. in resident 138's room revealed: *He was in a Covid quarantine room due to being a new admit. -It was his twelfth of fourteen-day quarantine period. *Nurse aide (NA) C walked into the room. -He had a surgical mask on with no other personal protective equipment (PPE). --Posted signs outside of the room indicated gloves, gown, mask and goggles or face shield should have been worn before entering the room. *NA C entered the room with a blood pressure cuff, saturation of peripheral oxygen (SPO2) monitor, an electronic oral thermometer, and a clipboard. -He placed the items on the resident's bed except the clipboard which he placed on the over the bed table. *He took the resident's vital signs and recorded them on the sheet of paper on the clipboard. *Without washing his hands or removing his mask he left that quarantine room. Interview on 4/21/21 at 12:30 p.m. with NA C revealed he: *Was aware that he was to have worn the required PPE before entering that quarantine room. *Stated he had forgot due to not having anyone on quarantine for awhile. *Thought he had cleaned the vital sign equipment before leaving the room. 5. Observation and interview on 4/20/21 at 11:28 a.m. of social services designee D while performing a brief change revealed: *She performed hand hygiene and went into resident 28's room. *She placed the needed equipment on the bed and put on gloves.	F 880	Monitoring results will be reported by Administrator, DON, and/or infection control person to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director.	

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F 880	Continued From page 47 *The resident was on his back. -She removed the brief tabs and removed the front of the brief and cleaned the resident's front area. *Without performing hand hygiene she replaced her gloves. *She rolled him onto his side and: -Cleansed his back area. -Placed a soaker pad under him. -Placed a new brief under him. -Grabbed the container of wipes she had used and pushed the one sticking out down into the container and placed it on his dresser. -She rolled him onto his back. *Without performing hand hygiene she replaced her gloves. *She tightened the brief, removed her gloves and completed hand hygiene. *When asked she stated that had been her normal routine of completing that task. Interview on 4/21/21 at 10:35 a.m. with CNA D regarding the above observation revealed she was aware that she should have been completing hand hygiene in-between changing gloves. Surveyor: 41895 6.a. Observation on 4/20/21 at 9:30 a.m. of DON B completing wound care for resident 4 revealed she: *Had entered the resident's room and set down three E-Z Graph Wound Assessment Measuring Guides on the residents bed side table. -Those guides had other residents names and wound assessments on them and had not had the soiled backing removed. *Opened a dresser drawer, pulled out some 4 x 4 gauze pads, a bottle of sterile water, and a roll of tape, and laid them on top of the residents	F 880		

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F 880	Continued From page 48 dresser with no barrier under them. *Went into the bathroom, washed her hands, and put on a pair of gloves. *Moved the 4 x 4 gauze pads, sterile water, and tape to the bedside table with out a barrier under them. *Handed the unidentified physicians assistant an E-Z Graph Wound Assessment Measuring Guide to assess the residents wound. -With out removing the soiled backing she set it back on the bedside table with the other residents assessment guides. *With out cleaning the wound she wet the 4 x 4 gauze pads put them on the wound and taped them in place. *Removed gloves, washed her hands, picked up the E-Z Graph Wound Assessment Measuring Guides, and exited the room. Interview on 4/20/21 at 9:38 a.m. with DON B regarding the above observation revealed she: *Agreed the E-Z Graph Wound Assessment Measuring Guides would have been contaminated from touching other residents wounds. -She should have removed the soiled backing and not carried them into other resident's rooms. *Agreed she should have washed her hands when entering the room before touching the dressing supplies. *Agreed by setting the dressing supplies on top of the dresser and bedside table without a barrier could have contaminated those supplies. *Should have cleaned the wound prior to placing a dressing on it. 6.b. Observation on 4/19/21 at 3:17 p.m. of LPN I completing wound care for resident 18 revealed he had not worn gloves when cutting a piece of	F 880		

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F 880 Continued From page 49
Opticell to put into the wound.

F 880

Interview on 4/19/21 at 3:29 p.m. with LPN I regarding the above observation revealed he:
*Did not usually wear gloves when cutting the Opticell because it made it harder to hold on to.
*Thought because he washed his hands first it was appropriate to touch the clean dressing.
*Agreed he should have gloves on when touching all clean dressing supplies.

Surveyor 40053
7. Interview on 4/21/21 at 4:37 p.m. with DON B regarding infection control revealed:
*She would have expected resident use equipment including blood pressure cuffs, saturation of peripheral oxygen (SPO2) monitors, blood glucose monitors, and temperature gauges to have been cleaned with alcohol or disinfectant wipes after each use and in-between resident use.
*She had expected all indicated PPE would have been worn before performing care on a resident who was currently on contact precautions.
*Her expectation would have been that handwashing would have been completed before entering a room, when hands were soiled, after removing gloves, when leaving a room, and in-between resident care.

