STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435062	A. Building B. Wing	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcester Care and Rehab Center, Inc	101 Church Street Alcester, SD 57001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06365 Based on observation, interview, record review, and policy review, the facility failed to document medical symptoms for two of two residents (20, 21) with physical devices that could restrict their free movements. Findings include: 1. Observation on 11/2/21 at 9:00 a.m. of resident 20 while he was seated in a wheelchair in the dining room for morning exercises revealed: *A cushion in a pillowcase was set on top of the right wheelchair arm rest. *The resident's right arm was resting on top of it. *A buckled black strap was wrapped across the top of his right arm and under the arm rest holding his arm on the top of the pillow. Interview with the resident at that time about the strap revealed he had no comment on it. Review of the 9/19/21 quarterly minimum data set (MDS) assessment in resident 20's electronic medical record (EMR) revealed: *Limb restraint was checked as not used. *The resident: -Had impaired range of motion on an upper extremity on one side of his body. -Was dependent on staff for all activities of daily living (ADL). -Had moderately impaired cognitive abilities. -Clearly understood conversations and was understood when he spoke. Review of the care plan focus for limited range of motion of right upper extremity, initiated on 10/2/20 and revised on 9/29/21, revealed neither the cushion nor the black strap were listed as interventions. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/3/21 at 11:16 a.m. revealed certified nursing assistant (CNA) DD picked the arm rest cushion off the dining room floor and placed it under resident 20's right arm. The black strap was not in place. Interview on 11/3/21 at 3:20 p.m. with interim director of nursing (DON) and MDS coordinator B revealed: *Therapy had recommended the cushion for positioning of his arm. *She had never seen a black strap being used. *They do not have a documented assessment of the strap as a potential restraint. Interview on 11/4/21 at 12:45 p.m. with interim DON/MDS coordinator B revealed she learned that activity director EE put the black strap on the resident on 11/2/21. Interview on 11/4/21 at 12:57 p.m. with activity director EE revealed: *The therapist instructed her how to put the black strap on. *She took photos to show others how to put the strap on. *The photos were posted in resident 20's room. Observation at that time with activity director EE revealed three photos hanging on the wall in resident 20's room. 2. Observation of resident 21 revealed: *On 11/2/21 at 9:15 a.m., she was lying in bed on her back with a positioning alarm clipped to her gown on her left side. The resident was awake, talking nonsensically while looking at the wall, moving her legs up and down under her covers. *On 11/2/21 at 1:00 p.m., she was at the nurses desk with eyes closed in a reclined position with feet on the floor in a wheelchair that had a padded full upright back supporting her head while she was humming along with music playing through headphones. *On 11/3/21 at 11:20 a.m., she was sitting in the same wheelchair at the dining room table and rocking back and forth in it. A positioning alarm was clipped to her shirt on the left side. Review of resident 21's care plan in her EMR revealed the following focuses but did not specify the use of a reclining wheelchair nor the use of a positioning alarm in bed: *Resident wanders aimlessly, initiated on 7/8/21. *ADL self-care performance deficit, initiated on 8/30/21. *Actual fall with a minor injury, initiated on 7/21/21, with interventions initiated on 10/1/21: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-May require the use of a wheelchair. -While in a wheelchair, staff were to use an alarm at all times for safety & [and] to notify staff during self-transfers. Review of incident progress notes in the EMR revealed resident 21 had fallen on: *6/30/21 at 4:05 a.m., an unwitnessed fall with a cut above her left eye. *8/30/21 at 10:15 a.m., an unwitnessed fall with resident found scooting on her bottom across the floor in her room. *9/13/21 at 2:10 a.m., a witnesssed fall in the dining room when resident tripped over the foot rest of another resident's reclining chair. *9/23/21 at 1:20 p.m., an unwitnessed fall with resident found scooting on her bottom across the floor in her room. *9/23/21 at 2:55 p.m., an unwitnessed fall in the hallway. She appeared weaker with ambulation and leaning more to the left. Will obtain a rocker WC [wheelchair] .due to weakness and leaning. Review of the 9/19/21 quarterly MDS assessment revealed: *Chair prevents rising and alarms for bed and chair were each checked as not used. *Mobility devices, such as a walker or wheelchair, were not checked as used. *The resident: -Had fallen before that MDS was completed. -Needed guided assistance with transferring and walking. -Had severely impaired cognitive abilities. Review of the EMR also revealed an in progress significant change MDS dated [DATE]. Interview on 11/3/21 at 2:03 p.m. with social services designee (SSD) X revealed: *There seemed to be a sudden change recently with the resident's gait from walking to small steps to shuffling. *The rocker wheelchair keeps her from getting up and the rocking seems to be a calming movement for her. Interview on 11/3/21 at 3:20 p.m. with interim DON/MDS coordinator B revealed: *There were no assessments of the positioning alarm and rocker wheelchair as potential restraints. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*They did not have a tool for assessment of potential restraints. Interview on 11/3/21 at 4:49 p.m. with interim DON/MDS coordinator B confirmed the care plan in the EMR was current through 12/29/21.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 26632 Based on interview, record review, and policy review, the facility failed to investigate an incident of alleged abuse that involved two sampled residents (4 and 14). Findings include: 1. 