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
	435088	A. BUILDING ______ B. WING ______	10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

(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: 26632 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/18/21 through 10/20/21. Centerville Care and Rehab Center Inc was found not in compliance with the following requirements: F574, F578, F582, F609, F610, F657, F658, F684, F686, F689, F744, F835, F837, F841, F867, F880, F881, F883, and F886.	F 000		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact	F 574	F 574 DOH contact information posted in same spot as other state agencies information. SSD or designee will audit availability of DOH contact information once per week for 4 weeks and monthly for 2 additional months. SSD or designee will report findings at monthly QAPI meetings.	11/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst
TITLE: Administration
(X6) DATE: 11/22/21

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 574	Continued From page 1 agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance	F 574		

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F 574	Continued From page 2	F 574		

directives requirements and requests for information regarding returning to the community.
This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on observation and interview, the provider failed to make accessible to all residents and their representatives the contact information for filing a complaint with the state survey agency.
Findings include:

1. Interview on 10/19/21 at 3:40 p.m. with eight residents (2, 4, 7, 12, 17, 18, 22, and 24) who identified themselves as regular attendees of the Resident Council revealed none of them knew about their right to:
*Read the state survey results nor where to find them without having to ask for them.
*Contact the ombudsman nor where to find the contact information.
*Formally complain to the state survey agency about facility care and services nor where to find the contact information.

Observation on 10/19/21 at 4:30 p.m. of the facility lobby and public area in the center of the facility by the administrator A's office:
*A wire bin hanging on the wall with a blue binder in it that contained the results of the most recent survey results.
*A poster about the ombudsman including contact information.
*No posting was found providing contact information for reporting a complaint with the state survey agency.

Interview and observation on 10/20/21 at 7:45 p.m. with administrator A confirmed a posting with contact information for reporting complaints with

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F 574	Continued From page 3 the state was not found.	F 574		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to	F 578	F 578 Revised and updated advanced directives for residents 4, 7, 9 and 29. All other residents advanced directives will be reviewed with quarterly assessments and as needed All residents will have their advanced directives review at time of admission. Administrator, DON, and interdisciplinary team reviewed, revised, and created necessary policies and procedures. SSD or designee will audit advanced directives weekly for 4 weeks and monthly for 2 additional months. SSD or designee will report findings at monthly QAPI meetings.	11/11/21

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F 578	Continued From page 4	F 578		

provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Surveyor: 26632

Surveyor: 42477

Surveyor: 06365
Based on interview and record review, the provider failed to:
*Review one of one sampled resident's (30) advance directive code status during the care planning process after the resident had a change of condition.
*Document communication with the physician and obtain a physician's order for the advance directive code status for two of twelve sampled residents (5 and 27).
*Revise and update the provider's code reference sheet for four of twenty-two listed residents (4, 7, 9, and 29).
Findings include:

1. Review of documentation from resident 30's record revealed there was no formal review of the advance directive code status when the resident transitioned from the assisted living to the nursing home on 7/5/21 following a hospital stay and subsequent change in condition:
*An admission summary progress note dated 11/29/19 indicated resident 30 admitted to the assisted living on that date.
*A scanned copy of an advance directives form

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F 578	Continued From page 5	F 578		

was signed by the resident and the social services designee (SSD) C on 11/29/19 and the physician on 11/30/19 with the code status checked for "Request for a Resuscitate."
*The admission record noted an admission date of 7/5/21 to "long term [care]" after a recent hospital stay.
*The code status listed on the admission record was CPR (resuscitate).
*The admission summary progess note dated 7/9/21 did not document the resident's advance directive code status was reviewed with the resident.
*The care plan initiated on 7/19/21 noted a focus of CPR.
*The care team progress note dated 7/20/21 did not document resident 30's advance directive code status was reviewed with the resident.

Interview on 10/20/21 at 3:30 p.m. with director of nursing (DON) B and administrator A revealed:
*The advance directive discussion occurs at admission.
*Social services designee (SSD) C carries out that task. (SSD C was not available for interview.)
*There had not been a process for reviewing a resident's advance directive code status when a resident transitioned from assisted living to long-term care due to a change in condition.
*The advance directive form "in the box" today to be signed by the physician.

2. Review of resident 27's record for advance directive documentation on 10/19/21 at 3:20 p.m. revealed:
*A scanned copy of resident 27's "living will - durable power of attorney for health care center" signed by resident 27 on 7/11/19 with her initials on the line noting, "If my death is imminent or I

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F 578	Continued From page 6 am permanently unconscious, I choose not to prolong my life." *The admission record noted a code status of "DNR" (do not resuscitate) on the admission date of 8/6/19. *The admission summary progess note dated 8/6/19 did not document a review of the resident's code status with the resident or the designated power of attorney (POA). *The care plan initiated on 8/7/19 noted a focus of DNR. *The care team progress note dated 8/9/19 did not document a review of the resident's code status with the resident or the POA. *The active order summary report on 10/21/21 did not include a physician order for DNR. Interview on 10/20/21 at 3:30 p.m. with director of nursing (DON) B revealed: *There was no order for do not resuscitate. 3. Review of resident 5's medical record revealed: *A durable power of attorney for health decisions. *A living will declaration that she had signed on 5/14/09. *She had chosen on her living will declaration "Treatment for Restoration. Provide life-sustaining treatment only if any for so long as you believe treatment offers a reasonable possibility of restoring to me the ability to think and act for myself." *Her code status was listed as "CPR - No life support, No tube feeding, Comfort care." *There was no physician's order for her code status. Surveyor: 42477 4. Observation and interview on 10/20/21 at 1:00	F 578		

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F 578	Continued From page 7 p.m. with registered nurse (RN) D revealed they had a sheet in the nurses' office with code statuses. Review of the full code sheet that the nurses used for their reference revealed: *Resident 4 and Resident 9 were not on the sheet. *Resident 7 and Resident 29 were not on the sheet and were of full-code status.	F 578		
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 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	F 582	F 582 Cannot go back and correct non-compliance for lack of SNF/ABN forms provided. Will ensure that residents receive the correct forms going forward. Administrator, DON, and interdisciplinary team reviewed, revised, and created necessary policies and procedures SSD or designee will audit correct NOMNC forms given weekly for 4 weeks and monthly for 2 months. SSD or designee will report findings at monthly QAPI meetings.	11/11/21

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F 582	Continued From page 8	F 582		

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 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: 26632
Based on interview and record review, the facility failed to provide proper notices to two of three reviewed residents (22 and 133) informing them that facility charges would no longer be covered under Medicare when their skilled therapy services ended. Findings include:

1. Review of resident 22's medical record revealed she had been admitted with Medicare A services on 10/5/21. Her last covered day of Medicare A services was on 10/12/21. She stayed

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F 582	Continued From page 9 in the facility at that time. A skilled nursing facility/advanced beneficiary notice (SNF/ABN) had not been been provided to her. She had only received a Notice of Medicare non-coverage (NOMNC). 2. Review of resident 133's medical record revealed she had been admitted with Medicare A services on 6/9/21. Her last covered day of Medicare A services was on 8/14/21. She stayed in the facility at that time. She had only received a NOMNC. A SNF/ABN had not been been provided to her. She had received a "Medicare Secondary Payer" notice instead. That was a provider form. Interview on 10/20/21 at 5:31 p.m. with administrator A revealed: *Those were the only forms residents 22 and 133 had signed. *Social service designee (SSD) C was responsible for providing the Medicare notices to the residents. *SSD C was out of the facility at that time. *There was no policy for the completion of the Medicare notices.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609	F 609 Cannot go back a correct lack of reporting to DOH on previous incidents. Will ensure that reporting is completed to the DOH for all mandatory reportable events by reviewing resident charting. Education provided at the all staff meeting on 11/19/21 about mandatory reporting and investigations.	11/11/21

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F 609	Continued From page 10 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, record review, the provider failed to report: *Fall incidents resulting in a serious bodily injury for two of two residents (4, 29). *Resident to resident altercations (verbal or physical threats) as potential allegations of abuse for two of two residents (2, 14). *Unsafe exiting (elopement) from the facility for one of one residents (28). Findings include: 1. Review of risk management reports and progress notes in the electronic medical record (EMR) for resident 29 between 1/26/21 and 10/20/21 revealed sixteen falls (see F610, finding 1), including one fall resulting in a serious bodily injury on 5/20/21 at 9:45 a.m.:	F 609	F 609 Administrator, DON, and interdisciplinary team reviewed, revised, and created necessary policies and procedures. Administrator or designee will audit reporting of all incidents weekly for 4 weeks and monthly for 2 additional months. Administrator or designee will report findings at monthly QAPI meetings.	

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F 609	Continued From page 11 *The resident fell while standing and hit his forehead on a table. *He then had low blood pressure, "three partial seizures back to back," and was perspiring. *The resident was sent by ambulance for physician evaluation. Review of the submitted online state reports revealed the fall on 5/20/21 had not been reported as a serious bodily injury. 2. Review of risk management reports and progress notes in the EMR for resident 14 between 1/16/21 and 10/20/21 revealed six resident to resident altercations (see F610, finding 2), including one with an injury of unknown source on 5/9/21 at 4:29 p.m.: *Residents 14 and 2 were sitting together in the television lobby. *Resident 2 was observed with "fingernail marks on the inside of (resident 2's) wrist." Review of the submitted online state reports revealed the altercation on 5/9/21 was not reported as an injury of unknown source. Surveyor: 42477 3. Review of submitted online South Dakota department of health submitted reports revealed: *Not all the falls with resident 4 had been reported. Refer to F689, finding 4. *The incident with resident 2 that resulted in fingernail marks had not been reported. Refer to F689, finding 5. *The elopement with resident 28 had not been reported. Refer to F689, finding 3.	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		

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F 610	Continued From page 12 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, and record review, the provider failed to investigate: *Fall incidents, including one that resulted in needing more than first aid for two of two residents (4 and 29). *Resident to resident altercations (verbal or physical threats) for four of four residents (2, 14, 27, and 29). Findings include: 1. Review of risk management (RM) reports and progress notes (PN) in the electronic medical record (EMR) for resident 29 between 1/16/21 and 10/20/21 revealed the resident had sixteen falls: only four were witnessed, six did not have correlating progress notes in the resident's EMR. *1/26/21 at 4:38 p.m. Found lying on his back in	F 610	F 610 Due to time passed cannot go back and investigate falls and other incidents. Will ensure proper investigations done going forward. Education provided at the all staff meeting on 11/19/21 about mandatory reporting and investigations. Administrator, DON, and interdisciplinary team reviewed, revised, and created as necessary policies and procedures. Administrator or designee will audit all investigations weekly for 4 weeks and monthly for 2 additional months.	11/11/21

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F 610	Continued From page 13 the center of his room, had a one-inch lump on the back center of his head. *1/28/21 at 11:40 p.m. Found lying face down in his room facing the bathroom, had abrasions to his right and left forehead above the eyes. *1/29/21 at 8:45 a.m. Found lying face down on the floor in his room facing the bathroom. *3/22/21 at 9:36 a.m. Found on the floor next to his wheelchair with a bruise on the top of his right hand. *3/22/21 at 6:12 p.m. Tripped over his feet when walking and hit his chin on top of the wing-back chair as he fell forward. *5/20/21 at 9:45 a.m. Fell forward from a standing position and hit his forehead on the side table between two recliners at the nurse's desk resulting in a serious bodily injury. (See F609, finding 1.) *6/3/21 at 1:00 p.m. Could not be redirected from climbing onto the wheelchair scale, then was found kneeling on it. *6/13/21 at 5:33 p.m. Found in the dining room sitting on the floor in front of his wheelchair facing the doorway. *6/19/21 at 9:27 a.m. Found sitting on the floor beside his bed with a skin tear to his right arm above the elbow. *6/23/21 at 6:25 p.m. Observed standing in the doorway to his room with a small amount of blood dripping from his right ear area, he stated he fell. *6/29/21 at 6:10 p.m. Walking with staff assistance to the dining room but lowered to the floor when his legs became shaky. *8/16/21 at 6:00 p.m. Found sitting on the floor in the lobby facing the television with a small skin tear on his right elbow. *9/28/21 at 4:45 p.m. Found sitting on the floor between his wheelchair and the wall of the television lobby facing the television, he said he	F 610		

