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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

(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: 42477 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/3/21 through 8/5/21. Aurora Brule Nursing Home Inc. was found not in compliance with the following requirements: F580, F582, F684, F700, F835, F837, F865, F880, F881, and F882. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/3/21 through 8/5/21. Areas surveyed included quality of care and nursing services. Aurora Brule Nursing Home Inc. was found not in compliance with the following requirement: F697.	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580	Director or Nursing will review and revise as necessary the family notification policy to include family notification for change of skin condition for a resident. All staff responsible for family notifications will be re-educated on the updated policy and procedure for family notifications of change in resident skin condition. Resident 13 family have been notified by 8-30-21 KS **Director of Nursing** on the change in skin condition. All other residents with skin condition issues will be audited by 9-30-21 KS **Administrator** to ensure that staff have notified the family of the skin condition.	09/01/2021

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

Kathleen Styles | Emergency Permit Holder | 08/25/2021

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 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview and record review, the provider failed to ensure notification to a family for change in skin condition for one of one sampled resident (13). Findings include: 1. Interview on 8/4/21 at 9:42 a.m. with resident	F 580	Director of Nursing or designee will audit all new skin condition changes once per week for 4 weeks then once per month for two more months to ensure that family are being notified of the skin condition changes. Director of Nursing will present the audit findings at the monthly QAPI meeting for review and consideration.	

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F 580	Continued From page 2 13's power of attorney (POA) and legal guardian revealed: *They had not called her regarding any skin concerns or changes. *If he would have had any open areas she believed they would call her. *She would want to know if he had any open areas on his skin. Interview on 8/5/21 at 9:28 a.m. with director of nursing C regarding resident 13 revealed: *She agreed his POA should have been called if he had an open area. *She was unable to find documentation if his POA had been notified. Review of the provider's November 2011 Physician and Family Notification policy revealed: *The family and physician was to be notified on all acute changes, including: -An accident that required physician intervention. -A significant change. -A need to alter treatment. -A decision to transfer or discharge. -A change in resident rights. -A change in roommate or room. Refer to F684, finding 4.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and	F 582	Director of Nursing will review and revise as necessary the Medicare Notice policy to ensure the resident or responsible party are receiving the required Medicare Advanced Beneficiary Notice when coming off of a Medicare qualified stay. All staff responsible for completion of the Medicare Advanced Beneficiary Notice will be re-educated on the updated policy and procedure.	09/01/2021

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F 582	Continued From page 3 for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's	F 582	Resident 23 and 284 ABN's have been completed. All other residents that have completed a Medicare Stay at the facility since 1/1/2021 will be audited by **business manager** to determine if the required ABN's have been completed. If they have not been completed then they will be completed. Director of Nursing or designee will audit all Medicare qualified stays once per week for 4 weeks and once per month for two more months to ensure that residents coming off Medicare Qualified Stays are receiving the Advanced Beneficiary Notice within the required time frame. The Director of Nursing will report the audits findings at the monthly QAPI meetings for review and consideration.	

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F 582	Continued From page 4 date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on record review and interview, the provider failed ensure the proper Medicare notice was provided for two of three sampled residents (23 and 284) who had remained in the facility following their discharge from skilled services. Findings include: 1. Review of resident 23's Medicare Part A Denial Notice revealed: *Her last day of covered services was on 2/12/21. *She had covered days remaining and continued to reside in the facility. *She had not received the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form as required. 2. Review of resident 284's Medicare Part A Denial Notice revealed: *Her last day of covered services was on 2/12/21. *She had covered days remaining and continued to reside in the facility. *She had not received the SNF ABN form as required. 3. Interview on 8/4/21 at 10:01 a.m. with director of nursing C regarding SNF ABN forms revealed she had: *Been responsible to provide the Medicare discharge notices. *Not been aware the form was required when the resident remained in the facility.	F 582		

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F 582	Continued From page 5 *Thought it was only required if the resident wanted to appeal the discharge.	F 582		
F 684 SS=H	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, and record review, the provider failed to perform routine assessments, revise care plans, and provide interventions for residents who were at risk for developing skin integrity issues for 8 of 8 sampled residents (9, 10, 13, 18, 20, 22, 23, and 32). Findings include: 1. Observation and interview on 8/3/21 at 11:19 a.m. with resident 20 revealed: *She had a wound on her bottom. -It caused her pain. *She stated she also had wounds on her feet and on her hip. Surveyor 42558 Observation on 8/4/21 at 11:15 a.m. of resident 20's skin with licensed practical nurse (LPN) E and certified nursing aide (CNA) M revealed: *Resident's right heel revealed: -An approximate 1.5 centimeter (cm) yellow scab	F 684	Administrator, DON, medical director, **wound care consultant, facility's governing body** and nurse designated responsible for resident skin assessments and care will review, revise and create as necessary the policies and procedures **to ensure skin assessments occur timely, and appropriate per each residents needs.** Individual risk assessments for those with no risk identified, weekly skin assessments for those residents identified with risk, preventive measures care planned and routinely reviewed and identify interventions for those residents with skin integrity concerns **performed by Director of Nursing or designee** All staff responsible for skin care will be re-educated on the updated policy and procedures for skin care. Resident 20, 10, 9, 13, **22, 23, 32** and 18 skin conditions will be re-assessed based on the updated skin care policies and plans of care will be updated per the updated policies **performed by Director of Nursing or designee** . All other residents will be re-assessed based on the updated policies and procedures to ensure that they have been identified as high risk or as having a skin condition and appropriate treatment and preventions are in place and being assessed per the updated policies and procedures.	09/01/2021

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F 684	Continued From page 6 with a 0.2 cm dark brown center. This area also had approximately 3.0 cm of pink, newly healed skin surrounding the yellow scab. -LPN E cleansed the area with wound cleanser, applied MediHoney ointment to the scab, and covered it with a 4 inch by 4 inch gauze pad. -She then wrapped the entire foot with a gauze wrap and applied a netting cover. *Resident's coccyx (tail bone) revealed: -A deep stage 4 (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures. Undermining and sinus tracts also may be associated with stage 4 pressure ulcers) measuring approximately 6 cm in circumference. Surrounding tissue had been a normal tan skin tone. No surrounding redness had been identified. -LPN E had been unable to identify if this had been facility acquired or was present upon resident's admission. -LPN E cleansed the area with wound cleanser spray along with using a sterile cotton swab covered with wound cleanser soaked gauze to clean around the inside periphery of the wound. -She packed the wound with twelve inches of alginate packing, swabbed the outside periphery with skin prep, and applied an adhesive gauze cover. *Resident's left hip revealed: -A 2.0 cm by 1.0 cm pink, intact skin surrounded by dry flaky skin. -No open areas had been observed to this site. -LPN E stated the area had been healed for approximately one week. -CNA M stated they had applied lotion to the site every day. Surveyor 42477	F 684	Director of Nursing or designee will audit all residents with skin conditions once per week for 4 weeks and once per month for two more months to ensure that the residents identified as high risk for skin conditions or those with skin conditions are receiving the appropriate care for treatment or prevention of skin conditions. Director of Nursing will present audit findings at the monthly QAPI meetings for review and consideration.	