1. Review of residents 4's and 14's medical record revealed a interdisciplinary notes revealed: *On 7/31/21 at 6:32 p.m. Resident [4] is found sitting in tv area next to a female resident holding her unclothed breast. Resident did not appear to be making any further advancements and does not appear distressed about the situation but was separated from the other resident. ADON [assistant director of nursing] and Administrator notified. *On 7/31/2021 at 6:29 p.m. Resident [14] is found sitting in tv area with shirt unbuttoned next to another male resident while he was holding her breast. Resident did not appear to be distressed about the situation but was separated from the other resident. ADON and Administrator notified. *Continued review of residents 4 and 14's progress notes revealed their representative and physicians had not been notified of the above incident. Interview on 11/3/21 at 12:58 p.m. with administrator A revealed she had not reported the above incident to the SDDOH. That was because resident's 4 and 14 had not appeared upset about the incident she did not feel it was necessary. Interview on 11/3/21 at 2:00 p.m. with interim director of nursing (DON)/ Minimum Data Set (MDS) coordinator B stated she had not remembered having been contacted regarding the above incident. She had not been involved with the investigation. Review of the investigation documentation provided by administrator A revealed: *On 7/31/21 at 6:00 p.m. Nurse called due to [resident 4] touching [resident 14] breast while shirt was unbuttoned. Educated nurse to separate the residents and monitor throughout the evening to observe any further direction towards each other. *Investigated [investigation] conducted by asking nurse about incident. Nurse stated they were in the lobby, both smiling and pleasant, not in distress. They both were easily separated and asked if anything was wrong. Both were pleasant about situation. *When resident residents were checked on later, they did not seem unusual in any sense. *Residents have been living across the hall in the same facility for 3 years, have never made accusations for/against one another. *8/6/21Two residents have not had any further accusations since incident. Review of the provider's revised 5/19/21 Abuse, Neglect, and Exploitation policy revealed: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*All reports of abuse, neglect, and exploitation will be taken seriously with a thorough evaluation. *The department of Health will be informed within 24 hours by Administrator, Director of Nursing, or Social Worker. *Facility Ombudsman will be contacted by Social Worker. *The police may be contacted at the discretion of the Administrator. *Family will be notified by Administrator, Director of Nursing, or Social Worker

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 06365 Based on interview and record review, the facility failed to provide notice of bed hold for one of one residents (33) discharged to the hospital. Findings include: 1. Review of progress notes for resident 33 in the closed electronic medical record (EMR) revealed a pattern of increasingly aggressive behaviors that put other residents at risk for injury and resulted in injury to some staff. (Refer also to F760, finding 1). A behavioral expression note on 10/21/21 stated orders were received to transfer the resident to the emergency room for evaluation due to increased behaviors and aggression. There was no progress note in the EMR documenting notification of the bed hold policy to the resident's representative. Interview on 11/4/21 at 1:07 p.m. with administrator A, interim director of nursing (DON)/minimum data set (MDS) coordinator B, and business office manager GG revealed: *No bed hold form had been completed. *They held the bed for five days. *The resident's representative told the interim DON/MDS coordinator B today that the resident will not be coming back.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 06365 Based on observation, interview, record review, and policy review, the facility failed to revise the care plans to address: *The use of physical devices to reduce the risk of falls for three of four sampled residents (20, 21, and 33). *Communication needs and discharge plan for one of one sampled resident (18). *Behavior symptoms for one of three sampled residents (33). *The use of bed rails for one of six sampled resident (25) with bed rails. *Risk of accidents related to wandering for one of three sampled residents (33). *The use of assistive devices with transferring for one of one sampled resident (22). *Pressure ulcer healing for one of one sampled resident (25). Findings include: 1. Observation on 11/2/21 at 9:00 a.m. of resident 20 while he was seated in a wheelchair in the dining room for morning exercises revealed: *A cushion in a pillowcase was set on top of the right wheelchair arm rest. *The resident's right arm was resting on top of the pillowcase. *A buckled black strap was wrapped across the top of his right arm and under the arm rest holding his arm on the top of the pillow. Review of resident 20's electronic medical record (EMR) care plan focus for limited range of motion of the right upper extremity, initiated on 10/2/20 and revised on 9/29/21, revealed neither the cushion nor the black strap were listed as interventions. (Refer also to F604, finding 1.) 2. Observation of resident 21 revealed: *On 11/2/21 at 9:15 a.m., she was lying in bed on her back with a positioning alarm clipped to her gown on her left side. The resident was awake, talking nonsensically while looking at the wall, moving her legs up and down under her covers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*On 11/2/21 at 1:00 p.m., she was at the nurses desk with eyes closed in a reclined position sitting in a wheelchair that had a padded full upright back supporting her head while she was humming along with music playing through headphones. *On 11/3/21 at 11:20 a.m., she was sitting in the same wheelchair at the dining room table and rocking back and forth in it. A positioning alarm was clipped to her shirt on the left side. Review of resident 21's care plan in the electronic medical record (EMR) revealed the following focuses did not specify the use of a reclining wheelchair nor the use of a positioning alarm in bed: *Resident wanders aimlessly, initiated on 7/8/21. *Activities of daily living (ADL) self-care performance deficit, initiated on 8/30/21. *Actual fall with a minor injury, initiated on 7/21/21, with interventions initiated on 10/1/21: -May require the use of a wheelchair. -While in a wheelchair, TABS alarm at all times for safety & [and] to notify staff during self-transfers. Interview on 11/3/21 at 4:49 p.m. with interim director of nursing (DON)/minimum data set (MDS) coordinator B confirmed the care plan in the EMR was current through 12/29/21. (Refer also to F604, finding 2.) 