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F 610	Continued From page 14 hit his head. *9/29/21 at 3:30 p.m. Registered nurse heard a thud in the therapy room and found the resident lying on his left side facing the windows. *10/11/21 at 2:29 p.m. Was seen falling to the floor after losing his balance in the dining room. *10/20/21 at 12:30 p.m. Found him out of his wheelchair and lying on his right side on the dining room floor with a two-inch lump on the right forehead. In addition, review of progress notes for resident 29 between 1/16/21 and 10/20/21 revealed nine resident to resident altercations caused by resident 29. *3/21/21 at 6:20 pm. Resident 29 was entering several residents' rooms and "firmly said to (resident 1) Are you just going to sit there? (resident 1) responded yes. (Resident 29) was aggressive not re directable." *4/10/21 at 4:19 p.m. The resident was "going into rooms and has been found to get into dresser drawers and moving things around in the rooms." *6/3/21 at 3:02 p.m. Resident 1 reported to social services designee (SSD) C that resident 29 was "rummaging through his stuff" and a female resident reported that resident 29 "keeps going into her room and she doesn't like it." *8/25/21 at 2:48 p.m. Resident 29 wandered into a room occupied by a resident who then screamed. *9/4/21 at 2:31 p.m. The resident "slapped (resident 2) in the mouth." (Reported to the state as physical harm/abuse.) *9/12/21 at 3:13 pm. The resident "had been rolling up to others resident in the dining room and running into them. When approached by staff to move him from others he would strike out and	F 610		

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hit staff."
*9/26/21 at 1:00 p.m. Staff tried to reposition resident 29 in his dining room chair and he became "combative" and then "picked up a bib laying on the table and threw it across the table hitting the liquid drinks another resident had sitting there."
*10/3/21 at 1:58 p.m. The resident entered resident 27's room. "They had a verbal altercation but did not hit each other."
*10/10/21 at 10:34 a.m. Resident 29 was "going around and pinching people."

During interview on 10/20/21 at 3:30 p.m. with administrator A and director of nursing (DON) B confirmed there were no investigations completed nor documented beyond what was in risk management reports or the state online reports.

2. Review of risk management reports and progress notes in the EMR for resident 14 between 1/16/21 and 10/20/21 revealed six resident to resident altercations with resident 2 were noted on:
*2/18/21 at 3:14 p.m. Residents 14 and 2 shouting, yelling, threatening, and hitting each other.
*5/9/21 at 4:29 p.m. Residents 14 and 2 sitting together and an observation of "fingernail marks on the inside of (resident 2's) wrist." (See F609, finding 2.)
*5/10/21 at 12:17 p.m. Social services designee (SSD) C followed up with resident 14 about an incident that was reported to SSD C during the daily stand-up meeting. Resident 14 told her that she and resident 2 "got into an argument."
*5/11/21 at 10:08 a.m. SSD C noted a report to her that "resident (14) was slapped on the hand/arm by her peer (resident 2)."

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F 610	Continued From page 16 *7/18/21 at 10:53 a.m. "Resident (14) was slapped on the right forearm by female peer (resident 2). *7/24/21 at 10:20 a.m. "Resident (14) hit female peer (resident 2) and (resident 2) hit her as well." There were no documented investigations in the resident's EMR for the altercations that occurred on 5/9/21, 5/11/21, 7/18/21, and 7/24/21. SSD C had documented investigations for the altercations on 2/18/21 and 5/10/21 in behavior notes. Surveyor: 42477 3. Review of incidents regarding residents 2, 4, and 28 revealed there had been no investigations completed regarding the incidents. Refer to F689, findings 3, 4, and 5.	F 610		
F 657 SS=F	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657	F 657 Reviewed and revised as necessary care plans for residents 2, 4 9, 14, 28, and 29. All other resident care plans reviewed and revised as necessary and quarterly with all disciplines and family. Administrator, DON, and interdisciplinary reviewed, revised, and created necessary policies and procedures. MDS coordinator ana/or designee will audit care plans weekly for 4 weeks and monthly for 2 additional months. MDS coordinator and/or designee will report findings at the monthly QAPI meetings.	11/11/21

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and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on observation, interview, record review, and policy review, the provider failed to revise the care plan as needed based on:
*Falls for four of twelve sampled residents (4, 9, 28, and 29).
*Dementia-related behaviors resulting in resident to resident altercations for three of four sampled residents (2, 14, and 29).
*Unsafe exiting from the facility for two of two sampled residents (28 and 29).
*One of three sampled residents (23) with chronic urinary tract infections and oxygen use.
Findings include:

1. Review of risk management reports and progress notes in the electronic medical record (EMR) for resident 29 between 1/16/21 and 10/20/21 revealed:
*Sixteen falls (See F610, finding 1), including one fall resulting in a serious bodily injury on 5/20/21 at 9:45 a.m. (See F609, finding 1.)
*Nine resident to resident altercations (See F610, finding 1) caused by resident 29 when he wandered into other resident's rooms, became combative risking harm to other residents, or made physical contact with other residents.

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F 657	Continued From page 18 *Six documented behavior notes of resident 29 exiting or attempting to exit the building. (See F689, finding 1.) Comparative review of resident 29's admission minimum data set (MDS) assessment dated 1/21/21 and the quarterly MDS dated 9/25/21 revealed the resident: *Needed supervision for walking in room and hallway and moving about with his wheelchair. *Needed supervision or touch assistance to go from sitting to standing and transferring to or from a chair. *Walked up to 50 feet independently on 9/25/21, an improvement from supervision on 1/21/21. *Had severely impaired cognitive ability on both assessments with a lower score on 9/25/21. *Displayed physical behavioral symptoms directed toward others on 9/25/21 (not on 1/21/21) that: -Put the resident and others at significant risk of injury. -Interfered with the resident's care and social interactions. -Intruded on the privacy of others. -Disrupted the living environment for others. *Wandered 1 to 3 days on both assessments that significantly intruded on the privacy or activities of others. Review of resident 29's current care plan revealed no revisions were made to adjust interventions in response to each fall, resident to resident altercation, and exiting-seeking incident including: *The provision of care before each incident. *The environmental conditions present at the time of each incident. *The possibility that an unmet physical or	F 657		

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psychosocial need contributed to each incident.
*Other interventions that might prevent similar incidents from occurring.

The care plan focuses included:
*High risk for falls (11 of 16 falls were listed) related to confusion, gait and balance problems, unaware of safety needs, wandering, and psychoactive drug use (initiated 1/27/21, revised 10/1/21) with interventions dated:
-1/27/21 Anticipate and meet needs, promptly respond to all requests, be sure my call light is within reach, encourage resident to use it, ensure proper footwear, safe environment, follow fall protocol.
-9/30/21 "Monitor when sitting down, I will sit on the arm of a chair or try to climb on the chair rather than sitting in it." "I sometimes sit or kneel on the floor." "Family and Dr. are aware that I have potential to fall."
*Potential to be resistive with cares and wandering related to dementia and adjustment to new environment (initiated 1/25/21, revised 9/30/21) with interventions dated:
-1/25/21 "Answer door alarms promptly and promote safety."
-1/25/21 "Assess for thirst, hunger, pain, discomfort, or need for toileting if I am restless and/or wandering."
-7/12/21 "Monitor for wandering into other residents rooms. Watch from a distance, I usually don't enter all the way, sometimes I just peek my head in and leave."
-9/9/21 "Monitor for aggressive behavior towards peers."

2. Review of risk management reports and progress notes in the EMR for resident 14 between 1/16/21 and 10/20/21 revealed six

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resident to resident altercations with resident 2. (See F610, finding 2.)

Interview on 10/20/21 at 10:33 a.m. with certified medication aide/certified nursing aide (CMA/CNA) M and certified nursing aide (CNA) N revealed:
*Resident 14 and resident 2 both like to sit in the television lobby area.
*The staff "move them apart if they are close together."
*They also try to not seat the residents next to each other.

Comparative review of resident 14's annual MDS assessment dated 6/2/21 and the quarterly MDS dated 8/27/21 revealed the resident:
*Was independent with some supervision for walking and moving about the facility with her walker.
*Needed touch assistance to go from sitting to standing and transferring to or from a chair.
*Had moderately impaired cognitive ability.
*Displayed no physical behavioral symptoms directed toward others.
*Had no problems with hearing, vision, or speech.

Review of resident 14's current care plan (initiated 8/6/19, revised 9/7/21) revealed a focus for behavior problems related to obsession with "food/candy/jewelry, baby doll, etc. that do not belong to me" and "child-like behaviors".
*One of the goals was to "not have verbal or physical altercations with my peers."
*Interventions were as dated:
-5/12/21. Remind resident "that it is not nice to hurt my friend."
-5/12/21. Monitor for "resident to resident altercations with (resident 2)."
-4/10/20. Monitor for "me taking things that do not

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belong to me."

The care plan does not include interventions as mentioned by CMA/CNA M and CNA N during the interview noted above.

Surveyor: 26632
3. Review of resident 23's medical record revealed:
*Interdisciplinary progress notes (IPN) from 4/18/20 through 10/18/20 revealed he had urinary tract infections (UTI) six times. Those UTIs occurred on 4/27/20, 7/30/20, 8/12/20, 12/15/20, 2/23/21, and 10/13/21.
*Review of physician orders revealed:
-On 3/2/21, a physician's order for oxygen at 2 liters per nasal cannula as needed for shortness of breath and oxygen saturation levels below 90%.

Review of resident 23's last revised 9/27/21 care plan revealed:
*The only intervention related to his frequent UTIs as in the nutrition focus area. The interventions included:
-"Encourage fluid intake throughout the day and monitor if he is drinking fluids offered to prevent further UTIs."
*No focus area was initiated for his use of oxygen.

Review of the provider's 6/14/19 Comprehensive Care Plan and Care Conferences policy revealed:
*A comprehensive care plan would be developed for each resident that included measurable objectives and timetables to meet a residents medical, nursing, mental, and psychosocial problems, needs, and/or strengths that was identified in the comprehensive assessment.

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*The comprehensive care plan would be periodically reviewed and revised by the care team after each assessment review.
*The services provided must meet professional standards of quality and would be provided by qualified persons in accordance with each residents care plan.
*Each residents care plan would be updated if a goal was met or if a new focus arose.

Surveyor: 42477
4. Review of resident 2's October 2021 care plan revealed:
*Resident 2 had many altercations with other residents.
*Her care plan had not been revised and the interventions changed those incidents.
*Interventions were very general:
-"I need reminders that I should worry about [resident 2's name] and not my peers."
-"I need reminders that it is not nice to hurt my friends."
-Monitor for certain resident's sitting by her.
-Monitor for yelling.
-"...Encourage separation if there is an altercation."
*These interventions had not addressed her all her incidents.
*Resident 2 had a primary diagnosis of post-traumatic seizures.
-Seizures were not addressed in her care plan.

5. Review of resident 4's October 2021 care plan revealed:
*She had experienced eight falls in four months.
*Her interventions had not been revised or changed.
*The fall interventions were last revised on 5/18/21.