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F 684	Continued From page 7 Review of resident 20's electronic medical record (EMR) revealed: *She was admitted on 2/26/21. *Her Braden assessment scale was scored at 17, that meant she was "at risk" for developing pressure injuries. -That was the only Braden assessment that had been completed on resident 20. *On 3/1/21 LPN L completed a skin assessment which indicated: -She had a unstageable pressure ulcer to her sacrum/coccyx region. *On 5/13/21 LPN L completed a skin assessment which indicated: -A stage four pressure ulcer to her coccyx that measured 3 cm long by 2.5 cm in width. -A 3.5 cm by 2.5 cm suspected deep tissue injury on her right heel. *On 5/19/21 LPN L noted: -She had a stage four pressure injury to her coccyx and "stage two maceration" to her left buttock. *On 7/13/21 she was listed as having a stage four injury to her coccyx and a stage three pressure injury to her right heel. *On 7/21/21 she had the stage four injury to her coccyx and an unstageable injury to her right heel. *On 7/29/21 she had a stage four injury to her coccyx. *On 8/2/21 she had a stage four pressure injury to her coccyx. Review of resident 20's August 2021 care plan revealed: *Staff were to: -"Monitor/document/report PRN [as needed] any s/sx [signs or symptoms] of immobility: contractures forming or worsening, thrombus	F 684		

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F 684	Continued From page 8 formation, skin-breakdown, fall related injury..." -Help the resident lay as flat as possible to reduce shear. -Administer treatments as ordered and monitor effectiveness. -"Assess/record/monitor wound healing (weekly) Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing process. Report improvements and declines to the MD." -"Avoid positioning the resident on her back." -"Follow facility policies/protocols for the prevention/treatment of skin breakdown." -"Inform the resident/family/caregivers of any new area of skin breakdown." -"The resident requires (SPECIFY: Pressure relieving/reducing device) on (SPECIFY: bed/chair)." --This was not specified or completed. Review of resident 20's skin observation that was completed by CNAs revealed: *Out of a 30 day time period, she was marked to have an open area two times. *Most of the documentation stated: -"None of the above observed." *In 30 days she was listed as have no red areas. 2. Review of resident 10's EMR revealed: *He was admitted to the facility in 2017. *His diagnoses included: -Traumatic brain injury. -Encephalopathy. *He was unable to perform movements, and only responded to painful stimulus. *He was totally dependent upon staff for "every need." Surveyor 42558	F 684		

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F 684	Continued From page 9 Observation on 8/4/21 at 3:00 p.m. of resident 10's skin with LPN E revealed: *Resident's right fifth toe revealed: -LPN E stated the resident had a bath the day before and a dressing had not been applied following his bath. --Stated, "I missed it (dressing change)." -The outside edge of his right fifth toe had a raised approximate 0.5 cm dry callous, with an approximate 0.1 cm black depressed center. -There had been no surrounding redness. -LPN E cleansed the toe with wound cleanser soaked gauze and covered it with adhesive gauze and Hypafix wound tape. *LPN E stated resident had not been seen by podiatry but his primary doctor inspected the toe last month. *Resident's inner buttocks revealed: -This surveyor had to ask to inspect the inner buttocks as LPN E had been preparing to leave the room. --LPN E stated she did not have the supplies for this and had left the room to retrieve the supplies. -His left upper inner buttock near his coccyx had revealed a white macerated (moisture associated skin discoloration) area measuring approximately 2.0 cm with a stage 2 slit (partial thickness skin loss involving the epidermis, dermis, or both) measuring approximately 1.0 cm in length by 0.2 cm in width. -LPN E measured the area with a paper towel and stated it had not been open the last time she had viewed it several days ago. -She cleansed the area with wound cleanser and applied a mix of collagen cream and skin barrier cream. --She stated this had been a daily treatment until it was healed.	F 684		

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F 684	Continued From page 10 Surveyor 42477 Review of resident 10's progress notes regarding skin issues revealed: *He has had some open skin areas. *He had been dealing with open areas on his coccyx for the last 6 months or so. *He also had an area on his right foot. *From 2/1/21 through 8/4/21 he was documented to have: -Off and on open slits on his coccyx. -An open area on his right foot, by his fifth toe. Review of resident 10's Braden assessments revealed he was at a very high risk to develop skin sores. Review of resident 10's skin assessments revealed: *He had a skin assessment that was started by registered nurse (RN) D on 7/4/21. -It had not been completed or filled out. *The last skin assessment completed before 7/4/21 was completed on 6/18/20. *There was a twelve month period without a completed skin assessment for resident 10. Review of resident 10's May 2021 care plan revealed: *He had a pressure ulcer due to incontinence. *"[resident's name] is totally dependent on 2 staff for repositioning and turning in bed Q2hrs [every two hours] and as necessary..." *"[resident's name] requires SKIN inspection every shift. Observe for redness, open areas, scratches, cuts, bruises and report changes to the Nurse." *"Follow facility policies/protocols for the prevention/treatment of skin breakdown." *"Monitor/document/report PRN any changes in	F 684		

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F 684	Continued From page 11 skin status: appearance, color, wound healing, s/sx of infection, wound size (length x width x depth), stage." Review of resident 10's turning and repositioning chart revealed: *On 8/1/21 he was repositioned at 10:00 a.m. *He was next repositioned/changed at 3:30 p.m. *He was in his wheelchair from 10:00 a.m. until 6:30 p.m. when he was positioned on his left side. *The repositioning chart that was filled out for resident 10 included: -Missing information. -Wrong dates/times. -Gaps longer than two hours. Review of resident 10's skin observation that was completed by CNAs revealed: *Out of 30 days he was noted to have an open area three times. *There were a few times where he was documented to have a reddened or discoloration area. *Most of the documentation revealed that he had "None of the above observed." 3. Review of resident 9's EMR revealed: *He was admitted on 4/29/21. *He was admitted with a stage 2 pressure injury to his coccyx. *His diagnoses included: -Type II Diabetes with foot ulcer. -Ischemic cardiomyopathy. -Hyperlipidemia. -Hemiplegia and hemiparesis following cerebral infraction. -Amputation. Review of resident 9's progress notes revealed:	F 684		

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F 684	Continued From page 12 *He had been receiving dressing changes to his coccyx, amputation site, and skin tears. *His coccyx wound had been documented as healed on 5/13/21. *He was receiving dressing changes to his amputation site. *He also had frequent skin tears. Review of resident 9's skin observations that had been completed by CNAs revealed: *From 7/4/21 through 8/4/21 he had been marked as not having any skin tears. *He had been documented as having some skin discoloration a couple of times. *Most of the time he was documented as having "none of the above observed." Review of resident 9's assessments revealed: *He had not had a skin assessment completed since he was admitted on 4/29/21. *LPN L completed his admission assessment and admission skin assessment. *His Braden assessments listed him as: -On 4/29/21 moderate risk for skin issues. -On 5/6/21 high risk for skin issues. -On 5/13/21 high risk for skin issues. -On 6/1/21 at risk for skin issues. Review of resident 9's May 2021 care plan revealed: *He had the potential impairment to skin integrity related to neglect of left arm, had noted skin tears on admit-applied geri sleeve to protect arm and removed watch due to it catching on things and causing skin tears. *Staff were to: -"Monitor/Document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration to	F 684		

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F 684	Continued From page 13 doctor. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes." Interview on 8/4/21 at 9:27 a.m. with director of nursing (DON) C revealed: *Wound assessments in the EMR were under assessments. *Anyone who had skin issues would have skin assessments done weekly. *Someone who did not have issues or was at risk, their skin was checked weekly by the CNAs giving baths. 4. Review of resident 13's EMR revealed: *He was admitted on 2/11/21. *His diagnoses included: -Intellectual Disabilities. -Major Depressive episode. -Dementia with behavioral disturbance. -Scoliosis. *On 4/5/21 it was documented he had small open area on his scrotum. Review of resident 13's assessments revealed: *On admission he was at moderate risk for skin break down. *He had never had a skin assessment completed since he was admitted to the facility. Review of resident 13's June 2021 care plan revealed: *His interventions included: -Avoiding scratching. -Educating family/resident/caregivers of causative factors and measures. -Encourage good nutrition.	F 684		

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F 684	Continued From page 14 -Follow facility protocols for treatment of injury. -Use a draw sheet or lifting device. -Identify potential causative factors and eliminate/resolve where possible. -Use caution during transfers. Review of resident 13's 7/5/21 through 8/5/21 skin observation task list that was completed by CNAs revealed: *He had been marked as having skin discoloration six times. *He was marked as having a red area once. *All the other documentation stated, "none of the above observed." Phone interview on 8/4/21 at 9:42 a.m. with resident 13's legal guardian and power of attorney revealed: *He had been in the facility for about 6 months. *She had never been asked to help participate in his care conferences. *She participated in resident 13's care conferences at another facility. *Since this was his first stay in a nursing home she did not know if they completed care conferences or if she could join. 5. Review of resident 18's EMR revealed: *He was admitted on 4/28/21. *His diagnoses included: -Peripheral vascular disease. -Myocardial infarction. -Amputation. -Hyperlipidemia. -Osteomyelitis. -Chronic ulcer of the right heel. *He was admitted with a right heal wound. Review of resident 18's progress notes revealed:	F 684		