Surveyor 40788
Interview on 4/21/21 at 10:21 a.m. with infection preventionist N revealed she:
*Had assumed this position in November 2020 for both the nursing home and adjoining hospital.
*Oversaw weekly infection control meetings that included education, observations and concerns discussed between department managers.
*Said she had initiated infection control audits for

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F 880	Continued From page 50	F 880		

the nursing home within the last month.
-Results from those audits indicated "things are going well" with infection control processes and practices.
*Stated she was unaware of the outcome of previous nursing home focused infection control surveys that had occurred during the current pandemic.
-That information should have been included in her current audit tool.

8. Review of the Updated Date 7/2019 Infection Control Policy revealed:
*"Policy: Infection Control
A. Handwashing: Good hand hygiene using soap and water ad scrubbing for at least 20 seconds (CDC guidelines) shall be employed when:
9. The use of antiseptic foam/gel is to be used before entering a patient's room and after leaving "Foam In Foam Out." Antiseptic foam is also used after glove removal.
E. Patient Care Equipment: Any patient care equipment should be handled so as to prevent contamination of skin, mucous membranes or clothing. Clean between uses with PDI Sani-Cloth wipes and allowed to air dry.
II Transmission Based Precautions:
B. Droplet Precautions:
2. Mask shall be worn within 3 feet of patient.
4. Patient care equipment shall be dedicated to infected patient and shall be cleaned with PDI Sani-Cloth Plus wipes in between uses and allowed to air dry.
C. Contact Precautions:
2. Wear gloves when coming in direct contact with patient.
3. Wear a gown when entering the room...
4. All patient care equipment shall be dedicated to the infected patient. Adequately clean the

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F 880	Continued From page 51 equipment between uses with the PDI Sani-Cloth Plus wipes."	F 880		

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

PRINTED: 05/04/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments Surveyor: 40053 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 4/19/21 through 4/21/21. Bennett County Hospital and Nursing Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE Administrator   (X6) DATE 5/14/2021

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A075	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/21/2021

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K 000	INITIAL COMMENTS Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/21/21. Bennett County Hospital and Nursing Home was found not 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 upon correction of the deficiencies identified at K232 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 232 SS=C	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to maintain the width of corridors (clear and unobstructed) for two of three (north and south) exit corridors. Stools, wheelchairs, medication carts, bio-hazard trash bins, vitals monitors, lifts, and coat racks were stored unattended in those corridors. Findings include:	K 232	1-Facility will ensure that the width of aisles or corridors will remain clear and unobstructed so that they can service as exit access; through the Environmental Services manager conducting training with nurses, CNAs and other nursing home staff to instruct them that bar stools, rolling stools, wheelchairs, medication carts, large bio-hazard trash bins, vitals monitors, lifts, coat racks or other obstructions are to be safely stored elsewhere, not in exit hallways and that lifts and wheel chairs used during baths will remain in the hallway for no more than 30 minutes while resident is being bathed and personal cares given. The facility has developed a policy on the storage of unattended items in corridors which prohibits items to be stored in egress hallways or areas.	4/29/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
TITLE Administrator
(X6) DATE 5/14/2021

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	43A075	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/21/2021

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K 232	Continued From page 1 1. Observation on 4/21/21 from 10:00 a.m. to 12:30 p.m. revealed the following items stored unattended in the north and/or south corridors: bar stools, rolling stools, wheelchairs, medication carts, large bio-hazard trash bins, vitals monitors, lifts, and coat racks were stored in those corridors. Interview at the time of the observation with the environmental services manager confirmed that finding. He stated: *He had been told by the previous administrator those items could be stored to one side in a corridor. *The facility had no policy on the storage of unattended items the corridors.	K 232	Training was completed. Manager of Environmental Services will monitor weekly for 6 weeks then will monitor bi-weekly for 6 weeks. Findings will be reported by the Environmental Services manager in Quality Assurance and Performance Improvement (QAPI) meeting monthly and to CEO monthly X 4 months, then report quarterly **The Manager of Environmental Services completed the training .**	04/29/2021

South Dakota Department of Health

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	10646	A. BUILDING: ______ B. WING ______	04/21/2021

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S 000	Compliance/Noncompliance Statement Surveyor: 40053 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/19/21 through 4/21/21. Bennett County Hospital and Nursing Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 40053 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 4/19/21 through 4/21/21. Bennett County Hospital and Nursing Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE Administrator (X6) DATE 5/14/2021

STATE FORM 6899 I4R611