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F 657	Continued From page 23 6. Review of resident 9's October 2021 care plan revealed: *He had a fall upon admission to the facility. *Fall interventions on his care plan were not revised specifically to his needs. *Interventions related to the following: -He had weakness in his legs due to his knees giving out. -He needed his electric wheelchair nearby due to his weakness. Refer to F689, finding 6. 7. Review of resident 28's October 2021 care plan revealed: *She had many falls and exit-seeking incidents. *Her care plan had not been revised with interventions after the incidents. *Her care plan stated she used a front-wheeled walker. -Surveyors only observed her using a wheelchair. *Hospice had identified an increase in exit seeking related to pain, this was not mentioned on her care plan. Interview on 10/20/21 at 1:37 p.m. with MDS Coordinator E of the above revisions: *Nursing did not always inform her of the changes so she could update the care plans. *She spends a lot of time trying to go through the charting to find things out in order to update the care plans and MDS reports.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		

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F 658	Continued From page 24 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Surveyor: 26632 Based on observation, interview, record review, and manufacturer's recommendation review, the provider failed to ensure professional standards of care had been followed for four of twelve sampled residents (5, 23, 32, and 33) as evidenced by: *Lack of appropriate application by staff of Tubigrip (medical stockinettes) for resident 5. *Lack of appropriate documentation by staff about a laceration on the hand of resident 23. *Lack of appropriate documentation by staff about resident 32 as she transitioned through; -End stage renal disease and peritoneal dialysis. -Pain management. -Hospice services and death. *Lack of complete and accurate documentation by staff about what "home meds" were sent when resident 33 was discharged. Findings include: Surveyor 42477: 1. Review of resident 32's closed electronic medical record revealed: *She had: -Been admitted to the facility on 4/30/21. -Admitted to receive therapy to regain her strength. -Been the facility's only peritoneal dialysis patient. *Staff helped her with her nightly dialysis treatments and care. *She began to have a decline in her health. *On 10/2/21: -"Recorder called on call after hours phone	F 658	F 658 Cannot correct prior non-compliance on tubigrip for resident 5, resident 33 discharged with home meds and documentation on resident 32 comfort cares. Appropriate documentation completed on resident 23 laceration on hand. Administrator, DON and interdisciplinary team reviewed, revised and/or created necessary Policies and procedures. DON and/or designee will audit correct wearing of tubigrips, residents being discharged home with meds, comfort cares, and skin assessments Weekly for 4 weeks and monthly for 2 additional months. DON and/or designee will report findings at Monthly QAPI meetings.	11/11/21

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number for home dialysis clinic and explained how resident's blood pressure was 86/55 even after 2 attempts. Nurse stated that resident runs low so if she is asymptomatic she should be ok for now. She was indeed asymptomatic. Nurse stated that if resident starts to become symptomatic, to call back. For now we are to continue with the three green bags."
*The next note on 10/2/21 stated:
-The resident was drowsy on the toilet.
-She had been weak and having a hard time sitting up.
-She was experiencing double vision.
-Her leg was dusky, her toe was purple but temperature of the extremity was the same as the rest of her body.
*Nurse made a note that resident 32 did not want to be transferred to the hospital for any reason.
*On 10/3/21:
-The nurse believed she had a blood clot in her left lower leg.
-The resident did state she was feeling better that today.
-She did not want to go to the doctor for her leg.
-Nurses made note that she was of full code status.
*On 10/4/21:
-She was having so much pain, stating "I can't stand it."
-Nursing stated she had been having "dry heaves" was restless.
-She had not been wanting to eat or drink.
-She stated she did not want to go to the hospital.
-Nursing asked her if she wanted cardiopulmonary resuscitation (CPR) and she replied "no."
-She had refused to take her medications that day.
-Nursing explained that they could start comfort

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F 658	Continued From page 26 cares so they could give her something for the pain and restlessness. --She stated "yes." -"She stated yes and I asked her if she understood that without having anything done with her situation is eventually terminal and she stated I understand. Called DON [B's initials], received comfort care orders from [a physician's name (not her physician)]. *On 10/5/21: -She had low blood pressures. -She was going to receive peritoneal dialysis with a low dextrose solution. *At 3:41 p.m. on 10/5/21 nursing asked: -If she was having any pain, she replied "no." -If she wanted to go to the hospital, she replied "no." -If she wanted to have hospice on board, she replied "no." -"...She looked straight at me when she gave these answer[s] and had eyes wide open." *On 10/4/21 a faxed note to the physician stated: -The resident was having a blood clot/ blockage for the last three days. -The resident was in intense pain. -Nursing stated the resident did not want CPR. -Comfort care was explained to the resident that it would help with her pain and restlessness and the resident agreed. *The physician signed back: -The prescription was sent to the pharmacy. -Have resident evaluated by hospice care. *A comfort care order was obtained on 10/5/21 at about 12:30 a.m. *Resident 32's full code advance directive was not changed from full code status. *Documentation on 10/5/21 at 6:23 p.m. stated resident was unresponsive. -Staff then initiated dialysis.	F 658		

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*The next note on 10/6/21 stated:
-"Resident passed away at 1:45 p.m. today..."

Interview on 10/20/21 at 11:51 a.m. with home dialysis unit manager revealed:
*Resident 32 had been experiencing a decline.
*The nursing home called the dialysis unit to let them know about comfort care.
*Resident 32's nephrologist had not wanted to stop dialysis.
*If resident 32 wanted to go on hospice care, they would then stop dialysis.

Interview on 10/20/21 at 1:59 p.m. with RN D and RN J revealed they:
*Had started Ativan and Morphine for pain and comfort.
*Acknowledged resident's advance directive was still of full code status.
-Did not get it changed.
*Did not reassess her code status after the conversation on 10/4/21.
*Had not reassessed her wishes after her pain was managed.

Review of resident 32's medication administration record (MAR) for October revealed:
*She could receive morphine every 1 hour as needed for pain and shortness of breath.
*She could receive Ativan every 2 hours.

Review of resident 32's pain level summary revealed:
*She had been experiencing a level 10 amount of pain.
-This was on a scale of 1 to 10 with 10 being most severe.
*This level 10 pain was around the same time that she wanted to go on comfort cares and

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receive pain medication.
*On 10/5/21 through 10/6/21 she was having pain ratings at 1 or 0.

Review of resident 32's October 2021 care plan revealed:
*She wished to have her code status honored.
*She wanted:
-CPR.
-No life support.
-Yes to tube feedings.
-Yes to comfort cares.

Interview on 10/20/21 at 3:40 p.m. with Administrator A, DON B, and administrator in training P revealed:
*Surveyor asked about resident 32 having low blood pressure symptoms and whether that would be considered symptomatic.
-DON B stated that "It's hard to tell."
-DON B agreed that being weak, double vision etc. could be symptoms of low blood pressure.
*They had comfort care orders for a doctor who worked with her physician.
*They had not changed resident 32's advance directive.

Review of the provider's July 2021 comfort care policy revealed:
*A physician order must be obtained.
*Comfort care decisions may be rescinded at anytime.
*The following provisions would be made to treatment:
-Pain management.
-Oxygen therapy to ease respiratory distress.
-Positioning changes and supportive devices for comfort.
-Antibiotic therapy.

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*Vitals and weights will be monitored per family request and nursing judgement.

Surveyor 26632:
2. Observation on 10/19/21 at 10:48 a.m. revealed resident 5 had Tubigrip stockinettes to both legs. The right stockinette was rolled around her ankle, the left stockinette was loose and could easily be pulled up or down. There was no compression applied to her legs from those stockinettes.

Review of the manufacturer's website revealed:
*"Using Tubigrip Compression."
*"It is essential to get the right size and to apply tubigrip correctly to ensure it works effectively and safely."
*"Too loose and it won't reduce swelling or provide support, too tight and it can be uncomfortable and could reduce circulation (blood flow).
https://www.performancehealth.com/tubigrip-wrap

3. Review of resident 23's medical record revealed:
*On 9/4/21 2:26 a.m. skin/wound note. He had a laceration to the top of his right hand.
*Steri-stips were applied and a covered with a 4 X 4 Mepilex dressing.
*A physician's order was received to change the Mepilex dressing every 3 days and as needed until healed.
*There was no further documentation of this laceration on his right hand.

Review of resident 23's September 2021 treatment administration record revealed:
*The last day the Mepilex had been changed was on 9/18/21.

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Interview on 10/20/21 at 5:25 p.m. with DON B revealed:
*She was not aware resident 5's Tubigrip compression stockings did not provide any compression to assist in lessening her edema.
*She agreed there was no documentation of resident 23's hand laceration after 9/4/21.
*There should have been documentation of the healing process and when it had healed.

4. Review of resident 33's closed medical record revealed:
*He had been discharged on 9/22/21.
*The provider's discharge report included:
-"Personal Effects Sent With." written in that area was "home meds [medications]."
*There was no documentation of what "home meds" he was taking with him.

Interview on 10/20/21 at 5:25 p.m. with DON B revealed:
*She stated resident 33 had brought in a sack of medications.
*Those medications had been left in the med room and gave them back to him when he left.
*She stated those medications had not been documented of what they were and how many medications of each there were.

Interview on 10/20/21 at 5:25 p.m. with administrator A and DON B revealed:
*There was no policy for professional standards.
*They did not have a specific reference they used for professional standards.

F 684 Quality of Care — F 684
SS=H CFR(s): 483.25

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F 684	Continued From page 31 § 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: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure residents received treatment and care in accordance with professional standards of practice and based on a comprehensive person-centered care plan. Findings include: 1. Noncompliance in the following areas demonstrated the provider's failure to provide residents with care and services necessary to obtain their highest practicable well-being: *Provide accessible contact information for filing a complaint with the state survey agency for all residents and their representatives. Refer to F574. *Document communication with and obtain a physician's order for the advance directive code status, and review code status as a resident's condition changed. Refer to F578. *Submit online state reports and investigate alleged violations of abuse or neglect for residents who experienced falls, resident to resident altercations, or unsafe exit-seeking. Refer to F609 and F610. *Ensure care plans had measurable goals, current status, and complete interventions and revise as needed to ensure staff provide specific	F 684	F 684 To ensure quality of care refer to F574, F578, F609, F610, F656, F657, F686, F689, F744, F880, F881, F883, F886	11/11/21

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F 684	Continued From page 32 and individualized and care and services to address the person-centered needs of the residents. Refer to F656 and F657. *Develop and provide a comprehensive skin program for the prevention of pressure ulcers. Refer to F686. *Provide adequate supervision and an environment free of avoidable hazards to reduce the risk for injury. Refer to F689. *Provide individualized treatment and services to meet the dementia-related psychosocial needs of the resident. Refer to F744. *Ensure infection control precautions had been initiated after an outbreak of vomiting and diarrhea in residents and staff. Refer to F880. *Develop and implement a comprehensive infection control program. Refer to F880. *Ensure there was an antibiotic stewardship program. This failure placed all residents at risk for potential adverse outcomes, associated with the inappropriate and/or unnecessary use of antibiotics. Refer to F881. *Ensure pneumonia vaccination had been offered, administered, or refused. Refer to F883. *Conduct routine COVID-19 testing for residents and staff. Refer to F886.	F 684		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686	F 686 Residents 7, 9 ,16, and 28 all are being monitored/ healing of pressure ulcers. Skin assessments completed on all other residents. Education provided at all staff meeting on 11/19/21 regarding pressure ulcers. Administrator, DON and Interdisciplinary team created, reviewed and/or revised necessary policies and procedures.	11/11/21

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F 686	Continued From page 33 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and policy review, the facility failed to ensure: *One of onesampled resident (9) with a history of pressure ulcers had ongoing skin assessments to prevent new ulcers from developing or recurring. Findingsinclude: 1. Interview on 10/18/21 at 3:31 p.m. with resident 16 revealed he: *Informed surveyors he had a bleeding area on his buttocks. *Stated he had informed staff about this problem. *Had been provided DynaShield by staff for him to apply to the bleeding area. Interview on 10/18/21 at 3:45 p.m. with minimum data set (MDS) Coordinator E revealed: *They had one resident who had a pressure ulcer in the building and that pressure ulcer was healing. -That resident was identified as resident 1. *Residents 7, 9, 16, and 28 were not the resident that she had mentioned. Further interview on 10/18/21 at 5:15 p.m. with MDS coordinator E regarding the facility matrix revealed: *Resident 28 had been marked for a stage II pressure ulcer.	F 686	F 686 Pressure ulcers/ skin assessments will be audited by DON and/or designee weekly for 4 weeks and monthly 2 additional months. Designated RN will be in charge of skin assessments/ pressure ulcer monitoring. DON or designee will report findings at monthly QAPI meeting.	