3. Observation of resident 18 revealed: *On 11/1/21 at 5:20 p.m., he sat in his wheelchair outside the kitchen serving window. The cook asked him if he was ready for his supper tray. He responded with a slurred word and nodded his head. *On 11/2/21 at 4:12 p.m., the resident responded to questions with guttural sounds and body movements that indicated he understood. Review of resident 18's care plan in the EMR revealed: *A focus for communication problem, initiated on 3/2/21 and revised on 3/24/21, with a goal target date of 6/22/21 to improve communication by: -Making sounds. -Using appropriate gestures. -Responding to yes/no questions appropriately. -Using communication board. -Writing messages. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*A focus initiated on 3/2/21 and revised on 3/24/21 that family would like resident to remain here, discharge unknown at this time, and a statement regarding a 100 day PASRR (pre-admission screening, determined by the state) upon admission to facility, with: -A goal for surgical abdominal wound to heal before discharge is feasible. -An intervention to establish a pre-discharge and revise plan according to the state's PASRR guidelines. Interview on 11/3/21 at 2:01 p.m. with social services designee (SSD) X revealed: *The staff do not need to use the communication board as they can understand resident 18's communication methods. *The 100-day PASRR limit was resolved and the state determined the resident needed long-term care. *She will get the care plan revised for both the communication board and reference to discharge related to the 100-day PASRR. Interview on 11/03/21 at 4:49 p.m. with interim DON/MDS coordinator B revealed: *She had multiple care plans that have been reviewed but she was behind getting the revisions in the EMR. *The care plan in the EMR for resident 18 is the current care plan, updated on 9/30/21 and through 12/30/21. Comparison review of the EMR care plan and a paper copy of it provided by interim DON/MDS coordinator B on 11/4/2021 revealed: *The communication board was still listed on both as part of resident 18's goal for communication. *The 100-day PASRR had been removed from the focus for remaining in the facility. 4. Closed record review of resident 33's progress notes between admission on 9/14/21 and his discharge to the emergency roiagnom on [DATE] revealed: *He was admitted with a cognitive decline and a history of frequent falls. *He attempted to exit the building in his wheelchair without supervision on 9/15/21. *He needed assistance with repositioning and transferring safely due to his impaired cognition and impulsive attempts to transfer himself. *His bed was in the lowest position with a pressure alarm and a fall mat on the floor beside his bed. *The use of a wheelchair for mobility with pressure alarms when in his wheelchair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*He was found in remote locations having a confrontation with other residents on 9/26/21 and 10/11/21. *He had an unwitnessed fall on 10/11/21 at 7:35 a.m., when the staff responded to the wheelchair alarm and found the resident on his back on the floor in his room by the window. *He had a near fall on 10/19/21 when staff responded to the alarm to find the resident standing on his wheelchair foot rests in his bathroom. *A pattern of increasingly aggressive behaviors that put other residents at risk for injury and resulted in injury to some staff. (Refer also to F760, finding 1). Review of the care plan initiated on 9/15/21 revealed no focuses, goals, or interventions related to:*Prevention of falls, nor revisions to address the unwitnessed fall on 10/11/21 and the near fall on 10/19/21. *Assistance with daily living tasks. *Behavior management related to cognitive impairment and how staff should approach him to minimize the risk of injury to the resident and staff related to his aggressive behaviors. *Risk of wandering and exit seeking, nor revisions to address the three times, he was found in potentially unsafe locations. Review of the admission MDS assessment dated [DATE] and signed as completed on 9/30/21 revealed: *He had a fall in the last month before admission. *Bed rail, bed alarm, and chair alarm were coded as used daily. The floor mat was coded as not used. *He needed staff assistance of two or more persons for bed mobility, transferring, mobility, dressing, and using the toilet. *No behaviors were coded. *The resident scored as being moderately cognitively impaired. *He reported having pain occasionally and gave an intensity rating of 5 out of a scale of 10. The care plan was not revised after the MDS was completed to address the fall risk, preventive devices used, staff assistance, behavior management, nor pain management. 43844 5. Observation on 11/2/21 at 9:45 a.m. of resident 22 revealed he had: *Been sitting in a rocking wheelchair, in the dining room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*A mechanical lift sling underneath of him. Review of resident 22's medical record revealed his EMR care plan had not been updated since 9/29/21. Interview on 11/4/21 at 10:38 a.m. with interim DON/MDS coordinator B regarding resident 22's care plan revealed she: *Had a printed copy of his care plan from his EMR. -Had made changes to this printed care plan in writing. -Agreed the written changes had not been updated in the EMR. *Stated there was an internal communication book for staff to be aware of any changes to resident cares. -Some of the information that had been included in the internal communication book had not been added to residents EMR. *Had a 10/14/21 physical therapy communication on her desk. -It stated, Patient should have Hoyer [mechanical] lift strap underneath him at all times (in bed, wc [wheelchair], recliner, etc.) in case Hoyer is needed for safety with transfers. If Hoyer is not needed, patient can transfer with FWW [front wheeled walker] and/or EZ [mechanical] stand lift, whichever is safest for staff/patient at that time. -This had not been included in his current written or EMR care plan. Review of resident 22's current paper care plan revealed: *It had been updated in writing to include: *He had been a high risk for falls. -He had fallen at the assisted living center before admission to this facility. -His bed was to be left in a low position. -He was to have had a pressure alarm on at all times. -Keeping the mechanical lift sling under him while in a chair had not been on the care plan. *Antipsychotic use. -There had been no goals or interventions listed. *Antidepressant use. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-There had been no goals or interventions listed. *The electronic record had not been updated with this information. 6. Observation on 11/03/21 at 8:58 a.m. of resident 25 revealed he: *Had been in the hallway, sitting in his wheelchair. *Did not have foot pedals on the wheelchair. *Feet did not touch the floor. *Had on blue gripper socks. *Had not been wearing any leg braces. Interview on 11/03/21 at 9:03 a.m. with certified nursing assistant (CNA) DD revealed she: *Had started her employment at the facility, A couple weeks ago. *Had thought she had access to residents care plans through the electronic medical records system, but was not certain. *Was not aware that resident 25 had leg braces. Interview on 11/3/21 at 9:07 a.m. with certified nursing assisant (CNA) DD regarding resident 25's leg braces revealed: *She had checked with a nurse and found out he did have leg braces. -The braces were not currently being worn due to his having a pressure ulcer on his right foot. --They would have been used to assist in transferring him. --She did not know how he transferred without the braces as she had not transferred him. Review of resident 25's current care plan revealed: *Staff were to assist him to put on leg braces before getting him out of bed. -There was nothing in the care plan about the braces not being used. *He had the potential for pressure ulcer development due to his obesity, immobility, and diabetes. -There was nothing in the care plan about currently having a pressure ulcer. Interview on 11/4/21 at 10:40 a.m. interim DON/MDS coordinator B regarding resident 25's care plan revealed she: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Thought he had been wearing, Blue boots as a protectant for the pressure ulcer on his right heel and to prevent one from developing on the left foot. *Thought his heels should be, Floated while in bed on a pillow. -Agreed these interventions were not on his care plan. -Agreed his using the braces had remained on the care plan and should not have been. 45683 7. Observation on 11/2/21 at 10:13 a.m. of resident 25 revealed the bed had one siderail on the side of the bed nearest the wall in the up position. Interview on 11/4/2021 at 2:45 p.m. with licensed practical nurse (LPN) M revealed: *Resident 25 did have a siderail that he used for repositioning in bed and turning when he was being helped with personal cares. Review of resident 25's medical record revealed: *The quarterly MDS dated [DATE] was marked no for siderail use. *There was no mention of siderail use in the care plan initiated 3/1/21. Under the focus for self-care performance deficit, the intervention for bed mobility does not include the bed rail. *There was no documentation of a siderail assessment in the chart. Review of the provider's updated 11/8/18 Care Plan policy revealed: *Each discipline would update the care plan as changes occur between assessments and scheduled care conferences. Those disciplines included: -Social services. -Dietary. -MDS Coordinator. -Activities.

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Alcester Care and Rehab Center, Inc	101 Church Street Alcester, SD 57001

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26632 Based on interview, record review, and policy review, the provider failed to ensure professional standards of care had been followed for one of three sampled discharged residents (34). The resident had discharged against medical advice (AMA) and the provider's policy had not been followed. Findings include: 1. Closed record review of resident 34's closed record revealed: *On 9/13/21 at 1:10 p.m. a nurses progress note revealed: *Resident 34's daughter and his alternate power of attorney stated she was discharging him at that time. *Veterans administration medications were sent with at that time. Those medications included: -Metoprolol 45 tablets. -Potassium liquid-full bottle. -Tamsulosin 90 capsules. -Omeprazole 90 capsules. -Furosemide 45 tablets. -Amlodipine 30 - 1/2 tablets. -Quetiapine 30 - 1/2 tablets. -Vitamin D3 100 tablets. -Vitamin B12 100 tablets. -Trazadone 60 tablets. -Aspirin 81 milligram 120 tablets. -Magnesium oxide 120 tablets. *A copy of the medication administration record was sent with the daughter. *On 9/13/21 at 1:22 p.m. a social services progress note revealed: -Residents daughter and alternate POA [power of attorney] presented at facility unannounced and went into resident's room without any facility witness and spoke with resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-OT [occupational therapist name] then came into writer's office and said to me 'Resident's daughter is here and said to me she is trying to take him out of the facility and said to me she is taking home.' -I then went to speak with the daughter and the daughter told me she is taking him out of the facility and there is no court order that deems resident incompetent. -Resident then expressed verbally in front of myself, and DON [director of nursing], and administrator that he wishes to go home with daughter [name] after [daughters name] told him 'If you don't come home with me then you have to stay here forever so do you want to go home with me or stay here.' *At that point resident hesitated but then did ultimately say 'I want to go home.' There was no documentation in resident 34's medical record that included: *A Leaving Hospital Against Medical Advice form had been presented for the daughter or resident to sign. *His physician had not been notified prior to him leaving. His physician had been notified by facsimile after he had already left. *Of any attempt to have resident 34's daughter sign