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F 684	Continued From page 15 *On 5/3/21 a dressing was changed to the left and right foot: -"...left foot removed telfa from top of foot no drainage noted, noted blister to heel cleaned and applied gauze to heel and top of foot wrapping with kerlix no pain or tenderness reported. right foot removed dressing cleaned heel with NS [normal saline] and applied betadine soaked gauze followed by dry gauze wrapped in kerlix..." *On 5/4/21, the dressing to right heel was intact. The left foot did not have any openings or drainage. *On 5/5/21 dressing to the right heel was completed, a foul odor was noted. *On 5/6/21 right heel dressing was changed, foul odor continued to be noted. They popped a blister to his left heel. *From 5/6/21 through 5/19/21 he was in the hospital. *On 5/20/21 he was documented to have pressure ulcers to heel, coccyx, and surgical incision to right amputation. *On 5/21/21 he was documented to have a pressure ulcer to his left heel. *On 5/26/21 he was documented to have a "purple discolored ulcer to right buttock." *The next note regarding the buttock was on 5/30/21: -"...stage II pressure ulcer noted to right buttock..." *The next note regarding buttocks was on 6/3/21" -"Res [resident] has two spots on his Lt [left] bottom..." *Documented note from wound care which stated: -"...If any changes in redness-please-call-do-not wait." *On 6/15/21 he was documented to have blisters on his amputation site that popped.	F 684		

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F 684	Continued From page 16 *On 6/21/21: "...Resident's stump has an open area with scabbing. Open areas appear to have some purulent drainage. Surrounding tissue is red." *On 6/24/21, "...stump is bright read [red] no drainage Incision healing..." *On 6/28/21, "...Dress [dressing] was changed on res [resident] stump. Area had some scabbing. There was a small amount of drainage. Incision had some open area with the wound bed that had some white area." *On 7/4/21, Yellow drainage was noted to old dressing. *On 7/9/21, "...open area that has purulent drainage..." *There was no documentation of notifying the wound clinic. Review of resident 18's April 2021 care plan revealed: *"Monitor/document/report PRN any s/sx [signs or symptoms] of skin problems related to PVD: Redness, Edema, Blistering, Itching, Burning, Bruises, Cuts, other skin lesions." *"[resident name] had R [right] BKA [below knee amputation], surgical wound intact. Apply lotion to stump, do not apply on surgical incision." *"Assess/record/monitor wound healing daily Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD." Review of resident 18's skin observation which was documented by CNAs revealed: *In 30 days he was documented once of having an open area. *Five times he was documented as having discoloration.	F 684		

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F 684	Continued From page 17 *Majority of the 30 day documentation listed, "none of the above observed." Review of resident 18's 6/28/21 podiatry note revealed, "R[right] stump- new wound from tape-stop using tape. Dressing secured with tubigrip-extra provided..." Resident 18's podiatrist was called for an interview on 8/4/21 at 3:04 p.m., left a message with the nurse. Survey team did not receive a return call. Interview on 8/4/21 at 9:35 a.m. with administrator A revealed: *They did not have a designated wound nurse. *They had a wound consultant from American Medical Technologies (AMT) that came in about once per month. Interview on 8/4/21 at 4:00 p.m. with wound clinic RN N revealed: *They had been seeing resident 20 and resident 18. *Resident 20 was referred to wound care from the emergency department prior to arriving at the facility. *They had been seeing resident 20 for a wound on her sacrum and right heel. *They had not been informed of the stage 2 injury on her hip. *Resident 18 was referred to wound care by his podiatrist. *They were very adamant the provider should have called them if the residents had any drainage, redness, or changes. -RN N stated, "That is a big thing for us." *They had not had phone calls from the provider regarding resident 20 or 18, only phone calls	F 684		

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F 684	Continued From page 18 confirming appointments. Interview on 8/5/21 at 9:28 a.m. with DON C revealed: *She believed RN D completed weekly wound assessments on the residents. *The LPNs documented wound information in the progress note but the RNs should be doing an assessment. *She was also in charge of Minimum Data Set assessments (MDS) for the residents. *She relied on the nurses' notes for updates. *She had been seeing issues with documentation, especially with wound documentation. *If a resident had a wound, then the RN would write up the assessment. *Families and physicians should have been updated with changes. *She did not believe LPNs could assess wounds. *CNAs look at the residents' skin weekly. -She agreed CNAs may not be aware of what to look for. *Care plans were not being updated as often as they should be. *Surveyor asked how she was made aware of changes that needed to be made to the resident's care plans: -She stated sometimes nurses will leave Post-It notes on her desk. Phone interview on 8/4/21 at 5:09 p.m. with AMT wound consultant RN O revealed: *He provided wound consulting for the residents that use AMT's products. *He provided clinical support. *He did not provide clinical support if the resident was not using AMT's products. *He provided clinical support for resident 10 in	F 684		

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F 684	Continued From page 19 July. *The first time he saw resident 10 was a couple of weeks ago. *He had also helped with resident 20 as needed. *Those were the only two residents he had recently provided clinical support for. Interview on 8/5/21 at 11:00 a.m. with infection control registered nurse (IC RN) D revealed: *She was designated as the wound care nurse. *She monitored residents' skin and wounds weekly. *Sometime last year was when she stopped assessing the wounds. *"It fell by the wayside with the COVID." *CNAs looked at resident's skin weekly. *She had received no wound care training. *She really did not understand wounds or what "slough" meant. Surveyor: 18560 6. Review of resident 22's medical record revealed: *She was admitted on 6/8/20. *Her 12/8/20 Braden assessment score was 12 indicating high risk for pressure ulcer. *Her 3/9/21 quarterly MDS assessment revealed: -Her cognition was severely impaired. -She was at risk of developing pressure ulcers. -No pressure ulcers were present. -Care and treatment for pressure ulcer included device in chair. *A 4/28/21 skin observation tool indicated "Skin intact, Dry areas noted to bilateral feet and heels lotion applied, skin warm and dry color pink, no open areas noted continue to monitor and assess." *A 5/31/21 skin observation tool indicated her right heel had a 2 x 2 unstagable area. -The right inner heel was noted to have hard	F 684		

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

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F 684	Continued From page 20 black tissue. *A 5/31/21 note to her physician "Resident has a 2cm x 2cm DTI [deep tissue injury] to her right inner heel. Wound is black, hard, and edges are intact. No drainage noted. Area is slightly tender for resident when touched. Protective heel boots applied. [Daughter's name] has been notified. Recommendations: Can we have an order for protective heel boots. Do you want any other treatment orders?" *A 6/1/21 order for protective heel boots on at all times and betadine twice a day until area healed. *Her 6/9/21 Braden assessment score was 12 indicating high risk for pressure ulcer. *Her 6/9/21 annual MDS assessment revealed: -Her Brief Interview for Mental Status (BIMS) score was 2 indicating severe cognitive impairment. -She was at risk of developing pressure ulcers. -She had one unstageable pressure ulcer. -Care and treatment for her pressure ulcer included pressure ulcer care. *Her pressure ulcer healed on 6/23/21. Interview on 8/4/21 at 9:31 a.m. with DON C regarding resident 22 revealed: *Her weekly skin assessments had not been done. *She had been treated with betadine. *The area had healed on 6/23/21. Further interview on 8/5/21 at 8:28 a.m. with administrator A and DON C regarding skin issues revealed: *Resident 22 was at high risk for pressure ulcers. *They believed resident 22 had protective boots prior to 5/31/21 but were unable to provide the documentation. *Nurses should have been doing weekly skin	F 684		