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*MDS coordinator E stated the matrix was not accurate as resident 28's pressure ulcer had healed.
-She stated it had been healed a couple of weeks ago.
*She was going to re-print a corrected facility matrix for the surveyors.

Observation on 10/18/21 at 5:41 p.m. of resident 16 and director of nursing (DON) B in conversation revealed:
*Resident 16 had been sitting at a table, eating dinner.
*DON B was completing medication pass.
*He was talking to DON B about the bleeding area on his buttocks.
*She replied, "well you are putting the Dynashield on it right?"
*He informed her he had been applying the cream to his buttocks.

Observation and interview on 10/19/21 at 11:12 a.m. with resident 16 and certified medication aide/certified nursing aide (CMA/CNA) H revealed:
*Resident 16 stated:
-The areas on his buttocks was sore and tender.
-He had been applying the Dynashield.
*The areas on his buttocks were sore and tender.
*Surveyor was able view and see the bleeding through the adult brief.
-He had two bilateral open areas.
*CMA/CNA H applied Dynashield to the two open areas on resident 16.
*CMA/CNA H stated he had not observed the open areas on resident 16 before.

Review of resident 16's EMR revealed:
*He had been admitted on 8/6/19.

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*He never had a skin assessment documented.
*DON B documented on 10/19/21:
-"Resident has redness to his bottom with some bleeding. He is self-sufficient with toileting and personal cares. Will assess bottom and send orders as needed. Will apply protective ointment as needed at this time.
*An assessment had not been completed, even after surveyors discussed the wound with DON B, MDS Coordinator E, and RN D.

Surveyor 42477:
2. Observation and interview on 10/20/21 at 9:35 a.m. with resident 28 and registered nurse (RN) D revealed:
*Surveyor had asked to observe resident 28's heel.
*RN D stated that she did not have an open wound on her heel.
*RN D lifted resident 28's heel off the pillow it had been lying on.
*There was an open area on the resident's left heel that was approximately 1 centimeters (cm) by 2 cm.
-It was located on the back of her heel, on the Achilles tendon.
*There was green and yellow drainage in the resident's sock.
*The heel was not being floated nor did it have a protective boot on.
*RN D agreed that the wound was open.
*The facility did not have a designated wound nurse.
*RN D stated that since resident 28 was on hospice, they do not do anything with her wound care or prevention of wounds.
*Surveyor asked how many pressure ulcers were in the building.
-RN D stated the same resident that MDS

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Coordinator E mentioned yesterday.
-RN D had not mentioned resident 7, 9, 16, or 28.
*Surveyor requested hospice RN's phone number to talk to her about resident 28's heel.
*Surveyor asked RN D how often they assess resident's skin once a pressure ulcer or opened area has healed.
-RN D stated that the CNAs look at the resident's skin when they get their baths but RNs do not do routine skin assessments.
*Any skin assessments would have been documented in the assessment tab on the electronic medical record (EMR).
*RN D agreed CNAs do not always know what to look for as far as skin injuries.
*Any wounds they have in the facility they treat with Betadine.

Review of resident 28's skin assessments revealed the following documentation:
*On 6/22/21:
-It had been the first observation of the wound.
-They requested betadine to treat the blister.
-Their preventative measures were leaving her shoes off.
-It had been classified as "other."
*On 6/29/21:
-There had been no improvement noted.
-Their preventative measures were leaving her shoes off.
-They were applying betadine.
-The wound progress was still marked as "first observation."
*On 7/6/21:
-It had been noted to be improving.
-"...Hospice nurse sees area several times a week."
-Interventions were "gripper socks only for the time being and no shoes currently."

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F 686	Continued From page 37 -Their treatment was betadine nightly. *On 7/13/21: -The acquired date was 6/15/21. -She was to be wearing a blue boot in bed. -It was a blister/black eschar. -Betadine two time per day and wound cleanser. -It was "almost healed." * On 7/21/21: -The date acquired was listed as 7/21/21. -It was currently a stage III pressure ulcer. -It was worsening. -Blister came off and foul odor drainage. -They would be receiving an air mattress for resident 28. -Hospice requested that they start using Medihoney, Telfa pad and Kerlex, every three days. *On 7/28/21: -The date acquired was still listed as 7/28/21. -Marked as a stage II, healing wound. -Will continue to monitor. *On 8/3/21: -They were using a foam boot as a preventative measure. -It had been marked as "other" with no staging. -Hospice nurses were completing the treatment every three days. -"Almost entirely healed." *The next assessment was on 8/24/21: -Gripper socks only were listed as a preventative measure. -It was listed as acquired on 6/30/21. -It was classified as "other." -They were applying betadine two times per day. *The next assessment was completed on 9/18/21: -The date acquired was listed as 9/18/21. -Listed as a stage II pressure ulcer. -Noted to be the first observation.	F 686		

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-There was no current treatment, they were reaching out to hospice.
-This assessment was still marked as "wound #1", the same wound as above.
*The next assessment was completed on 10/4/21:
-They were using an air mattress as a preventative measure.
-It was acquired on 9/18/21.
-It was a stage II, pressure ulcer.
-They changed the treatment order to Betadine.

Review of resident 28's 7/6/21 and 9/29/21 Braden scale assessments revealed she was at moderate risk for skin breakdown.

Review of resident 28's hospice notes revealed she had:
*Two pressure ulcers.
*One had been on the bottom of her heel.
*Other one had been located on the back of her heel on the Achilles tendon.
*An order for clean with wound cleanser, apply Betadine, and cover with Mepliex every three days.

Review of resident 28's hospice nurses' notes revealed:
*On 10/20/21:
-"Received a call from [RN D's name] requesting wound documentation for pt [patient]. Notified office and documentation were sent prior to arrival to SNF[skilled nursing facility]. Upon arrival to SNF Collab with [RN D's name] regarding [resident 28]..."
-"...[RN D's name] reported wound has reopened with scant amount of drainage noted. [RN D's name] and this HRN [hospice RN] assessed wound. Wound now measuring 0.6cm x [by] 1.5

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cm x 0.2 cm depth with red beefy center and scant amount of blooding discharge. Mild pain when assesses depth. PT [patient] moan out and was tense. Call placed to [doctor's name] for new wound care orders verbal orders received for Medihoney and cover with Mepliex. Dressed wound was cleansed and dressed. Hospice ordered wound care supplies to be delivered to SNF. Heel boot applied..."
-"Received a second call from [RN D's name] after HRN left facility regarding stages of wound. Collab with original wound was a DTI [deep tissue injury] but was downgraded to stage when we opened..."
*On 10/15/21 she was noted by hospice to have a stage II pressure ulcer to her left Achilles tendon.

Review of resident 28's progress notes revealed:
*Inconsistent documentation related to the wound on her heel.
*The stage II pressure injury was identified by hospice on 9/18/21.
*The documentation mentioned black eschar but then a few days later the wound was healed.
*The orders had always gone back to using betadine.
*The documentation did not mention location of the wound or which wound was being documented on.

Interview on 10/20/21 at 11:23 a.m. with hospice RN L revealed:
*It is the facility's responsibility to do assessments, staging, and treatments.
*Hospice nurses see the resident's two to three times per week so they need help from the facility's nurse to provide care to the residents.
*Surveyor asked about the Betadine order that the facility had been using.

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F 686	Continued From page 40 *RN L stated that an RN at the facility had always wanted to use Betadine on all their wounds. *RN L had obtained orders for various wound treatments and the facility would change those orders back to Betadine. 3. Review of resident 7's EMR revealed: *He had been admitted on 2/15/21. *He had one skin assessment completed on 2/24/21. -This was for his left toe. *He was a paraplegic. *There was a history of a stage four pressure ulcer to his coccyx, before admission. *On 2/15/21: -He had "...a .25 circular mostly healed open area. No drainage seen from this. Left buttock has a 1 cm by .75 cm mostly healed open area as well." *On 3/2/21: -"resident in on air mattress setting changed to variable. on assessment his abd [abdominal] fold right side has an open chafed area nystatin applied. rest of abd fold and groin area, thighs cleansed and antifungal applied. posterior peri area is very red chafed by his penis, left buttock. golfball size spongy area on coccyx and on his right posterior medial thigh a and d applied and area rubbed lightly for circulation..." *On 3/2/21: -He had a care team meeting and his daughters requested to keep him on protein powder because they wanted to ensure his coccyx continues to heal. *On 3/17/21: -"...area cleansed and Dyna Shield applied. noted area above coccyx, muscle flap suture line is pronounced and deeper or starting to open. area is chafed on one side gently cleansed and Dyna	F 686		

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shield applied. positioned on right side to keep him off his buttocks."
*On 3/29/21 an RD note stated:
-"Visited with DON. Res [resident] does not have any open areas..."
*On 4/17/21:
-"resident was caked with power to open right groin and four open chafed areas on buttocks two were bleeding. cleansed well and powder gently removed thin layer of dynashield applied. medipore to one area on buttocks..."
*On 4/19/21:
-Weekend nurses informed RN J to call and schedule an appointment with wound care.
-Wound care informed them that they would need a referral from the physician.
*On 4/23/21:
-There were orders for duoderms to open areas on coccyx, buttocks, and perineum."
*On 4/27/21:
-There was a note that the perineal and buttocks area is healing well.
*On 4/29/21:
-He returned from wound care.
-Staff were to apply Bactroban and leave coccyx open to air.
*On 5/26/21 his care team meeting noted:
-There were no open sores on his bottom.
*On 5/27/21:
-He returned from wound care with orders to cleanse scrotum two times per day and sage wipes.
*The next non MDS note that discussed wounds was on 10/20/21.
*On 10/20/21 RN D documented:
-"Coccyx assessed this AM. CNAS to continue with protective cream to the area."

Surveyor 45095

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Observation and interview on 10/19/21 at 11: 00 a.m. with resident 7 being assested by certified nursing assistant (CNA) K and CNA/certified medication aide (CMA) H revealed:
*CNA K and CMA/CNA H had been assisting resident 7 with personal cares.
*He had two open areas to his buttocks.
*CNA K and CMA/CNA H had not noticed those areas before.

Interview on 10/20/21 at 2:00 p.m. with RN D revealed:
*Her assessment was the above 10/20/21 documented note.
*She had not measured the wounds.
*Her note did not address:
-Details.
-Physician notification.
-Special equipment or preventative measures.
-Pressure ulcer stage.
-Type of wound.
-Overall impression.
-What type of tissue was present.
-Drainage.
-Odor.
-Presence of necrotic tissue.
-Measurements.
-Tunneling.
-Peri-wound tissue.
-Wound edges.
-Suspected infection.
-Changes to treatment plan.

Further interview on 10/20/21 at 5:15 p.m. with RN D revealed:
*She stated:
- There was no further documentation that had been completed regarding the wounds.
- "We just look at the coccyx and chart we looked

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at it."

Review of resident 7's Braden and skin assessments revealed:
*He had been identified as "At risk" for skin breakdown for three of three completed braden assessments.
*He had one weekly skin assessment documented.

4. Review of resident 9's EMR revealed:
*He had been admitted to the facility on 8/11/21.
*He had one skin assessment that had been completed on 9/25/21.
*The skin assessment on 9/25/21 stated:
-They were asking for orders for DuoDerm for incontinence issues.
-The special equipment was "reposition tpad w [with] insert to prevent incontinence over area."
-It was to his right inner buttock cheek.
-It had been marked as a stage II pressure ulcer, present from admission.
-Currently marked as a stage III pressure ulcer.
--Then marked as "unchanged."
-Comments: "Resident is incontinent."
-A scant amount of drainage.
-It had "white edges and wound was beefy red."
*His only Braden assessment was completed at admission and he was identified as "at risk" for skin breakdown.