an AMA form. Interview on 11/3/21 at 2:00 p.m. with interim director of nursing B revealed: *Resident 34's daughter had not been provided with a Leaving Hospital Against Medical Advice form. *There was no record of which dose of medication had been sent with resident 34. *Agreed the AMA policy had not been followed. Review of the provider's 12/10/09 AMA Release policy revealed: *When a resident or the resident's legal representative expresses the desire to leave the nursing facility before the attending facility before the completion of treatment or contrary to the advice of the attending physician. *The procedure included: -Notify the attending physician. -Notify the administrator. -Notify the director of nursing service. *The physician is to give the resident or his/her legal representative information concerning the risks involved in leaving the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Documentation guidelines included: -Complete the Leaving the Hospital Against Medical Advice release form. -Present form to resident or legal representative regardless of whether it is believed the resident or legal representative will sign. The release form should be offered for signature in the presence of witnesses. -On the Leaving Hospital Against Medical Advice form, endeavor to obtain the resident's signature and/or the signature of the legal representative. -If the resident refuses to sign: --In the space provided for the resident's signature, write the words Resident refuses to sign. Beneath this line, sign your name and the exact time, date, and give a brief notation concerning the circumstances of the refusal. --Any person, preferably an employee of the facility, who was present when the release was offered and refused, may sign as a witness to the refusal. -In addition to completing the Leaving Hospital Against Medical Advice form, complete all other documentation per facility procedure.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure safety assessments had been completed and documented for: *Four of four sampled residents (2, 22, 25, and 27) who had side rails on their beds. *One of one sampled resident (4) who used a rock in place wheelchair. Findings include: 1. Observation on 11/3/21 at 10:42 a.m. of resident 2's room revealed she had bilateral half side rails on her bed. Review of resident 2's medical record revealed: *She had been admitted on [DATE]. *Her brief interview of mental status (BIMS) completed on 10/25/21 revealed she had severe cognitive impairment. *Her care plan for activities of daily living had initiated the use of bilateral half side rails for bed mobility on 8/6/20. *There had been no documentation of a side rail safety assessment being completed. *There had been no documentation of risk of use education versus benefit of use education being completed. 2. Observation and interview on 11/2/21 at 4:07 p.m. revealed resident 27 had bilateral half side rails. She was not able to tell me how she used them. Was very confused of what they were even for. Review of resident 27's medical record revealed: *She had been admitted on [DATE]. *Her BIMS completed on 10/12/21 revealed he had moderate cognitive impairment. *Her last revised care plan 02/24/21 revealed she used bilateral one-half siderails to encourage independence with turning and red-positioning in bed. *There had been no documentation of risk of use education versus benefit of use education being completed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview 11/3/21 with interim director of nursing B revealed she did have an assessment tool to use for siderails. She had not been using the assessment tool. 43844 3. Observation on 11/2/21 at 9:42 a.m. of resident 22's room revealed his bed frame had side rails attached to the upper half of his bed. *He had not been in his room. Review of resident 22's medical record revealed: *He had been admitted on [DATE]. *His brief interview of mental status completed on 9/13/21 revealed he had severe cognitive impairment. *His handwritten care plan included the use of one-half side rails for bed mobility. *There had been no documentation of a side rail safety assessment being completed. *There had been no documentation of education of the risk of use versus benefit of use being completed. Interview on 11//3/21 at 11:37 a.m. with interim DON/MDS coordinator B regarding side rail assessments revealed: *They had not documented completion of a safety assessment. *They had obtained physician orders. *She had a sample of a side rail safety assessment. -The medical director needed to review and approve the form. *They did not provide informed consent for side rail usage. *She stated they did provide a verbal risk of use education versus benefit of use education. -They did not document that this education had been provided. 45683 4. Observation on 11/2/21 at 10:13 a.m. of resident 25 revealed his bed had one siderail on the side of the bed nearest the wall in the up position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 11/4/2021 at 2:45 p.m. with licensed practical nurse (LPN) M revealed resident 25 did have a siderail that he used for repositioning in bed and turning when he was being helped with personal cares. Review of resident 25's medical record revealed: *The quarterly MDS dated [DATE] was marked no for siderail use. *There was no mention of siderail use in the care plan initiated 3/1/21. Under the focus for self-care performance deficit, the intervention for bed mobility does not include the bed rail. *There was no documentation of a siderail assessment in the chart. Surveyor: 26632 5. Observation on 11/3/21 at 10:30 a.m. of resident 4 revealed he used a rock in place wheelchair. He was able to transfer himself out of the chair onto the couch. Staff were required to assist him with transfers to other surfaces. Review of resident 4's medical record revealed: *He had been admitted on [DATE]. *His BIMS completed on 8/2/21 revealed he had severe cognitive impairment. *His last revised care plan on 8/2/21 had no documentation on the use of the rock in place wheelchair. *There had been no documentation of risk of use education versus benefit of use education being completed. Review of the provider's revised June 2019 Physical Restraint policy revealed: *Prior to physical restraint application (other