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F 684	Continued From page 21 assessments. Surveyor: 43844 7. Interview on 8/4/21 at 10:26 a.m. with resident 23 revealed she had a wound on her right foot that started as "quarter size and is healing now." Observation on 8/4/21 at 4:21 p.m. of resident 23's wound care by LPN E revealed: *A callous on the ball of her right foot approximately the size of a quarter and light tan in color. *A wound within the callous measuring approximately 0.5 cm by 0.5 cm, round in shape, and appeared dark brown in color. Review of resident 23's revised 8/14/20 care plan revealed: *She had been at risk for impairment to both feet related to fragile skin and had hyperkeraotic (a condition of thickening of the outer layer of the skin) lesions on her foot. *The intervention had been weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (fluid from cells) and any other notable changes or observations. -There had not been any interventions to prevent or heal the wound. Review of resident 23's medical record revealed: *On 5/10/21 a progress note stated there was a blister and planter ulcer noted to right foot. *A 6/30/21 physician order to "clean right foot callus thoroughly with half vinegar and water and apply dressing with silver alginate change every 2-3 days, one time a day every other day for right foot callous" *On 8/3/21 an appointment had been made with wound clinic for 8/5/21.	F 684		

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F 684	Continued From page 22 *On 8/4/21 a progress note stated the wound bed was black/brown. *There had been no weekly measurements of the wound. *A licensed nurse had not completed any skin assessments in the last year. Surveyor: 42558 8. Observation and interview on 8/3/21 at 3:45 p.m. with resident 32 revealed: *He had been sitting in a recliner watching television with no pants on. -He had been wearing an incontinent under garment covering his groin. -Stated he did not like to wear pants. *He had a prosthetic leg applied below his right knee. *He had a right below the knee amputation a few years ago. -It had been caused by an infected sore to his right foot that had not healed. *He denied any current skin issues. *It had been his choice to remain in his room for the majority of the day, including meals. -Stated he did not like to be around people and usually sat in his recliner all day and watched television. *He moved from his bed to his recliner with a walker and staff assistance. *He had a suprapubic catheter. -Stated he had difficulty urinating normally and wore the incontinent brief in case the catheter leaked. Review of resident 32's EMR revealed: *His BIMS was 15, meaning he was cognitively intact. *His diagnoses included: Type 2 diabetes mellitus with foot ulcer, chronic kidney disease, chronic right heart failure, aortic valve stenosis, peripheral	F 684		

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F 684	Continued From page 23 vascular disease, atherosclerosis of native arteries of extremities-bilateral legs, bladder neck obstruction, neuromuscular dysfunction of bladder, anxiety, major depressive disorder, and adjustment disorder with mixed disturbance of emotions and conduct. *His 7/7/21 quarterly Braden assessment scale for predicting pressure sore risk had a score of 21, meaning he had been determined to not be at risk for pressure ulcers. *His 7/9/21 quarterly MDS revealed he was at risk for pressure ulcers. -This MDS revealed there were no pressure ulcers or skin wounds present. *His revised care plan dated 7/20/21 revealed interventions of monitoring residents body for breaks in skin, complications of immobility, and to treat promptly as ordered by the doctor. *There had been no: -Nursing skin assessments located in the medical record. -Skin assessments provided by the facility when requested. Interview on 8/4/21 at 2:39 p.m. with administrator A revealed the staff member in charge of wound care and skin assessments had been IC RN D. Interview on 8/4/21 at 2:42 p.m. with IC RN D revealed: *She had not done skin assessments since having personal health issues for the last six months. -LPN L had been following the wound care and skin assessments. --LPN L had not been in the facility during the survey. *IC RN D stated skin assessments should be	F 684		

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F 684	Continued From page 24 found in point click care under the 'assessments' tab but that she had doubted it had been done. *Skin assessments might also be found in the nursing progress notes and she would try to locate these. -She provided one progress note for resident 32 dated 7/9/21 which had been a Quarterly Assessment review stating, "Resident is a risk for skin breakdown, no concerns noted." *The current way they monitor residents for skin issues was having the CNAs observe resident's skin during their bath and report any issues to the charge nurse. *There had not been regular nursing assessments and documentation of resident's skin. Interview on 8/5/21 at 9:18 a.m. with CNA K regarding reporting of skin issues revealed: *The CNAs observed resident's skin during their bath. -All the CNAs had been expected to give baths to their assigned residents on the resident's scheduled bath day. -There were no bath aides. *She summoned the nurse if she observed any new skin issues. -They also had a bath book where they wrote any new observations. *Reporting of new skin observations was common sense, and she had been trained on how to report to the nurse and document in the bath book. *She did not know if there was a skin/wound nurse, but all concerns should have been reported to the charge nurse and placed in the bath book. On 8/4/21 at 10:00 a.m. LPN E had been given a	F 684		

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F 684	Continued From page 25 list of the residents (9, 10, 13, 18, and 20) the surveyors identified as opportunities to view for skin conserns. At the conclusion of survey on 8/15/21, surveyors had not been summoned to view residents 9, 13, or 18. They had been told resident 18 was scheduled in the evening only. Interview on 8/4/21 at 11:30 a.m. with LPN E regarding documentation of skin wounds revealed: *All wounds were measured once per week. *Stated, "Everybody [nurses] had their own way of documenting." *She documented her dressing changes and wound measurements in the nurse's progress notes. Surveyor 42477: Review of the provider's February 2014 Pressure Ulcer Prevention and Wound Care Policy and Procedure revealed: *"In order to promote healthy, intact skin, all new residents admitted to [nursing home name] will be assessed to determine if they are at risk for Pressure Ulcers, have a current pressure ulcer, or any current skin issues..." *Licensed nurses would visually assess all boney prominence's on admission and document findings on skin admission assessment form on point click care and in nurses notes as indicated. *A Braden scale would be completed by a licensed nurse within 24 hours of admission. *Any resident with a Braden score of less than 12 would have a weekly skin inspection by the licensed nurse. *CNAs will inspect skin during showers, bathing, incontinence episodes and report to Charge Nurse any changes. *Braden scales will be completed quarterly.	F 684		

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F 684	Continued From page 26 *Resident will have an individualized plan of care which will include, problem identification based on risk factors, realistic time-framed goals, interventions that address risk factors. *"1. Residents who have a pressure ulcer will have assessment completed weekly and as needed due to changes, by a Licensed Nurse. Assessment will be recorded on the Weekly Pressure Ulcer Record. This will be noted on the resident's TAR that this assessment is to be completed. Each Pressure Ulcer will have its own Weekly Pressure Ulcer Record Sheet." *Dressing changes and treatments will be completed by the licensed nurse per Physician orders. *Physician will be notified of any new pressure ulcers or of anytime a pressure ulcer is not responding to treatment. *"All non-pressure skin issues (Skin tears, abrasions, bruises, venous/stasis ulcer, arterial ulcers, surgical wound) will be monitored weekly and as needed due to changes, on the Non-pressure skin condition report. This will be placed on the TAR [treatment administration record] to monitor weekly and document any Non Pressure Skin Condition Report. Each skin issue will have its own sheet." Review of the provider's undated Wound Assessment Policy and Procedure revealed: *"All wounds will be evaluated weekly and whenever a change occurs in the wound. Pressure Ulcers will be documented on the Weekly Pressure Ulcer Record and Non Pressure wounds are to be documented on the Non-Pressure Skin Condition report. Further details may be documented in the Nurses Notes in the chart, which will be documented on each report sheet that a nurses note was made ..."	F 684		

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F 684	Continued From page 27 *Specific instructions for wound assessments included: -Measuring the size of the wound. -Depth of the wound. -Edges of the wound. -Undermining of the wound, by using a cotton-tipped applicator. -Documenting the necrotic tissue style and amount, indicating the percentage of wound involved. -Type of drainage and amount. -Skin color surrounding wound. -Peripheral Tissue Edema. -Induration, by assessing the tissues surrounding the wound. -Granulation of the tissue. -Any infection. -Any discomfort. -Wound status. -Staging of wound. -Notification of the Primary Physician. Review of the provider's February 2014 Care Plan Policy and Procedure revealed: *Care plan meetings would consist of the facility's interdisciplinary team. *They would notify the family of the meetings. *Care plans allowed each department to get a clear understand of the resident's conditions/needs and set attainable goals. *Care plans would be updated as needed.	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697	Administrator, DON and medical director in collaboration with the pharmacy consultant will review and revise as necessary the policy and procedures to ensure pain management is provided following physician orders and established standards of care.	09/01/2021