5. Interview on 10/20/21 at 3:50 p.m. with administrator A and DON B, and administrator in training P revealed:
*Surveyor observed open areas on resident 7 and 16.
*There had not been any nursing assessments or documentation completed on the resident's regarding these open areas.

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*DON stated she had educated staff regarding the wounds.
-She stated that she placed a sheet in the staff break room regarding the resident's skin and open areas.

6. Review of the provider's February 2021 Wound Care policy revealed staff were to document:
*The type of wound care given.
*Any change in the resident's condition.
*All assessment dates obtained when inspecting the wound.
*Inspection of the wound including:
-Wound bed color.
-Size.
-Drainage.
*How the resident tolerated the procedure.
*Any complaints made by the resident relating to the procedure.
*If the resident refused the treatment and reasons why.
*The signature and title of the person recording the data.

Review of the provider's November 2002 Nursing Policy and Procedure manual revealed:
*The following were established to help prevent pressure ulcers:
-"Dress chronic wounds using clean sterile technique, since all chronic wounds are contaminated."
-"Cleanse wounds using a non-toxic agent prior to making wound assessment and applying a new dressing."
-"Select a dressing that keeps the wound bed moist and the peri-wound skin dry."
-"Prepare the peri-wound skin with a skin sealant prior to the application of any adhesive dressing or tape."

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F 686	Continued From page 45 -"Reevaluate dressings every shift." -"Reevaluate the wounds response to the prescribed treatment. Make recommendations for changes at least every 2 weeks. Inform physician of changes in wound status." -"Document all wounds weekly on the pressure ulcer skin flow sheet." -"DNS [director of nursing services] should review all wounds weekly." Review of the provider's undated New Pressure Area form revealed staff were to document: *If the pressure area had been new. *If the pressure ulcer was facility acquired or present on admission. *Measurements of the wound. *The beginning of pressure ulcer weekly measurements. *Physician contact for orders and to schedule pain medications. *Notification of the DON. *Notification of the MDS coordinator. *Interventions in the care plan and tasks. *Nurses notes. *Completion of an incident form if acquired in the facility. *Notification of family. *Notification of CNAs, and add to their assignment sheets. *Communication with dietary. Review of the provider's May 2021 standing orders stated, "wound care protocol for initial wound care."	F 686		
F 689 SS=F	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Surveyor: 42477

Surveyor: 06365
Based on observation, interview, record review, and policy review, the provider failed to provide adequate supervision and an environment free of avoidable hazards to reduce the risk for:
*Falls for three of twelve sampled residents (4, 9, and 29).
*Resident to resident altercations for four of four sampled residents (2, 14, 27, and 29).
*Unsafe exiting from the facility for two of two residents (28 and 29).
*Three of three residents' (17, 28, and 30) potential access to hazardous chemicals.
Findings include:

1. Interview on 10/19/21 at 11:45 a.m. with resident 27 revealed she is afraid of resident 29 because he "comes into my room." One time he "tried to sit on my bed. I yelled at him and he left."

Review of risk management reports and progress notes in the electronic medical record (EMR) for resident 29 confirmed on 10/3/21 at 1:58 p.m. resident 29 entered resident 27's room. "They had a verbal altercation but did not hit each other."

Provider's Plan of Correction (F 689) — Completion date: 11/11/21

F689

Please refer to F657

Proper interventions put in place for residents 4, 9, 29 regarding falls. Proper interventions for residents 2, 14, 27, 29 for resident-to-resident altercations, interventions put in place for residents 23, 29 regarding unsafe exiting from building, ensured that residents 17, 28, and 30 do not have access to potential hazardous chemicals.

Ensure all other residents are safe from avoidable risks.

Education provided at all staff meeting on 11/19/21 regarding safety from avoidable hazards.

Administrator, DON and interdisciplinary team reviewed, revised, and created necessary policies and procedures.

DON and/or Designee will audit safety from avoidable risk weekly for 4 weeks and monthly for 2 additional months.

DON and/or Designee will report findings at monthly QAPI meetings.

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Review of the EMR for resident 29 between 1/16/21 and 10/20/21 revealed no investigation or evaluation of the risks nor the effectiveness of interventions before and after for:
*Sixteen falls, including one fall resulting in a serious bodily injury on 5/20/21 at 9:45 a.m. (See F609, finding 1 and F610, finding 1.)
*Nine resident to resident altercations caused by resident 29 when he wandered into other resident's rooms, became combative risking harm to other residents, or physically made contact with other residents. (See F610, finding 1.)
*Six documented behavior notes of resident 29 exiting or attempting to exit the building:
-1/18/21 at 11:20 a.m. "Continues to try different doors to leave the building." He told staff he was here because "his brother is mad at him." As he walked "throughout the hallways," he told staff he was "looking for a 'crosswalk to cross the street.'" At one point he "exited the 400 door but staff observed him stand in the doorway and come back in." The staff intervention was to tell him it was "very cold."
-3/9/21 at 9:57 p.m. The resident "set off the door alarm 3 times...Each time he stepped right outside of the door." He was "easily redirected back into the building. He was not using the wheelchair tonight."
-3/22/21 at 4:04 pm. "Went out the 100 wing door to the enclosed garden." He was within eyesight of staff and was redirected back into the facility.
-6/13/21 at 3:02 p.m. "Pacing up and down the hallways and asking how he gets out because he wants to leave the facility and home." Registered nurse (RN) J tried to redirect and asked if he needs anything "but he is crying" and said "he is tired of being here and wants to go home." RN J

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F 689	Continued From page 48 "will have resident take a walk with staff once one is available." -9/3/21 at 5:37 p.m. "Went out 300 door. Fast paced walking down the sidewalk." RN J walked with him, and he reentered the building after being redirected to another door. -9/4/21 at 9:40 a.m. "Went out 400 door with CNA by his side. They stopped at the exit until other staff let them back inside." Review of resident 29's admission minimum data set (MDS) assessment dated 1/21/21 and the quarterly MDS dated 9/25/21 revealed the resident had severely impaired cognitive ability, needed staff supervision or touch assistance, and had physical behavioral symptoms directed toward others. (See F657, finding 1.) Review of the resident 29's current care plan (see F657, finding 1) revealed the interventions had not been revised based on an evaluation of each fall, resident to resident altercation, and exit-seeking incident after they had occurred for the focuses of: *High risk for falls related to confusion, gait and balance problems, unaware of safety needs, wandering, and psychoactive drug use (initiated 1/27/21, revised 10/1/21). *Potential to be resistive with cares and wandering related to dementia and adjustment to new environment (initiated 1/25/21, revised 9/30/21). Review of the task list report revealed a task initiated on 2/25/21 to "encourage resident to use wheelchair outside of room. If he insists in walking provide (stand-by assistance) to reach destination or return to wheelchair."	F 689		

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F 689	Continued From page 49 Review of care team progress notes revealed a review of his physical functioning that impacts resident 29's risk for falls, resident to resident altercations, and exit-seeking behavior: *2/21/21. -Resident used to walk "20 miles daily. Even in his 60s he would walk the trail after work." -Struggles to keep his eyes open. "He will try to stand up and walk with his eyes closed." *7/13/21. -He "continues to be a high fall risk related to lack of safety awareness." -He does not "really participate in [restorative therapy]." -Staff "monitor to keep him as safe as possible." *10/5/21. -"Some days he is focused and attentive and other days he is not cooperative." -"He is getting harder to communicate with." -He "continues to be a high fall risk related to lack of safety awareness." -He does "still wander into other residents rooms." Review of assessments for wandering risk and fall scale, both dated 10/1/21, revealed the following factors were applicable for resident 29's high risk for wandering and falling: *Has multiple diagnoses related to dementia/cognitive impairment; impacting gait/mobility or strength. *Can communicate and follow instructions. *Overestimates or forgets limits. *Can move without assistance while in wheelchair. *Has history of wandering and falling. *Has wandered in the past month. *Gait is impaired defined as: -Difficulty rising from chair, uses arms to get up.	F 689		

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-Keeps head down when walking.
-Cannot walk unassisted.

Observation of resident 29 during the survey revealed he was walking alone away from his wheelchair on:
*10/19/21 at 12:30 p.m.
-He was standing in the television lobby in front of administrator A's office door.
-His wheelchair was parked in the hallway by the opening to the front foyer, at least 10 feet away.
*10/20/21 at 6:27 p.m.
-He was walking through the dining room over 10 feet away from his assigned dining room table.
-His wheelchair was parked at his table.
-Two unidentified dietary staff were doing tasks in the dining room; one looked at him but did not intervene.
-He walked down the hall towards administrator A's office.
-When he reached the television lobby, certified nursing assistant (CNA) O talked to resident 29 as he walked by him into the dining room.
-Administrator A walked out of his office and passed resident 29 without stopping to intervene.
-CNA O pushed resident 29's wheelchair from the dining room up to the resident and assisted him to sit in his wheelchair by guiding the placement of his right hand onto the armrest of the wheelchair.

Interview on 10/20/21 at 10:33 a.m. with certified medication aide/certified nursing aide (CMA/CNA) M and certified nursing aide (CNA) N revealed:
*Resident 29 is "slightly" more confused and he sometimes makes statements not based on reality, "like thinking the medication cart is where he can get airplane tickets."
*Resident 29 was wandering more now, he

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"travels about," and they "don't restrict his freedom."
*He has not tried to go out of the facility for a long time.
*He could "find his own room better than he used to," but he would wander from room to room.
*They reported resident 29 "is not attempting to hurt anyone."
*The resident used to "balance better" but can "transfer independently."
*He needs to be reminded to support himself with his good arm when getting in and out of his wheelchair.
*They monitor resident 29's location and respond as promptly as possible.

Interview with administrator A and director of nursing (DON) B on 10/20/21 at 3:30 p.m. revealed
*There was no investigation documentation beyond what was in the risk management reports.
*They do not have a process for evaluating and trending the falls.
*Administrator A stated, "This facility does not have that many falls."
*The process for evaluating other accident hazards or risks such as resident to resident altercations and exit-seeking was not discussed with administrator A and DON B.

2. Interview on 10/19/21 at 9:30 a.m. with resident 14 revealed she does not have concerns about any resident other than resident 2. She reported:
*Resident 2 has "hit me and I have hit her back."
*Resident 14 said she does not "feel safe" around her.
*She tries to "just stay away from resident 2."

Review of risk management reports and progress

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F 689	Continued From page 52 notes in the EMR for resident 14 between 1/16/21 and 10/20/21 revealed six resident to resident altercations with resident 2; one in February, three in May, and two in July. (See F610, finding 2.) Review of resident 14's MDS assessments dated 6/2/21 and 8/27/21 revealed no changes in the resident's physical and psychosocial functioning. (See F657, finding 2.) Review of the resident 14's current care plan (initiated 8/6/19, revised 9/7/21) revealed the interventions for a focus of behavior problem had not been revised since 5/12/21. (See F657, finding 2.) Surveyor: 45095 Surveyor 42477: 3. Observation on 10/18/21 at 4:09 p.m. of the facility's tub room revealed: *The tub room door had a keypad lock on the door. *The keypad lock was not engaged so the door was not locked. *Inside the tub room there were multiple tub cleaning chemicals in an unlocked cabinet. Observations made during the duration of the survey from 10/18/21 at 3:15 p.m. through 6:30 p.m., 10/19/21 from 7:30 a.m. through 6:00 p.m. and 10/20/21 from 7:30 a.m. through 8:00 p.m. revealed: *There had been multiple observations of various residents wandering the facility. *Residents 17 and 30 were observed frequently wandering the facility. -They wandered the hallway where the tub room had been located. *On 10/18/21 at 4:30 p.m. resident 17 was	F 689		

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wandering the hallway where the tub room had been located.
*On 10/19/21 at 9:00 a.m. resident 30 was observed wandering the hallway where the tub room had been located.