than emergency), the Assistive Device Assessment will be completed in PointClickCare. *The assessment will be reviewed by the Interdisciplinary Team, Resident/Representative, and the physician. *There was no mention of the use of assistive devices, such as side rails or rock in place wheelchairs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on observation, interview, record review, and policy review the provider failed to ensure: *Medication destruction one of three sampled resident's closed record (32) had been completed by a registered nurse (RN) and a witness. *Controlled medication of lorazepam had not been double-locked in the medication refrigerator. *The controlled medication of lorazepam in the medication refrigerator was not included in the daily count. Findings include: 1. Closed record review of resident 32's record revealed: *He had died on [DATE]. *His remaining medications had been destroyed on [DATE]. -The medications had been destroyed by a registered nurse and no witness. Interview on [DATE] at 4:44 p.m. with administrator A and interim director of nursing (DON)/Minimum Data Set (MDS) coordinator B revealed: *The process for medication destruction would have been: -Non-narcotic medications were to have been destroyed by one RN and a witness. -Narcotic medications were to have been destroyed by two RN's or an RN and a pharmacist. Review of the provider's undated Medication Destruction Policy revealed: *E) Medication destruction occurs only in the presence of at least two licensed healthcare professionals. -5)Signature of 2 licensed witnesses (2 Registered witnesses in the case of Narcotics). Interview on [DATE] at 4:58 p.m. with administrator A and interim DON/MDS coordinator B regarding medication destruction revealed they were not aware the provider's policy required two nurses to witness and document the destruction of medications. 26632 2. Observation and interview on [DATE] at 9:25 a.m. with RN JJ revealed: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A small clear plastic box in the medication room refrigerator. *That box had a numbered tag on it. *The box contained two lorazepam 2 milligram per milliliter (mg/ml) injectable vials. *There was also a full bottle of lorazepam 2 mg/ml oral solution. *RN JJ stated those medications were not counted with the rest of the controlled medications on the medication carts. *She agreed those medications were not double locked. Interview on [DATE] at 9:45 a.m. with interim DON/MDS coordinator B confirmed the above findings. Review of the provider's revised [DATE] Medication Storage in the Facility policy revealed: *Controlled-substances that require refrigeration are stored within a locked box within the refrigerator. *This box must be attached to the inside of the refrigerator.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 06365 Based on interview, record review, and policy review, the facility failed to ensure one of one resident (33) received a new order for antipsychotic medication to treat aggressive behaviors resulting in harm to others. Findings include: 1. Review of progress notes for resident 33 in the closed electronic medical record (EMR) revealed a pattern of increasingly aggressive behaviors: *On 9/16/21, resident is resistive with repositioning/transfers and yells out at that time. *On 9/24/21, continues to resist and yells out with transfers and repositioning. *On 9/26/21, the resident was seen kicking and swinging at another resident. *On 9/27/21, hitting at staff with clinched fists when turning resident in bed. Question if resident is in pain .or behavioral as resident is noted at times to get self up without concerns. *Between 9/29/21 and 10/2/21, resistance and yelling out during transferring and repositioning. *On 10/4/21, struck a certified nursing assistant (CNA) in the face while assisting the resident. *On 10/6/21, Physically abusive to staff with transferring as resident did hit staff multiple times today. *On 10/7/21, Pleasant except for transfers and repositioning as resident will resist and yell at staff. *On 10/10/21, resident hit two CNAs in the face or side of the head with closed fists and grabbed their hair, yelling profanity at them, while assisting him to bed. *On 10/11/21: -At 5:56 p.m., four staff assisted with toileting and perineal care due to yelling, screaming, and resistance. -At 7:46 p.m., the resident was heard yelling and found swinging a closed fist at another resident. -At 11:55 p.m., very combative with staff hitting and punching staff when they offer or attempt to assist resident. The resident told staff to leave him alone. *On 10/12/21: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-At 3:25 a.m., combative and yelling as two staff assisted with incontinence care and getting him into bed. -At 5:26 a.m., two staff held the resident's arms while a third cleaned him, and he attempted to hit staff and bite the arms. *On 10/14/21, CNA's report resident continues to yell out with transfers and toileting. MA (medication aide) reports she did not even touch him and he started yelling out. *On 10/17/21, the resident swung at another resident but was not close enough to hit the resident. *On 10/19/21: -At 9:53 a.m., the bath aide reported the resident swung out at her and punch [sic] her in her face. The resident also told another resident to move/get out of the way in a mean way. -At 10:16 a.m., CNA reported the resident punched her in the stomach during a transfer .he would not stay sitting up in bed and resistive with transfer. -At 7:28 p.m., the resident's chair alarm was sounding and was found in his bathroom by CNA and nurse standing on the foot pedals of his wheelchair by the toilet. He became physically aggressive swinging closed fists . The nurse was hit in the side of head to knock glasses off to floor. *On 10/21/21: -At 8:36 a.m., resident was yelling out and screaming when assisted by staff. -At 11:29 a.m., CNA reported to nurse about 9:15 a.m. that the resident kicked (another resident) in the right shin and attempted to punch the resident. Further review of the EMR revealed an antipsychotic medication was ordered but not started for seven days: *On 10/13/21, an order note documented a new order for an antipsychotic medication related to agitation. *On 10/13/21, the order summary report included monitor & document mood/behaviors/agitation .every day and night shift for monitoring for 14 days. *On 10/21/21, a physician communication note documented: -The physician responded to the fax sent yesterday re: Residents [sic] behaviors with an order to increase the dose of the antipsychotic medication. -The increase dose order was faxed to (facility) pharmacy. -The pharmacy called and said they never filled any (antipsychotic medication) for him yet. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-The nurse looked back and discovered the medication was never rec'd (received) and never started. -The physician was notified and he re-ordered the original dose of the antipsychotic medication. A behavioral expression note on 10/21/21 summarized actions taken in response to his behaviors: -Administration (admininstrator, assistant DON, and social services designee) informed of the (behavior pattern). -The antipsychotic medication was started in the morning. -The resident's respresentative and physician were informed of the resident's behavior patterns. -Orders received to transfer to (emergency room) for evaluation due to increased behaviors and aggression. Review of the medication administration record confirmed the antipsychotic medication was documented as given at 8:00 a.m. on 10/21/21. Interview on 11/04/21 at 12:00 p.m. with interim DON/MDS coordinator B revealed: *The pharmacy receives and processes orders every day. *It is very rare that a pending order would pass onto the next shift. *After this medication delay, she and the nurses got together and decided the nurses would monitor the pending order report and follow-up if the order was not processed the same day. *She said it was unknown if the resident's behaviors would have been better if he had been started on it sooner. *The resident had the same medication in the hospital before he transferred to the facility, but the order did not carry over to his admission orders at this facility. Review of the policy for processing medication orders at the pharmacy revealed: *New orders will be received and processed daily until the close of business and processed for normal delivery. *Any orders after normal business hours will be processed as STAT order for immediate delivery.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 06365 Based on interview and employee list review, the facility failed to designate a dietary manager to meet the requirements for certification no later than 5 years after November 28, 2016. Findings include: 1. Interview on 11/1/21 at 4:50 p.m. with dietary manager HH revealed she had: *Been the manager for years. *Not started dietary manager (DM) certification course. *Not decided yet if she wants to. Interview on 11/3/21 at 2:20 p.m. with DM HH confirmed she had been employed as the DM since before September 2016, and she had not started the certification course. Review of an employee list provided by the facility revealed the DM HH's hire date was 2/1/15. Interview with administrator A on 11/4/21 at 12:04 p.m. confirmed DM HH had not been enrolled in the DM certification course.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 06365 Based on observation and interview, the facility failed to ensure food safety during two of two meal services observed. Findings include: 1. Observation on 11/1/21 at 5:00 p.m. revealed unsafe serving and distribution of food: *Cook II moved between touching food items and non-food items using her gloved hands without hand hygiene and changing gloves throughout the meal service, including: -Shuffling through the residents' diet cards with both hands as she prepared to dish up the next group of residents' dishes. -Touching plates and serving utensils with her left hand and the handles of the delivery carts with her right hand to reposition them closer to her. -Picking up buttered bread slices with her right hand to place them on plates. -Using her right thumb to position the green beans that she scooped onto the plates with her left hand. -Getting the tip of her right forefinger into the applesauce in a small bowl as she picked it up to put it on the delivery cart. *After a resident requested a hamburger instead of the main entree, cook II: -Used the same gloved right hand to reach into the plastic bag with hamburger buns and removed one bun out of the bag. -Took off the top half of the bun with her left hand and laid it on the stainless steel counter opposite the stove top where the hamburgers were being kept warm. -While holding the bottom half of the bun in her right gloved hand, she used her left hand to scoop a hamburger from the pan onto the bun. -While holding the bottom bun and hamburger in her right hand, she used her left hand to pick up the top of the bun and move it towards the corner of the same stainless steel counter onto the top of papers in an open red binder. -Set the bottom bun and hamburger on a plate then used both gloved hands to squeeze ketchup onto the hamburger. -Used her right hand to place the top bun onto the completed hamburger. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*A plate of food dished up for a resident was incorrectly placed in front of another resident: -Dietary aide (DA) E served a plate of food from the delivery cart to resident 6. -Resident 6 repositioned herself up to the table and faced the plate while DA E walked away from the table toward the kitchen. -Before DA E got to the kitchen, cook II told her that plate was for resident 9. -DA E immediately turned around, walked back to the table, and removed the plate from in front of resident 6. -She then delivered the same plate of food to the resident 9. Observation on 11/2/21 at 11:07 a.m. revealed dietary aide F distributed beverages in an unsanitarty manner: -She touched various unclean surfaces, such as beverage containers and delivery cart handles. -She touched the rims (drinking surface) of glasses and cups when she placed them on the delivery cart in the kitchen and then placed them onto the table in front of the residents. -She did not practice hand hygiene between touching the unclean surfaces and the rims of the glasses and cups. Inteview on 11/3/21 at 2:20 p.m. with dietary manager HH revealed the above were unsafe food practices, and she had provided education to staff about hand hygiene and glove use.