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F 697	Continued From page 28 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on review of anonymous complaint, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (28) received pain management treatment per physician orders. Findings include: 1. Review of anonymous complaint received by the South Dakota Department of Health revealed: *Resident 28 had been in the facility for the past month. *She was to receive scheduled pain medication and as needed (prn) Tylenol. *The facility was giving scheduled pain medication late and not giving resident 28 her prn Tylenol. Interview on 8/3/21 at 11:11 a.m. with resident 28 revealed: *She stated: -She would often have to wait to receive her prn Tylenol. -Her other pain medication would often be given late. -She was not sure why she had to wait to receive prn Tylenol. -She often had a lot of pain. Review of resident 28's physician orders revealed: *She was to receive the following pain medication: -Oxycontin 10 milligram (mg) every night at 8:00 p.m. -Two tablets of 325 mg of acetaminophen as	F 697	8-30-21 K.S All staff responsible **to include LPN G and LPN F** for pain management will be re-educated on the updated policy and procedures for pain management. Resident 28 pain management regimen will be reviewed **by Administrator** per the updated policy and procedures. 8-30-21 K.S All other residents with pain management identified or with physician orders will be reviewed **by director of nursing or designee** per the updated policy and procedures. 8/30/21 K.S Director of Nursing or designee will audit all residents with pain management protocol in place to ensure that the resident(s) is receiving the appropriate pain management treatment once per week for 4 weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAI meetings for review and consideration.	

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F 697	Continued From page 29 needed for pain every four hours. Review of resident 28's current medical diagnoses included: *Scoliosis. *Femur fracture. *Chronic obstructive pulmonary disease. *Generalized Anxiety disorder. *Fibromyalgia. Review of resident 28's progress notes revealed: *She often requested medication for pain. *She was prescribed prn Tylenol for "breakthrough pain." *On 7/11/21 at 12:54 a.m. resident 28 received prn Tylenol. *On 7/11/21 at 3:02 a.m. prn pain medication was noted to be "ineffective." *On 7/11/21 at 4:13 a.m. licensed practical nurse (LPN) F documented: -"Resident did come to this writer about pain medication before resident could have pain medication. This writer let resident know that pain medication would be administered around 2100 [9 p.m.]. Resident was okay with that. Throughout this shift resident came to this writer at 0100 [1:00 a.m.] and asked for Tylenol. Resident then came to this writer 0300 [3:00 a.m.] asking for Tylenol and Zofran. Zofran was able to be administered as resident had had Zofran earlier during shift at 1900 [7:00 p.m.] for nausea from med aide. This writer informed resident Tylenol was not able to be administered d/t [due to] it not being long enough time from previous administration..." *The next time resident 28 was marked as receiving Tylenol was on 7/11/21 at 10:42 a.m. *On 7/12/21 at 8:48 a.m. LPN F documented: -"...Resident continues to ask for pain medications before scheduled medication is due.	F 697		

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F 697	Continued From page 30 Resident continues to ask for Tylenol within an hour after receiving Oxycodone. This writer educated resident on the use of over taking medications and how this is unhealthy for the body. Resident tried making excuses stating that taking her pain meds [medications] was not a problem and she used to be worse. This writer acknowledged residents explanation but educated resident that asking for Tylenol an hour after oxycodone is still seeking pain medication. This writer stated Tylenol could be administered 2 hours after Oxycodone but this still is quite a bit of Tylenol. This writer stated to resident that this is something to think about. Resident stated they were in pain. This writer stated that some times we always can't make the pain go away. Some times we may have to deal with a little discomfort and never be pain free..." *On 7/15/21 resident 28 requested to have Tylenol. *On 7/15/21 at 10:57 p.m. LPN G documented: -"...Resident came to desk asking for Tylenol it had only been a hour since she had taken oxycodone. Resident was reminded the issues with taking to many pain meds. Resident stated at [hospital name] I took both together and nothing happened. She was told to wait for awhile..." *On 7/16/21 at 3:20 a.m. LPN G gave resident 28 Tylenol. *On evening of 7/19/21 resident 28 had requested Tylenol. *On 7/19/21 at 1:48 a.m. LPN F documented: -"Resident asked this writer during HS [evening] medication administration if resident could have extra Tylenol with scheduled Oxycontin. This writer explained to resident that the Oxycontin has Tylenol in it and taking extra Tylenol with it is not necessary but resident could have Tylenol in a couple of hours. Resident agreed to this.	F 697		

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F 697	Continued From page 31 Resident stated pain 8/10 with administration of Oxycontin. This writer administered resident Tylenol at 2300 [11:00 p.m.]. At this time of medication administration, resident stated pain 6/10. Will continue to monitor resident for pain." *Resident 28 received Tylenol on 7/19/21 at 8:33 a.m. *There had no documentation of the physician being notified. Review of resident 28's June 2021 care plan revealed: *Resident 28 had chronic pain related to Fibromyalgia, Scoliosis, Chronic Pain syndrome, postural kyphosis. *Staff were to: -Anticipate resident 28's need for pain relief and respond immediately to any complaint of pain. -Evaluate the effectiveness of pain interventions daily. -Identify and record previous pain history and management of that pain. -Identify, record and treat the resident's existing conditions which may increase pain and or discomfort. -Resident 28's pain was aggravated by activity at times, weather, depression. -Monitor/record pain characteristics daily and prn. Quality, severity, anatomical location, duration, aggravating factors, and relieving factors. -Notify physician if interventions were unsuccessful or if current complaint was a significant change from resident's past experience of pain. -Provide the resident with reassurance that pain was limited. -Encourage resident to try different pain relieving methods, positioning, relaxation therapy, progressive relaxation, bathing, heat and cold	F 697		

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F 697	Continued From page 32 application, muscle stimulation, and ultra-sound. Interview on 8/5/21 at 8:02 a.m. with LPN G about resident 28 revealed: *Resident 28 would ask for Tylenol after she had her oxycodone. *LPN G would ask the resident to wait to see if her scheduled oxycodone worked first before administering prn Tylenol. *They did not provide any non-pharmaceutical pain interventions to help resident 28 with break through pain. Interview on 8/5/21 at 8:25 a.m. with LPN F about resident 28 revealed: *Resident 28 asked for Tylenol most nights. *Tylenol did seem to help resident 28. *She thought Oxycontin contained Tylenol. -The physician order did not state this, she looked it up online. *The order did not tell her to wait a certain amount of time before administering Tylenol. *Surveyor asked if they tried to utilize any non-pharmaceutical pain interventions for resident 28. *LPN F stated they were not allowed to use heat, and she believed they may have some ice packs. *LPN F was unable to mention any other non-pharmaceutical pain interventions that could have been used. Interview on 8/5/21 at 9:43 a.m. with director of nursing C revealed: *She agreed resident 28 should have been given her prn Tylenol as requested. *She was not aware that LPN F and LPN G were withholding her prn Tylenol. *Staff should be utilizing non-pharmaceutical pain interventions such as:	F 697		

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F 697	Continued From page 33 -Music. -Distractions. -Asking more questions. -Ice. Review of the provider's March 2020 Pain Management Policy revealed: *"The facility shall provide adequate management with pain to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being." *Residents should be evaluated for various behavior signs that may suggest the presence of pain. *If a resident's pain was not controlled by the current treatment regimen their physician should be notified. *The interdisciplinary team and the resident should come up with pertinent, realistic, and measurable goals. *Non pharmacological pain management included: -Room temperature. -Smoothing linens. -Turning and repositioning in a comfortable position. -Loosening bandages. -Applying pillows or blankets. -Warm showers, cold compresses, bath, etc. -Exercises. -Music, diversions, pain education, or other behavioral interventions. *"g. Some clinical conditions may require several analgesics or adjuvant medications, documentation should help clarify the rationale for a treatment regimen and to acknowledge associated risks." *"Reassess residents with pain regularly based on the facility's established intervals."	F 697		