Review of resident 28's electronic medical record (EMR) revealed she:
*Had a diagnosis of dementia.
*Had a history of wandering.
*Had wandering into the tub room twice, thinking it was her bed.
*Was frequently exit seeking, to locate her husband.
*Wandered outside of the building, setting off the door alarm.
*Had been reported to nursing by Dietary.
*Was found outside the building, with her bottom on the ground and her back against the wall.
-she had been found on the side of the building.
*Eloped outside of the building without staff being with her.

4. Review of resident 4's revealed:
*She had been admitted to the facility on 5/5/21.
*On 5/6/21 she:
-Had been found lying face-first on the floor.
-Was lifted with a Hoyer.
-Needed stitches to her right finger.
-Had an "egg" forming on her forehead.
-Was transferred to the hospital for stitches and evaluation.
*On 5/14/21:
-A CNA was getting her up and resident 4 "attempted to get up on own" and fell and hit her face on her garbage can.
-The garbage can cut the bridge of her nose.
-She starts developing a lump on the right side of her forehead.

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F 689	Continued From page 54 *On 5/16/21: -She was noted to have bruising on her right face/eye orbit and a goose egg on her forehead. -This had been a result of her fall on 5/14/21. *On 5/31/21 she was found to be on the floor. *On 6/12/21 she had been found after staff heard a "thud." -She had a scrape to her left elbow. *On 7/1/21 she had been found on the floor. Review of resident 4's neurological checklist from the event on 5/6/21 revealed: *She had vitals and neurological signs checked at 7:30 p.m. -This was five minutes after her fall with injury. *She had been sent to the emergency department. -Documentation was not clear how long she had been out of the facility or when she left. *The next documented neurological signs and vitals were documented at 12:30 a.m. on 5/7/21. Review of resident 4's fall incident documentation forms revealed: *She had only two forms filled out, those dates were: -5/6/21. -7/1/21. *There were not any additional forms for the other fall occurences. Review of the provider's fall prevention tool completed for resident 4 revealed: *It had a scan date of 5/26/21. -The form itself was undated. *The following fall prevention ideas had been marked: -Low bed. -Mats on floor beside bed.	F 689		

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-Gripper socks.
-Toileting times/schedule "every 4 hours."
-Refer to therapy and/or restorative therapy.
-Bed/Chair alert system.
-Bed/Chair alarm system.
*Other ideas were documented as:
-"Staff education, Reminders for staff- bed alarm, bed low position, fall mat, weighted blanket."
*Also, starred was "Add a few more signs."
*The form had a spot for the family representative/ responsible part to sign and date.
-The form had been not signed or dated.

Review of the provider's South Dakota Department of Health reported events for resident 4 regarding falls revealed:
*She only had one report submitted and that was submitted for a fall on 8/26/21.
*Her other falls had not been reported.

Review of resident 4's neurological checklist from the event on 5/14/21 revealed:
*Her fall had been documented in charting at 9:15 a.m.
*Her neurological assessment and vital signs were started at 6:30 a.m.
*On one entry she did not have blood pressure obtained because she was sleeping, but had the following documented:
-Hand grasps.
-Pupil size.
-Pupil reaction.
-Speech.

5. Review of resident 2's EMR revealed she had:
*Multiple altercations with other residents.
*Physical and verbal altercations with residents.
*Injuries from another resident's finger nails on her wrist.

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*Staff would keep reminding the residents who had altercations to separate.

6. Random observations on 10/18/21 at 3:45 p.m. and on 10/20/21 at 9:30 a.m. of resident 9 in his room revealed his electric wheelchair had not been placed close to him to prevent falls.

Review of the provider's July 2017 Fall policy revealed:
*Residents who had a fall would be thoroughly assessed by an RN or LPN.
*Staff would immediately report the location of the fall.
*Before moving the resident, they would be assessed for the following:
-Pain.
-Tenderness.
-Swelling.
-Deformity.
-Distal Cyanosis (bluish coloration to the extremities).
-Numbness or tingling.
-Absence of pulse in extremities.
-Completing the fall report.
*Staff would thoroughly assess the resident by completing the fall report.
*If a head injury is suspected the following would be done:
-Neurological exam every 30 minutes for two hours, then as needed.
-Assess vital signs every 30 minutes for two hours, then every shift for three days.
*Physician and the responsible party would be notified as soon as possible.
*If the fall occurred during the night shift, the physician and responsible party would be notified the next shift.
*In the nurses notes the following would be

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F 689	Continued From page 57 documented: -Date and time of fall. -Activity prior to the fall. -Condition of the resident. -The date and time the physician was notified. -The date and time the responsible party were notified. -Other important information. *Staff were to complete the neuro check/vital sign flow sheet, incident reporting, and reporting to the South Dakota Department of Health. *A licensed nurse would update the care plan and complete investigation follow-up form to reflect interventions instituted to prevent further falls. *The incident report and investigation follow-up form will be reviewed and signed by the administrator, DON, and medical director. The fall would be discussed at the quality assurance process improvement meeting. Review of the provider's neurological checklist form and policy revealed there were inconsistencies in the requirements of documentation. *The form stated vitals and neurological signs should be assessed every 15 minutes for one hour. *Then every 30 minutes for one hour. *Then every hour for four hours. *Then every four hours for 24 hours. *This had been different than what the fall policy had instructed.	F 689		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or	F 744	F 744 Dementia interventions put into place for residents 28 and 29. All other residents with dementia diagnosis reviewed for proper dementia interventions.	11/11/21

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F 744	Continued From page 58 maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on observation, interview, and record review, the facility failed to provide individualized interventions to support the dementia-related psychosocial needs for two of two sampled residents (28 and 29). Findings include: 1. Observation of resident 29 on 10/19/21 at 12:30 p.m. and on 10/20/21 at 6:27 p.m. revealed he was walking alone away from his wheelchair. Various staff, including administrator A were observed walking past resident 29 without intervening. (See F689, finding 1.) Review of risk management reports and progress notes in the electronic medical record (EMR) for resident 29 between 1/16/21 and 10/20/21 revealed no investigation or evaluation of the risks nor the effectiveness of interventions before and after for: *Sixteen falls (See F610, finding 1), including one fall resulting in a serious bodily injury on 5/20/21 at 9:45 a.m. (See F609, finding 1.) *Nine resident to resident altercations (See F610, finding 1) caused by resident 29 when he wandered into other resident's rooms, became combative risking harm to other residents, or made physical contact with other residents. *Six documented behavior notes of exiting or attempting to exit the building. (See F689, finding 1.) Review of resident 29's admission minimum data set (MDS) assessment dated 1/21/21 and	F 744	F 744 Administrator, DON and interdisciplinary team reviewed, revised, and created necessary polices and procedures. Training/ education will be provided at the all staff meeting on 11/18/21. SSD and/or designee will audit dementia interventions weekly for 4 weeks and monthly for 2 additional months. SSD and/or designee will report findings at monthly QAPI meetings.	

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quarterly MDS dated 9/25/21 (See F657, finding 1), and assessments for wandering risk and fall scale both dated 10/1/21 (See F689, finding 1), revealed the resident:
*Had no hearing or vision problems, understands communication, but speech was unclear on 9/25/21.
*Had severely impaired cognitive ability, and overestimates or forgets his limits.
*Had different mood symptoms on each MDS, with scores of mild to minimal depression.
*Had physical behavioral symptoms directed toward others on the 9/25/21 MDS.
*Needed more touch assistance on 9/25/21 when transferring or using the wheelchair.
*Was independent with supervision for walking.
*Reported on 1/21/21 his very important preferences included:
-Choosing what clothes to wear, bathing method, and bedtime.
-Taking care of personal belongings and having a place to keep them safe.
-Having family involved in discussions of care.
-Being able to use the phone in private.
-Listen to music, get outside when the weather is good, and participate in religious services.

Review of the resident 29's current care plan (see F657, finding 1) revealed the interventions had not been revised based on an evaluation of each fall, resident to resident altercation, and exit-seeking incident after they had occurred for the focuses of:
*High risk for falls related to confusion, gait and balance problems, unaware of safety needs, wandering, and psychoactive drug use (initiated 1/27/21, revised 10/1/21).
*Potential to be resistive with cares and wandering related to dementia and adjustment to

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F 744	Continued From page 60 new environment (initiated 1/25/21, revised 9/30/21). Additional review of the care plan revealed focuses and interventions were not specific with individualized interventions to maximize the resident 29's dementia-related psychosocial needs: *Psychotropic medications related to "vascular dementia with behavior disturbance" and antidepressant medication related to depression (initiated 1/27/21). Interventions addressed administering medications and monitoring side effects but did not include non-pharmacological approaches. *Dependent on staff for meeting emotional, intellectual, physical, and social needs (initiated 2/23/21, revised 3/22/21). Interventions included: -Ensure activities resident attends are "compatible" with "capabilities," "preferences," "abilities, and "age appropriate," but there were no specific activities listed that would be "compatible." -Make sure hymns are playing on the CD player in room, "I like listening to hymns." -"Invite resident to scheduled activities." No specific activities were listed. *Potential for psychosocial well-being "possibly" related to depression and dementia diagnosis (initiated 1/25/21, revised 7/12/21). Interventions included: -Consult with social services or psychological care, with the note ("brother/power of attorney (POA) [name] does not wish" to use psychological services.) -Invite and encourage to attend activities that are of interest to me. No specific activities were listed. Review of resident 29's EMR for activity	F 744		

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documentation revealed:
*Progress notes were documented between 2/17/21 and 8/13/21. There were no notes beyond 8/13/21.
*Activity participation calendars for May and June 2021 were the most recent available in his EMR.
*The resident was noted as independent with reading/writing, and participated in music, chapel, social time, television, or movies.

Review of care team progress notes revealed a review of his physical functioning (See F689, finding 1) and psychosocial well-being on:
*2/2/21.
-The POA said the resident's "clarity of mind has improved since he has admitted here."
-The POA is "pleased (resident 29) is telling the staff when he wants or needs something."
4/20/21.
-"If you approach him to come to something he go the other way but if you let him be he will come and join."
7/13/21.
-"It is difficult to find activities that interest him."
-"He does enjoy music but that is about it."
-"When activities offer an activity, he usually does the opposite."
10/5/21.
-"He has good and bad days."
-"Religion is still important to him."

Interview on 10/20/21 at 10:33 a.m. with certified medication aide/certified nursing aide (CMA/CNA) M and certified nursing aide (CNA) N (see F689, finding 1) confirmed the resident is:
*"Slightly" more confused.
*Wandering more now.
*"Is not attempting to hurt anyone."
*Needs to be reminded to support himself with his

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

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F 744	Continued From page 62	F 744		

good arm.
*"Frequently keeps his eyes closed."
They also reported that staff:
*Monitor his location and respond as promptly as possible.
*Have had dementia training at staff meetings.
*Have been taught how to respond to behavior using "de-escalation."

Surveyor: 42477
2. Review of resident 28's EMR revealed:
*She had dementia.
*She was often wandering.
*One time she had been exit seeking trying to find her late husband.
*The facility called her daughter.
*Her daughter came in and brought in an obituary of resident 28's late husband.
*Documentation revealed staff used the obituary of resident 28's late husband to redirect or wandering/exit seeking.

Interview on 10/20/21 at 3:00 p.m. with administrator A revealed:
*Resident 28's daughter had wanted them to use the obituary to help with her mom's behaviors.
*Administrator A stated he was hesitant to use the obituary but the daughter requested it.
*He stated that using the obituary would help redirect resident 28 for a while.