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F 697	Continued From page 34 *"If when re-evaluated, findings indicate pain is not adequately controlled, revise the pain management regimen and plan of care as indicated." Review of the provider's March 2018 PRN [as needed] Medication orders policy and procedure revealed "PRN orders must specify the administration time if applicable and the maximum daily dosage, ex: [example] Tylenol 3-4 gms [grams] within 24 hrs [hours]." Review of the provider's May 2021 Facility Assessment tool revealed: They offered pain management which included: -An assessment of pain. -Pharmacologic and nonpharmacologic pain management.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions	F 700	Administrator, DON and medical director in collaboration with the maintenance manager will review, revise, create as necessary the policy and procedure about the appropriate assessment for use and safety of bed side rails. All staff responsible for bed rail usage will be re-educated on the updated policy and procedures for use of bed side rails. Resident 283 and 5 bed rail usage will be audited by **Director of Nursing** and plans of care updated per the updated policies for bed rails usage. 8.30.21 KS All other residents using bed rails will be audited **by Director of Nursing** and plans of care updated per the updated policies for bed rail usage. 8.30.21 KS	09/01/2021

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F 700	Continued From page 35 are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Side rails were not used for one of two sampled residents (283) with decreased cognition. *Safety assessments were completed and documented for one of two sampled residents (283). *Physician orders were obtained for side rail use for one of two sampled residents (283). *The care plan included the use of side rails for two of two sampled residents (5 and 283). Findings include: 1. Observation on 8/3/21 at 3:07 p.m. of resident 283's bed revealed a side rail in the up position on the top right side of the bed. Interview on 8/4/21 at 9:03 a.m. with resident 283 revealed she had been using her side rail when in bed and it helped "very much." Review of resident 283's medical record revealed: *The use of a side rail had not been included in her care plan. *There had not been a physician order for side rail use. *There had been no side rail utilization assessment completed. *Her Brief Interview for Mental Status (BIMS) score was an eight, meaning she had impaired	F 700	Director of Nursing or designee will audit all residents with bed rails once per week for 4 weeks and once per month for two more months to ensure bed rails are being utilized by the residents per the bed rail policy and procedures. Director of Nursing will present audit findings at the monthly QAI meetings for review and consideration.	

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F 700	Continued From page 36 cognition. 2. Observation and interview on 8/3/21 at 2:20 p.m. with resident 5 revealed: *His bed had a side rail in the up position on the top right side of the bed. *He used the side rail to assist with transferring. Review of resident 5's medical record revealed: *A 12/2/19 physician order to have a quarter size rail on his bed to assist in getting in and out of bed. *A 5/19/21 care plan that stated: -He required extensive assistance of one to two persons to turn and reposition in bed. -The care plan had not included the use of side rails. *A 5/5/21 and a 5/6/21 plan of care progress notes had not addressed the use of side rails. Interview on 8/4/21 at 2:29 p.m. with director of nursing (DON) C regarding side rail assessments revealed side rails assessments were completed each quarter. Interview on 8/5/21 at 10:00 a.m. with maintenance manager H revealed he had not assessed side rails attached to beds for safety. Interview on 8/5/21 at 11:45 a.m. with DON C regarding the process for side rail use revealed: *Resident requested use of side rail. *They reviewed the resident's BIMS score and completed a repositioning assessment. *Physical therapist was involved if necessary. *Physician was notified. *Care plan was updated when side rails were used. *She agreed the safety assessments had not	F 700		

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AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

(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 700	Continued From page 37 always been completed and should have been. Review of the provider's 10/2/19 Side Rail policy revealed: *"Side rails will be placed on a bed per residents request or as determined by the side rail utilization assessment. *Before a side rail is placed a physician order will be obtained and the charge nurse will complete the utilization assessment. *All in use side rails will be re-assessed quarterly. *Any resident with decreased cognition or a BIMS score of 8 or less will not be allowed a side rail on their bed."	F 700		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being for all thirty-four residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the course of the survey revealed management consultant B, administrator A, and director of nursing services C had not ensured the safe management and	F 835	Administrator, management consultant and governing board will review and revise as necessary the policies of the facility to ensure the facility is operated and administered in a manner that ensures the safety and overall well-being of all residents in the facility. All residents are possibly affected by this policy so administration and management will ensure appropriate implementation of this plan of correction. All staff will be educated on the necessity of implementation and success of this plan of correction. Administrator will audit the completion of plan of correction once per week for 4 weeks and once per month for 2 more months to ensure the successful implementation of this plan of correction. Administrator will present audit findings at the monthly QAPI meetings for review and consideration.	09/01/2021

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F 835	Continued From page 38 overall well-being of all the residents who lived in the facility. Interview on 8/5/21 at 3:30 p.m. with administrator A revealed: *She was the emergency permit holder for the facility. *She was being precepted by management consultant B. *Management consultant B came to the facility about two times per month. *During their visits they went over accounting and payroll. *They did not go over any care items or care topics. *Surveyors requested preceptor training forms, they were not provided. Review of the provider's January 2012 Administrator job description revealed: *Duties included: -Manage and facilitate all the daily operation within the nursing home. -Prepare agendas for meetings. -Undertakes supervision of all property. -Consistently review service programs for efficiency and effectiveness in operations. -Supervises all department heads and staff. -Develops and reviews all operational policies. Review of the provider's March 2021 signed Preceptor Agreement revealed: *Management consultant B agreed to provide appropriate supervision to the emergency administrator. *Observe the emergency administrator at least two days per month in the facility and keep a written memorandum of what was accomplished or discussed at these visits.	F 835		

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F 835	Continued From page 39 Surveyors had requested signed preceptor forms on 8/5/21 at 3:30 p.m. and at 4:15 p.m. the surveyors had not received these forms.	F 835		
F 837 SS=F	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: 42477 Based on observations, interviews, record reviews, job description reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being for all thirty-four residents in the facility. Findings include: 1. Refer to F580, F582, F684, F697, F700, F835, F880, F881, and F882.	F 837	Administrator, management consultant and governing board will review and revise as necessary the administration policies of the facility to ensure the facility is operated and administered in a manner that ensures the safety and overall well-being of all residents in the facility. All residents are possibly affected by this policy so administration and management will ensure appropriate implementation of this plan of correction. All staff will be educated on the necessity of implementation and success of this plan of correction. Administrator will audit the completion of plan of correction once per week for 4 weeks and once per month for 2 more months to ensure the successful implementation of this plan of correction. Administrator will present audit findings at the monthly QAPI meetings for review and consideration.	09/01/2021
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	F 865	Administrator will review and revise as necessary the quality assurance performance improvement (QAPI) process to ensure process is all encompassing of the care of the residents and that the staff that participate	09/01/2021

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F 865	Continued From page 40 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on record review and interview, the provider failed to ensure performance improvement projects (PIP) had been thoroughly examined and resolved with an effective quality assurance performance improvement (QAPI) process. Findings include: 1. Interview on 8/5/21 at 11:00 a.m. with administrator A and Infection control registered nurse (IC RN) D revealed: *They both attended QAPI meetings. *IC RN D stated she did not participate, she "just listened." *They have not had any PIPs in place. *They were not aware of any issues with wounds or assessments. Refer to F880, F881, and F882.	F 865	are engaged in the process. The administrator has implemented a new QAPI program to ensure the program covers all departments and all areas of resident care including but not limited to infection control, skins, medication administration, personnel management and many others. All residents are possibly affected by this policy so administration will ensure appropriate implementation of this QAPI program. All staff will be educated on the necessity of implementation of this QAPI program. Administrator will audit the implementation of this QAPI program once per month for three months to ensure the successful implementation of this QAPI program. Administrator will present audit findings at the monthly QAPI meetings for review and consideration.	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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	Time cannot be turned back to a time prior to the identification of lack of: *appropriate use of barrier during use of glucose meter and insulin pen. *appropriate hand hygiene and glove use and procedural technique during provision of resident personal cares. *appropriate maintenance and sanitation of individual resident care items in shower rooms. The administrator and DON in collaboration with the medical director will ensure the designated infection control nurse: *Uses data collection of antibiotic use in the facility to contribute to the development of antibiotic protocols. *Routinely report antibiotic use and findings to QAPI committee. *Effectively implements and executes facility policy through staff education and competency demonstration. *Routinely report staff education and competency monitoring to QAPI committee. The administrator and DON in consultation with the medical director and infection control nurse and whomever else identified will review, revise, create as necessary policies and procedures about: *Appropriate use of barriers during procedures that include glucose meter and insulin pens. *Appropriate hand hygiene and glove use and procedural techniques during resident personal care. *Appropriate maintenance and sanitation of individual resident care items in shower rooms. *Necessary infection control and prevention plan that includes effective compliance. All staff who provided above care and services to residents will be educated/re-educated by 8/31/2021 by the Director of Nursing.	09/01/2021

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F 880	Continued From page 42 (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: 42558 Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control practices were: *Followed by one of one licensed practical nurse (LPN) E and one of one certified nursing assistant (CNA) J while performing resident cares. *Maintained for two of three facility shower rooms. Findings include:	F 880	Identification of Others: 1. ALL residents have the potential to be affected if staff do not adhere to: *Appropriate use of procedural techniques that includes the use of a barrier when using a glucose meter and insulin pen. *Appropriate hand hygiene and glove use as well as procedure technique when providing personal cares. *Appropriate maintenance and sanitization of individual resident care items in shower rooms ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by 8/31/2021 by the Director of Nursing. System Changes: 2. Root cause analysis conducted answered the 5 Whys Administrator, DON, infection control nurse, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency. Administrator will contact the South Dakota Quality Improvement Organization (QIN). On 08/23/2021, spoke with **Quality Improvement advisor** reviewed infection control plans. Resources sent. All questions answered. Monitoring: 3. Administrator, DON, infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis.	8/31/21 KS

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F 880	Continued From page 43 1. Observation on 8/4/21 at 8:04 a.m. with LPN E providing a glucometer (blood sugar) test with resident 32 revealed she: *Brought the glucometer into resident 32's room and placed it on the resident's nightstand without placing a protective barrier underneath. *Obtained a sample of blood from the resident, then placed the used blood-infused test strip into the resident's personal garbage upon completion of the test. *Removed the glucometer from the resident's room and placed it on top of the medication cart prior to disinfecting it with a sani-wipe. 2. Observation on 8/4/21 at 8:10 a.m. with LPN E providing insulin administration to resident 3 revealed she: *Laid the pre-drawn insulin pen on the resident's overbed table without an underlying barrier. *Removed the insulin pen from the resident's room and returned it back into the medication cart without disinfecting the outside of the insulin pen. Interview on 8/5/21 at 8:50 a.m. with infection control registered nurse (IC RN) D regarding the above observations revealed she: *Agreed those were not acceptable infection control practices. *Expected the glucometer and insulin pen to be sanitized prior to placing it on or in the medication cart. *Had not thought of placing a barrier under a glucometer once it was set down in a resident's room. *Agreed used glucometer test strips containing blood should have been placed into the sharps container for disposal. Interview on 8/5/21 at 10:19 a.m. with LPN E	F 880	After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person, or whomever else is determined necessary, to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

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F 880	Continued From page 44 regarding the above observations revealed she: *Had been aware she needed to place a barrier underneath the glucometer when placing it on resident furniture. *Had not known she should not place used insulin test strips containing blood into the resident's garbage. *Had not realized she needed to disinfect the outside of insulin pens if they were placed on resident furniture. 3. Observation on 8/4/21 at 3:00 p.m. with CNA J during peri (groin) care to resident 10 revealed: *She applied gloves and removed the resident's urine soaked incontinent pad and cleansed his genitals with a pre-moistened wipe. *Without washing her hands and using the same soiled gloves she: -Pulled back the divider curtain to talk with the resident's roommate. -Opened the shared bathroom door to remove a clean incontinent pad from a package. -Applied a clean incontinent pad to the resident's groin. -Turned the resident onto his side touching his shirt and hip. -Applied a clean incontinent pad to his mattress. -Readjusted his head and pillow. -Pulled a top sheet over his body. Interview on 8/4/21 at 3:30 p.m. with CNA J revealed: *She agreed she had missed the opportunity to change her gloves and wash her hands when going from a dirty to clean procedure. *She had been employed as a CNA since 3/21/21. *She had recently passed her CNA test. *She did not recall doing education or online	F 880		

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F 880	Continued From page 45 training for hand hygiene and infection control. -It may have been included in her training modules. -Her training mostly consisted of on-the-job training. *IC RN D had showed her some papers on how to do resident cares. Interview on 8/5/21 at 8:50 a.m. with IC RN D revealed: *She had been aware of the above observation with CNA J. *CNA J should have washed her hands and changed her gloves following removal of the incontinent pad. -CNA J had just become certified in the past few months. --Infection control had been included in the CNA education competency exam. *She had already re-educated CNA J on hand washing and glove use since yesterday's observation. Review of the provider's March 2014 Hand Washing Policy and Procedure revealed: *"Purpose: To decrease the risk of transmission of infection by appropriate hand hygiene.1. Handwashing. When hands are visibly dirty or contaminated with proteinaceous material, are visibly soiled with blood or other body fluids, after going to the restroom, before eating, before performing [an] invasive procedure, and after providing care to a resident with [a] spore-forming organism (i.e. c. difficile), perform hand hygiene with either a non-antimicrobial soap and water or an antimicrobial soap and water." Review of the provider's updated 2/2/15 Glucometer Cleaning Policy revealed:	F 880		

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F 880	Continued From page 46 *"Procedure: -"1. The nurse will obtain the glucometer along with the wipes and place the glucometer and the wipe container on the overbed or nightstand on a clean surface, i.e. paper towel, wax paper. Nurse will don gloves prior to obtaining blood sample." -"Cleaning and disinfecting the glucometer:" --"A. After performing the glucometer testing, the nurse shall perform hand hygiene, don gloves, and use the disinfectant wipe to clean all external parts of the glucometer. Leave surface wet per wipes protocol." Surveyor: 42477 4. Observation on 8/3/21 at 10:48 a.m. of the facility's shower room located on the 100 hallway revealed: *Sign on cabinet stated please lock before leaving, it was unlocked. *Inside the unlocked cabinet were: -Three dirty nail clippers, with visible debris inside them. -One used nail file. -Bottles of shampoo, lotion, without resident names on it. -Used deodorant, was not identified with a resident's name. 5. Observation on 8/3/21 at 2:58 p.m. of the facility's shower room located on the 200 hallway revealed: *Inside the unlocked cabinet, there were: -Dirty nail clippers, with visible debris inside them. -Used deodorant without a resident's name. -Used nail file. Interview on 8/5/21 at 10:07 a.m. with IC RN D revealed: *Any items in the shower rooms should be labeled with a resident's name.	F 880		

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F 880	Continued From page 47 *Finding those items had been an ongoing issue within the facility. *There was not a contact time for disinfecting glucometers. *She stated, "I believe there is no contact time, it is instant." Review of the provider's March 2020 General Infection Prevention and Control Policies revealed: *"Infection surveillance will be either "whole-house" (i.e., include all residents), or "targeted" toward high risk/high volume, whichever is in accordance with local and state department of health requirements. Data will be reported internally-monthly, quarterly, or as indicated by the Quality Assurance Committee."	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview and record review, the provider failed to have an ongoing Antibiotic Stewardship program. This failure placed all residents at risk for potential adverse outcomes, associated with the inappropriate and/or unnecessary use of antibiotics. Findings included:	F 881	The administrator, DON and infection preventionist in consultation with the medical director, Pharmacist and whomever else identified will review, revise, create as necessary policies and procedures about: **infection prevention and control program (IPCP) that will include, at a minimum, the following elements: An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.** **Administrator, DON, and other designated staff will complete infection control specific QAPI meeting with Root cause analysis (RCA) identifying the five "whys" (step 5) with plan for correction.** **Monitoring:**	09/01/2021 8-30-21 KS