Interview on 10/20/21 at 1:37 p.m. with MDS coordinator E revealed:
*The family of resident 28 wanted them to use the obituary.
*No education had been provided to the family to educate if that would be a good intervention or if it would cause trauma.

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F 835 SS=F	Administration CFR(s): 483.70	F 835	F 835	11/11/21

F 835 Administration
SS=F 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: 26632
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 of all thirty-one residents in the facility. Findings include:

1. Observations, interviews, record reviews, and policy reviews from 10/18/21 at 3:15 p.m. through 6:30 p.m., 10/19/21 from 7:30 a.m. through 6:00 p.m. and 10/20/21 from 7:30 a.m. through 8:00 p.m. revealed administrator A had not ensured the safe management and overall well-being of all the residents who lived in the facility.

Review of the provider's 8/5/13 Administrator job description revealed the administrator:
*"Reports to the Governing Board/Management."
*"Administers, directs and coordinates all activities of the care center to carry out its objectives as to the care of the individuals who need nursing care. Carries out programs within policies and general directives from the governing board/management. Promotes public relations within the community. Coordinates activities of the medical staff. Recommends and develops policies and procedures for aspects of the care center according to state and federal regulations.

F 835

Administration will be directly involved in resolving all identified deficiencies.

Administration will be a part of the process for reviewing, revising, and creating policies.

Will review all audits completed weekly for 4 weeks and monthly for 2 additional months.

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Performs related administrative and supervisory duties to ensure efficient operations of the care center."
*"Coordinates and integrates the total overall program of the facility."
*"Interprets and transmits policies of the governing board/management to the medical staff and personnel of the facility to assure compliance with policies and that residents are meeting their highest level of professional care needed."
*"Develops and monitors all departments within the facility to meet the standards put forth by the governing board, management, and state and federal regulations."

Review of the provider's 1/15/14 Director of Nursing (DON) job description revealed the DON:
*"Reported to the administrator."
*Would direct the licensed and non-licensed staff who provided health care and nursing services to the residents in the facility.
*Primary responsibility was to ensure the provision of quality nursing care on a twenty-four hour basis.
*Was to plan, organize, and direct the activities of the nursing department to ensure the delivery of quality nursing care with the goal of facilitating the highest level of functioning and independence for each resident.
*Monitored the job performance of the nursing staff by use of performance evaluations.
*Monitored the staffing levels of various nursing sections, and as necessary, directed staff rotations and rescheduled personnel to meet increased or decreased nursing service demands.
*Continuously monitored quality measures, federal, and state regulations and revised departmental procedures.

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F 835	Continued From page 65 *Reviewed grievances and responsible for overseeing and implementation of the infection control program. *Participates in committees for quality review for falls, skin, pharmaceutical, and restraints. *Responds to incident reports. *Oversees the ongoing quality improvement activities and any survey plans of correction.	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: 26632 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-one residents in the facility. Findings include: 1. During the survey, from 10/18/21 at 3:15 p.m.	F 837	F 837 Refer to: F574. F578, F582, F609, F610, F657,F658, F684, F686, F689, F744, F835, F837, F841, F867, F880, F881, F883, and F886.	11/11/21

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F 837	Continued From page 66 through 6:30 p.m., 10/19/21 from 7:30 a.m. through 6:00 p.m. and 10/20/21 from 7:30 a.m. through 8:00 p.m., the provider had not been operated in a manner to ensure the residents had received quality care. Administrator A had not been assisted with his duties to ensure he was able to effectively provide guidance to staff to be able to provide quality care. Refer to: F574. F578, F582, F609, F610, F657, F658, F684, F686, F689, F744, F835, F837, F841, F867, F880, F881, F883, and F886.	F 837		
F 841 SS=E	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and record review, the provider failed to ensure the medical director had provided oversight into the overall care within the facility. Findings include: 1. Observations, interview, and record reviews during the course of the survey revealed medical director F had not been actively involved in the overall quality assurance process improvement meetings as well as oversight into the ongoing issues within the facility.	F 841	F 841 Set up meeting with medical director to go over his responsibilities to the facility and other identified deficiencies within the facility. Medical director will continue to attend quarterly QA meetings and also will review findings from monthly QAPI meetings.	11/11/21

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F 841	Continued From page 67 Phone interview on 10/20/21 at 2:54 p.m. with medical director F revealed he: *Had been the medical director for approximately one and one-half years. *Did not participate in the quality assurance program. *Did not remember having been invited to those meetings. *Had an overview every three to four months of what was going on in the facility with administrator A. *Did not recall any information regarding falls, pressure injuries, infection control program, or the antibiotic stewardship program. *Was at the facility every Thursday for rounds. Refer to all findings for F684, F686, F689, F867, F880, F881, F883, and F886.	F 841		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, job description review, and policy review, the provider failed to identify concerns with facility delivery of cares and services and to implement and effective preformance improvement plan and quality assurance program. Findings include: 1. Interview on 10/20/21 at 2:00 p.m. with	F 867	F 867 Will initiate PIPs to work on identifying and correct areas that need improvement. Will ensure that medical director is aware of and apart of QAPI meetings. Administrator and/or designee will audit for PIPs in place and medical director involvement in QAPI meetings monthly for 3 months.	11/11/21

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F 867	Continued From page 68 administrator A regarding quality assurance process improvement (QAPI) revealed: *QAPI program was meeting on a regular basis. *There had been no PIP's in place for the past six months. *QAPI had not identified any areas of improvement for the facility. *Their medical director is unable to attend QAPI because he is "too busy." Interview on 10/20/21 at 2:53 p.m. with medical director F revealed he: *He had not been aware of the issues surveyors mentioned. *He had been the medical director for the past year and a half. *Surveyor asked if he attends QAPI meetings. -He asked what QAPI meetings were. *He was unable to recall if he had ever been invited the facility's QAPI meetings. F574. F578, F582, F609, F610, F657, F658, F684, F686, F689, F744, F835, F837, F841, F880, F881, F883, and F886.	F 867		
F 880 SS=H	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	F 880	F 880 For the identification of lack of Appropriate infection control precautions implemented with an outbreak of vomiting and diarrhea in both residents and staff. Comprehensive infection control program. Staff identified as responsible infection control program and process given sufficient time and resources to be effective. Appropriate cleaning and disinfection of care items used with multiple residents such as nail clippers.	11/11/21

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F 880	Continued From page 69 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under 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	F 880	F 880 The administrator, DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 11/10/21. ALL residents and staff have the potential to be affected if staff do not adhere to identified areas. Administrator, DON, 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 and documentation. MDS coordinator or designee will audit appropriate cleaning and disinfecting of resident care items 2 times weekly for 4 weeks and monthly for two additional months. Monitoring results will be reported by MDS coordinator and/or a designee 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 70 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: 42477 Surveyor: 26632 Based on observation, interview, record review, job description review, and policy review, the provider failed to: *Ensure infection control precautions had been initiated after an outbreak of vomiting and diarrhea in residents and staff. *Have comprehensive infection control program. *Ensure items that had been used on all residents had been properly cleaned and disinfected. Findings include: 1. Observation on 10/19/21 at 10:22 a.m. revealed resident 11 was lying in her bed. A large amount of vomit was on the blanket in front of her. She stated she felt fine. MDS coordinator E was notified and assisted the resident. Interview on 10/19/21 at 10:28 a.m. with MDS	F 880		

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F 880	Continued From page 71	F 880		

coordinator E revealed:
*She was aware that residents and staff are ill with a "bug."
*She had tested a few of the residents for COVID-19, but they were all negative.
*She had not tested any of the staff.
*None of the residents have a fever.
*No isolation of those residents was necessary.
*Did not think any PPE other than gloves and the face masks they wear was necessary.

Interview on 10/19/21 at 10:30 a.m. with certified nursing assistant (CNA) K revealed there were some of the residents that had signs and symptoms of the "stomach flu."

Interview on 10/19/21 at 11:00 a.m. with registered nurse (RN) D and MDS coordinator E revealed:
*There were several residents who were having either vomiting or diarrhea or both.
*Three CNAs and one RN had called in sick today as there were having the same symptoms.
*Had not notified the South Dakota Department of Health (SDDOH) reportable disease department.
*Did not feel it was an outbreak of any sort.

Interview on 10/19/21 at 11:15 a.m. revealed the maintenance supervisor and the dietary manager were also out with those symptoms. The maintenance supervisor had also been out ill on 10/18/21.

Interview on 10/19/21 at 12:12 p.m. with director of nursing (DON) B revealed residents 5, 8, 9, 11, 16, and 21 had either vomiting or diarrhea or both.

Observation on 10/19/21 from 1:30 p.m. through

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F 880		F 880		

Continued From page 72
5:00 p.m. revealed:
*No other PPE had been put in place for staff when they assisted residents with vomiting, diarrhea, or both.
*The DON had ordered tea and toast for those residents for supper.
*There were 13 total residents that were having gastrointestinal (GI) upset symptoms.

Review of a list of residents given by the DON on 10/20/21 revealed there were five additional residents who had GI upset symptoms.

Interview on 10/20/21 at 1:38 p.m. with MDS coordinator E revealed:
*She had reported the outbreak of residents ill to the SDDOH yesterday afternoon.
*Did not think any other PPE was necessary.
*Agreed it had spread to other residents and staff.
*There were more staff ill today.

Interview on 10/20/21 at 3:30 p.m. with administrator A and DON B revealed:
*Medical director F had been notified of the GI outbreak.
*He had replied and did not advise to place any residents on precautions.

Review of the 10/19/21 facsimile sent at 4:00 p.m. to medical director F revealed:
*He had sent it back with his recommendations on 10/20/21 at 9:45 a.m.
*The provider had sent the following message:
-"Please see attached sheet for residents that recently came down with diarrhea and loose stools - What are your recommendations going forward. They are afebrile."
*Medical director F replied:
-"Suspect likely viral etiology. Able to keep

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F 880 Continued From page 73
residents in their rooms that are symptomatic. Continue supportive care. Staff & roommates [unreadable word] to promote good liquid intake/water at bedside. Also able to do sot diet and gradually titrate back to their usual diets as they recover."
*Medical director F had not advised on precautions.

F 880

Review of the provider's revised February 2021 Infection Prevention Precautions policy revealed:
*Standard precautions would be used for situations when staff provide care for any resident where there was the potential for contact with bodily fluids or excretions. Those precautions included:
-PPE was to be used appropriately when the possibility of contact between bodily fluids of the resident and skin or mucosal membranes of staff was existing.
-Gloves for contact with hands, gown for contact with clothing, trunk, or limbs, mask for splatter contact with mouth or nose, and goggles for splatter contact with eyes.
*Contact precautions were used for residents with known or suspected infections whose transmission was by direct or indirect contact mechanisms. Those precautions included:
-PPE would be provided outside the residents room. PPE provided would be gloves and gowns at a minimum.
-A trash container would also be provided near the door for doffed PPE.
-A communication card for staff would be provided in the container with the PPE which would list the infection type and procedures to be utilized.

Review of the provider's revised February 2021

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F 880	Continued From page 74 Initiating and Discontinuing Expanded Precautions policy revealed: *The provider would make every effort to use the least restrictive approach in the management of potentially communicable infections. Those procedures included: -If a resident was suspected of or identified as having a communicable infectious disease, the charge nurse would notify the infection prevention staff, director of nursing, and the resident's attending physician for the appropriate expanded precaution. -When expanded precautions were implemented, the charge nurse would ensure that protective equipment was maintained near the residents room. 2. Interview on 10/20/21 at 2:00 p.m. with MDS coordinator E revealed she: *She used the Centers for Disease Control and Prevention (CDC) guidelines for infection control guidelines. *Had been the infection control nurse for approximately 18 months. *Had taken the infection control preventionist class. *Had the nurses keep track of when a resident was prescribed an antibiotic. *Did not review that list to ensure if a resident had a culture taken, if the antibiotic prescribed was effective, or if the residents infection had resolved. *Did not analyze if there was a trend with residents who had similar infections. *Did not have an antibiotic steward ship program. *Did feel she had been given the time or resources to develop an infection control program. *Did not understand how to monitor and run an	F 880		

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	435088	A. BUILDING ______ B. WING ______	10/20/2021

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F 880	Continued From page 75	F 880		

infection control program.
*There was no infection control plan.