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F 881	Continued From page 48 1. Interview on 8/5/21 at 10:51 a.m. with infection control registered nurse D revealed: *She was in charge of the antibiotic stewardship program. *She had a log of antibiotics that residents had been on. *She was not monitoring any trends or patterns with infections or antibiotics. *She did not have any tracking or monitoring of cultures or lab results. *In their April quality assurance process improvement (QAPI) meeting, their pharmacist stated they should start using a situation, background, assessment, recommendation (SBAR) form. -That form had not been implemented. *She stated there was no collaboration with the pharmacist and medical director regarding antibiotic usage. *There was not a committee for the Antibiotic Stewardship program. *She stated she did not report any findings to QAPI. Review of the provider's August 2017 Antibiotic Stewardship Program (ASP) policy and procedure revealed: *"Develop and implement protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic." *The program must include leadership support and accountability. -This was via the participation of the medical director, consulting pharmacist, nursing and administrative leadership, and individual with designated responsibility for the infection control program.	F 881	**Administrator, DON, infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance.** **Designated staff will be educated on how and when to use pharmacist recommended/ pharmacy provided SBAR physician antibiotic request forms to ensure specific criteria is met per antibiotic stewardship guidelines**	8-30-21 KS

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

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F 881	Continued From page 49 *The committee were responsible for setting standards for prescribing practices. *"The facility will establish standards for nursing staff to assess, monitor and communicate changes through the utilization of SBAR forms (e.g., Situation, Background, Assessment, Review & Recommend) in a resident's condition that could affect the need for antibiotics." *"The ASP group will collect and review antibiotic use data and ensure best practices are followed. Antibiotic usage and outcome data will be collected and documented using a facility approved surveillance tracking form..."	F 881		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least	F 882	**Administrator, DON and designated staff will review and revise how Infection Prevention and Control Program (IPCP) audits, competencies and antibiotic use are completed and documented.** 8-30-21 KS **Administrator, DON, and other designated staff with consult from medical director and pharmacist will educate infection preventionist on properly documenting audits competencies antibiotic use and other items monitored by the infection preventionist for presenting usable data at monthly QAPI meeting.** **Infection preventionist will be provided remedial training in Infection prevention and control program (IPCP) with mentor-ship by experienced IP.** **Administrator, DON, Infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above.** **Progress will be monitored weekly for 4 weeks then twice monthly for one month then monthly with data documentation brought forth to QAPI meeting.**	09/01/2021

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F 882	Continued From page 50 one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview, policy review, and job description review, the provider failed to ensure one of one infection control registered nurse (IC RN) D established and followed infection control monitoring and surveillance. Findings include: 1. Interview on 8/5/21 at 10:07 a.m. with IC RN D revealed: *She had completed infection prevention training. *When asked about her audits she stated: -She performed audits in the break room. -She audited staff sanitizing their hands before and after they ate their meals. *This surveyor asked if she had audited any resident cares. -She stated that she had not. *She was usually not out on the floor because of her back. *She put signs up in the break room for education. *She had no way of knowing who received the education. *She had completed donning and doffing competencies for six employees. -She was not able to complete donning and doffing competencies for the other employees. Review of the provider's infection control audits revealed: *There were check marks. *The audits did not mention: -Who was audited or what was audited.	F 882		

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F 882	Continued From page 51 -The date of the audit. -The result of the audit.. Review of the provider's July 2014 Infection Control Nurse Job description revealed: *"The infection control nurse is responsible for the quality of resident care as it relates to investigation, control and prevention of infection ..." *The infection control nurses duties included: -Performing surveillance to identify infections in residents and staff, in a timely manner. -Tracking trends in infections within the facility. -Identifying infection control issues during environmental rounds. -Monitoring infection prevention and control practices and employee compliance. -Develop and revise infection control policies and procedures. -Conduct outbreak investigation and initiate control measures. -Provided orientation and continuing education related to infection control for all staff. -Actively participate and report to the Quality Assurance Committee. -Perform any other infection prevention and control duties that will improve resident care. *"The infection control nurse will report to the Quality Assurance Committee and consult to all departments in the facility, in recognition of the fact that an effective infection prevention and control program necessitates the cooperation of the entire staff."	F 882		

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E 000	Initial Comments Surveyor: 42477 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 8/3/21 through 8/5/21. Aurora Brule Nursing Home Inc. was found not in compliance with the following requirement: E001.	E 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to	
E 001 SS=D	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001	Administrator and leadership team will review and revise as necessary the emergency preparedness program so that includes policies, procedures, communication plan and contact information. This would include but not limited to: 1. Sewage and wasted disposal 2. Sheltering in place 3. Preservation of resident medical information 4. Roles of volunteers 5. Emergency transfers for residents 6. Communication plan Administrator will present the updated emergency pan to the governing board for review and consideration. All staff will be re-educated on the updated emergency preparedness plan. Administrator will complete staff competency audits around the updated emergency preparedness plan to ensure staff are aware of the existence of this plan, location of this plan and how to carry out this plan once per month for 3 months.	09/01/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen Styles	Emergency Permit Holder	08/25/2021

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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E 001	Continued From page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview and record review, the provider failed to establish a complete emergency preparedness program that included policies, procedures, communication plan, and contact information. Findings include: 1. Interview and review of the provider's emergency preparedness program documentation on 8/5/21 at 9:35 a.m. with administrator A and maintenance manager H revealed: *They did not have a complete emergency preparedness program. *They had not: -Addressed policies and procedures for sewage and waste disposal. -Addressed policies and procedures for sheltering in place for residents, staff, and volunteers who remained in the facility. -Addressed policies and procedures for medical	E 001	Administrator will present audit findings at the monthly QAPI meetings for review and consideration.	

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E 001	Continued From page 2 documentation that preserved resident information, protected confidentiality of resident information, and secured and maintained availability of records. -Addressed the use and role of volunteers in their policies and procedures. -Developed arrangements with other long term care facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to residents. -Developed and maintained a communication plan and reviewed and updated it at least annually. -Developed a communication plan that had: --Included names and contact information for staff, residents' physicians, other long term care facilities, and volunteers. --Included emergency officials contact information. *They had not been aware of all requirements for a complete emergency preparedness program.	E 001		

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	435132	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2021**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/3/21. Aurora Brule Nursing Home Inc 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 deficiency identified at K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to.	
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to maintain egress paths free of hazards for 1 of 11 exits (employee entrance /service door area). Findings include: 1. Observation on 8/3/21 at 2:18 p.m. revealed the path of egress for the employee entrance to the west (exit door number three.) The concrete path at that location was broken up and had an	K 211	Facility will repair concrete at exit door number 3. Maintenance Director will clean up area and place safety cones around area to alert staff of broken-up concrete until the concrete is repaired. Maintenance Director will audit concrete at all other exit doors monthly to ensure safe surfaces and repair as needed. Maintenance Director will audit completion of this concrete repair once per month until project is complete. Maintenance Director will report audit findings at the monthly QAPI meetings for review and consideration.	09/01/2021

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

Kathleen Styles | Emergency Permit Holder | 08/25/2021

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	435132	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2021**

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K 211	Continued From page 1 abrupt level change in the path of egress of five-eighths of one inch. LSC 7.1.6.2 Interview with the director of environmental services at the time of the observation confirmed that condition. He stated he had not been made aware of that condition. The deficiency had the potential to affect 100% of the occupants.	K 211		

South Dakota Department of Health

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	10709	A. BUILDING: _____ B. WING _____	08/05/2021

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S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/3/21 through 8/5/21. Aurora Brule Nursing Home Inc was found in compliance.	S 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to.	
S 000	Compliance/Noncompliance Statement Surveyor: 18560 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 8/3/21 through 8/5/21. Aurora Brule Nursing Home Inc was found in compliance.	S 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to	

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

Kathleen Styles

TITLE

Emergency Permit Holder

(X6) DATE

08/25/2021