Surveyor 42477:
3. Observation and interview on 10/19/21 at 10:08 a.m. with CNA K in the tub room revealed:
*She stated the door does not lock unless you turn the knob on the backside of the door.
*There had been a silver canister with resident's hairbrushes soaking.
*She stated the solution in the silver canister was water from the whirlpool.
*The nail clippers were used for all the residents.
*Surveyor asked how often she cleans them, she replied:
-She tried to clean them once or twice a month.
-She cleans them by swishing them around in the bath water.
-Surveyor pointed out that they were dirty and still had about five to six various sized nail clippings located inside of them.

Surveyor 26632:
Interview on 10/20/21 at 3:00 p.m. with administrator A and DON B revealed:
*They were not aware there was not an effective infection control program.
*It was the job duty of MDS coordinator E to manage the infection control program.

Review of provider's 1/15/14 MDS Coordinator job description revealed:
*Worked closely with the DON to direct the licensed and non-licensed staff who provided health care and nursing services.
*Ensured quality of nursing care on a 24-hour basis.
*Assist with planning, organizing, and directing the activities of the nursing department to ensure

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F 880	Continued From page 76 the delivery of quality nursing care with the goal of facilitating the highest level of functioning and independence for each resident. *Essential duties included: -Oversee, coordinate, and complete the process of MDS, assessment, and care planning. -Improvement of resident assessments. -Complete MDS's per schedule. -Coordinate and direct the care plan team and the care conference process.	F 880		
F 881 SS=E	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 Surveyor: 26632 Based on interview, record review, and policy review, the provider failed to have an 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: 1. Interview on 10/20/21 at 1:38 p.m. with	F 881	F 881 For the identification of lack of Antibiotic stewardship program. The administrator, DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Administrator, DON, 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 and documentation. MDS coordinator or designee will audit appropriate cleaning and disinfecting of resident care items 2 times weekly for 4 weeks and monthly for two additional months. Monitoring results will be reported by MDS coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	11/11/21

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F 881	Continued From page 77 Minimum Data Set (MDS) coordinator E revealed: *She was also the designated infection control nurse for approximately eighteen months. *Had completed the infection preventionist course approximately one year ago. *There was no antibiotic stewardship program when she had started in the infection control preventionist role. *She did not have the time to complete a antibiotic stewardship program. *She was not sure what the requirements of the program would have been. *Antibiotic use was not discussed at the quality assurance meetings. Interview on 10/20/21 at 3:00 p.m. with administrator A and director of nursing B revealed: *It was the responsibility of the infection control nurse to manage the antibiotic stewardship program. *They agreed the antibiotic stewardship program should have also been integrated into the quality assurance performance improvement plan. *There was no specific antibiotic stewardship policy. Review of the provider's February 2021 infection control policies revealed no procedure had been included for the antibiotic stewardship program.	F 881		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883	F 883 For the identification of lack of Appropriate documentation to support residents had been offered and administered or refused pneumonia vaccination.	11/11/21

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F 883	Continued From page 78 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883	F 883 The administrator, DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Administrator, DON, 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 and documentation. MDS coordinator or designee will audit appropriate cleaning and disinfecting of resident care items 1 times weekly for 4 weeks and monthly for two additional months. Monitoring results will be reported by MDS coordinator and/or a designee 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 883	Continued From page 79	F 883		

following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Surveyor: 26632
Based on record review and interview, the provider failed to ensure three of five randomly sampled residents (5, 17, and 31) had documentation a pneumonia vaccination had been offered and either administered or refused. Findings include:

1. Review of resident 5's medical record revealed she had been admitted on 8/25/20. There was no documentation she had received or refused a pneumonia vaccination.

2. Review of resident 17's medical record revealed she had been admitted on 8/18/21. There was no documentation she had received or refused a pneumonia vaccination.

3. Review of resident 31's medical record revealed she had been admitted on 10/17/20. There was no documentation she had received or refused a pneumonia vaccination.

Interview on 10/20/21 at 1:38 p.m. with Minimum Data Set coordinator E revealed:
*She was not aware of the requirement for a pneumonia vaccination to have been offered and administered or refused.

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F 883	Continued From page 80 *She did not ensure documentation was present if the resident had a previous history he/she had received the pneumonia vaccination prior. *There was no policy on providing a pneumonia vaccination.	F 883		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that	F 886	F 886 For the identification of lack of Appropriate documentation when outbreak and county level testing not followed or testing not conducted. The administrator, DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Administrator, DON, 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 and documentation. MDS coordinator or designee will audit appropriate cleaning and disinfecting of resident care items 2 times weekly for 4 weeks and monthly for two additional months. Monitoring results will be reported by MDS coordinator and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	11/11/21

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F 886	Continued From page 81 is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to: *Follow outbreak and county level testing procedures for staff and residents in their building. *Documentation of testing for COVID-19 with county level testing and outbreak testing of	F 886		

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F 886 Continued From page 82
residents and staff.
Findings include:

1. Review of the COVID-19 testing results for residents and staff revealed:
*A large amount of testing result papers was given for review.
*The testing results were not in any order.

Interview on 10/20/21 at 1:38 p.m. with Minimum Data Set (MDS) coordinator E revealed:
*She was also the infection control preventionist.
*The testing papers were the only documentation she had for COVID-19 testing.
*Stated administrator A checked the county positivity rates and would contact her when they were to have tested residents and staff.

Interview on 10/20/21 at 3:00 p.m. with administrator A and director of nursing B revealed:
*MDS coordinator E was in charge of testing for COVID-19.
*They were not aware no documentation, other than the test results sheets, had been maintained.
*Administrator A did not have the dates when residents and/or staff were tested based on the county positivity rates.

Review of Centers for Disease Control and Prevention's (CDC) Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing homes
<www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html> 9/10/21 guidance included:
*Unvaccinated staff were to be tested based off county level positivity rates.

F 886

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F 886	Continued From page 83 *An outbreak consisted of: -One resident or a staff person. *A person should be designated as the infection control person to oversee the COVID-19 effort and management of infection control program. Review of the provider's revised 3/20/20 COVID-19 policy revealed no procedure when testing of residents or staff for COVID-19 should have been completed.	F 886		

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FORM APPROVED
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 000	Initial Comments Surveyor: 26632 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 10/18/21 through 10/20/21. Centerville Care and Rehab Center Inc was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/15/21

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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	435088	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/19/2021**

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/19/21. Centerville Care and Rehab Center Inc. was found not in compliance with 42 CFR 483.90 (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 deficiencies identified at K223, K712 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain one of four hazardous areas	K 223	K 223 Door closure ordered for soiled utility room and will be installed once we receive it.	11/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Samuel Van Voorst
TITLE: Administrator
(X6) DATE: 11/15/2021

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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SD DOH-OLC

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K 223	Continued From page 1 (soiled laundry) as required. Findings include: 1. Observation on 10/19/21 at 8:30 a.m. revealed the soiled laundry room was 100 square feet and contained combustible items. The room door was not equipped with a closer. Interview with the administrator at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 223		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills) for two of four yearly quarters from January through December 2017. Two night drills had date and time recorded, but no other documentation. Two drills revealed inadequacy in the fire system, but	K 712	K 712 Cannot correct previous non-compliance for fire drills October 2020, April 2021, May 2021. All Deficiencies with fire system repaired or schedule for repair. Fire drill education to be completed at monthly all staff meeting on 11/18/21. Will audit completion and documentation of fire drills monthly for 3 months.	11/20/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE CARE AND REHAB CENTER INC	**500 VERMILLION ST** **CENTERVILLE, SD 57014**

(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
K 712	Continued From page 2 documentation of repair was not found. The drill performed during the survey on 10/19/21 at 10:30 confirmed the lack of training. Findings include: 1. Record review on 10/19/21 at 10:15 a.m. revealed there was no documentation of day or evening shift fire drill for October, 2020. There also was no documentation of fire drills for day or evening shifts in April and May, 2021. 2. Night shift drills done over the past twelve months are not well documented. Date and time is completed on the form, but little else. 3. Two drills (November, 2020 and March, 2021) note deficiencies with the fire system. However, no follow-up repair is noted. 4. A fire drill was performed on 10/19/21 at 10:30 a.m. during the survey. The drill was in the kitchen and kitchen staff responded by closing doors, and attempting to close the roll-down windows between the kitchen and the dining area. However, the windows could not be lowered due to malfunction. Staff in the dining area had moved residents to a sitting area adjacent and not seperated from the dining area. The open kitchen windows were visible. However, staff were unable to understand why this would require moving the residents to a different smoke compartment. Two additional staff brought extinguishers. However, when these staff were asked why they did not assist they said that they could not enter the kitchen to ask kitchen staff if they required assistance because they did not have hairnets. Interview with the Administrator at the time of the record review confirmed those findings.	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435088	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/19/2021**

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K 712	Continued From page 3 The deficiency had the potential to affect 100% of the occupants of the building.	K 712		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918	K 918 Established generator logs for maintenance and/or designee to complete. Battery replaced.	11/20/21

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	435088	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/19/2021**

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K 918	Continued From page 4 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 A. Based on record review and interview, the provider failed to document any generator testing. Findings include: 1. Record review on 10/19/21 at 11:10 a.m. revealed there was not any documentation of generator testing. The administrator called the maintenance man (home sick) and was told that he did not document any generator testing because it runs automatically. The deficiency affected all of numerous requirements for generator maintenance. B. Based on observation and interview, the provider failed to replace the generator battery as required (battery installed in 2017). Findings include: 1. Observation on 10/19/21 at 10:00 a.m. revealed the generator battery was marked with 2017 for the installation date. That made it approximately fifty months old. Generator batteries are recommended to be replaced every twenty-four to thirty months. Interview with the administrator at the time of the observation confirmed that finding.	K 918		

South Dakota Department of Health

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	10605	A. BUILDING: ______ B. WING ______	10/21/2021

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CENTERVILLE CARE AND REHAB CENTER INC	500 VERMILLION ST CENTERVILLE, SD 57014

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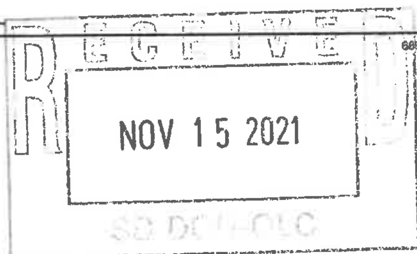
S 000	Compliance/Noncompliance Statement Surveyor: 40506 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/18/21 through 10/21/21. Centerville Care and Rehab Center Inc was found not in compliance with the following requirement(s): S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in three randomly observed rooms (soiled laundry, soiled utility, and janitor's closet). Findings include: 1. Observation on 10/19/21 at 8:05 a.m. revealed the exhaust ventilation for the room used for janitor supplies was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. 2. Observation on 10/19/21 at 8:07 a.m. revealed the exhaust ventilation for the room used for clean utility was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. 3. Observation on 10/19/21 at 8:20 a.m. revealed the exhaust ventilation for the room used for	S 157	S 157 Room used for janitor supplies repaired and ventilation functioning correctly. Scheduling date with contract to look at all other room for ventilation resolutions.	11/20/21

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

TITLE: Administrator

(X6) DATE: 11/15/21



South Dakota Department of Health

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	10605	A. BUILDING: ______ B. WING ______	10/21/2021

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S 157	Continued From page 1 clean utility was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Interview with the administrator on 10/19/21 at the time of each finding confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at these locations.	S 157		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/18/21 through 10/21/21. Centerville Care and Rehab Center Inc was found in compliance.	S 000		