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	435062	A. Building B. Wing	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcester Care and Rehab Center, Inc	101 Church Street Alcester, SD 57001

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 43844 Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices were completed for one of one observation of whirlpool tub cleaning by certified nursing assistant (CNA) (Z) had been completed correctly. 1. Observation, interview, and product directions review, 11/2/21 at 8:38 a.m. with CNA Z revealed she: *Rinsed the whirlpool tub with clean water and then began cleaning the tub. -Filled the whirlpool approximately half full of fresh water. -Had a gallon of Classic disinfectant. -Poured a capful of disinfectant into the tub. -Stated, A capful is about 2 ounces. --Thought this is the amount needed. -Turned the jets on in the tub. *Upon review of directions from the gallon of disinfectant, she agreed the directions stated to add two ounces of disinfectant per gallon of fresh water. Interview on 11/4/21 at 8:44 a.m. with maintenance director AA revealed the whirlpool tub contained approximately 60 gallons of water when full. Interview on 11/4/21 at 8:46 a.m. with CNA Z revealed she thought she had filled approximately 1/2 full when she added the disinfectant to it. Interview on 11/2/21 at 10:36 a.m. with licensed practical nurse M regarding the training of bath aide revealed she: *Had thought they were cleaning it correctly. *Had been doing random disinfecting audits. -Had not provided education to CNA Z on the appropriate way to disinfenct the whirlpool. *Thought the regular bath aide would have known how to correctly do the disinfecting. -The regular bath aide was not working for one month. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of manufacturer's directions for use of Classic disinfectant revealed 2 ounces of the disinfectant should have been added to each gallon of water. Review of provider's Revised October 2010 Whirlpool and Shower Cleaning/Disinfecting policy revealed: *Policy Statement: Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC [Centers for Disease Control] recommendations for disinfection and the OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens Standard. Properly cleaning a whirlpool tub is necessary to prevent growth of microorganisms and prevent cross-contamination from one resident to another. -For internal piping and pump disinfecting: Fill whirlpool to top of water inlet, add 10 oz [ounces] whirlpool disinfectant, circulate pump for one minute and let set for 10 minutes.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. 43844 Based on interview and policy review the provider failed to notify residents, their representatives, or families when the facility was in a COVID-19 outbreak. Findings include: 1. Interview on 11/2/21 at 3:25 p.m. with administrator A revealed: *A contracted speech therapist had tested positive for COVID-19 on 10/27/21. -Three residents had been exposed to this therapist and notified of same. --No other residents, their representatives or families had been notified of the outbreak status of the facility. *A dietary employee had tested positive for COVID-19 on 11/1/21. --No residents, their representatives, or families had been notified of this update in outbreak status of the facility. *She stated no notification was sent because the current positive cases did not provide direct patient care. *Administrator A provided, to the survey team, an undated letter notifying families that an employee had tested positive for COVID-19 on 10/31/21. Interview on 11/02/21 at 4:38 p.m. with administrator A revealed: *No staff had exposure to the speech therapist who had tested positive on 10/27/21. *Two staff members had been exposed to the dietary employee who had tested positive for COVID-19 on 10/31/21 -These two staff members were tested for COVID-19 on 11/1/21. *She would be sending the undated letter to families notifying them of an employee testing positive for COVID-19 on 10/31/21. -She sent this letter after speaking with this surveyor on 11/2/21 at 3:25 p.m. Review of Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality/Quality, Safety & Oversight Group QSO-20-29-NH memo of May 6, 2020 <https://www.cms.gov/files/document/qso-20-29-nh.pdf> regarding notification of confirmed or suspected COVID-19 cases among resident and staff in nursing homes revealed: (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The facility must inform residents, their representatives, and families of those residing in facilities by 5:00 p. m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19. 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 revealed: *Healthcare personal (HCP), residents and families were to be notified of an outbreak in the facility. *An outbreak consisted of: -One resident or HCP.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Perform COVID19 testing on residents and staff. 43844 Based on interview, record review, and policy review the provider failedto test all unvaccinated staff per their county positivity rate to detect COVID-19 in staff members. 1. Interview on 11/2/21 at 10:38 a.m. with administrator A regarding COVID-19 testing for non-vaccinated employees revealed she: *Stated testing was based upon county positivity rate. -The county positivity rate was above 10% from 8/8/21 through 10/31/21. *Had scheduled testing two times per week since 8/8/21, typically on Wednesday and Fridays. -Stated when staff was not able to test at the scheduled time, We try to catch them, probably miss occasionally. *Stated the social services designee, director of nursing, and all nurses knew how to test staff for COVID-19. *Stated staff who refuse testing would be required to wear an N95 mask while at work. *Thought there had been additional testing done that had not been placed in their documented testing binder. Interview on 11/3/21 at 1:03 p.m. with administrator A revealed she: *Had not been able to find additional test results. -Thought they had been done at the nurses station. Review of provider's employee vaccinated listing revealed there had been 19 of 51 employee's (C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, and U) who had not been vaccinated. Review of the provider's COVID-19 documented testing for staff from 10/1/21 through 10/31/21 revealed: *Testing had been completed on the following dates. -10/1/21 for one unvaccinated staff person (U). -10/7/21 for two unvaccinated staff persons (C and F). -10/9/21 for one unvaccinated staff person (F). -10/12/21 for one unvaccinated staff person (F). (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10/15/21 for two unvaccinated staff persons (N and U). -10/20/21 for three unvaccinated staff persons (C, R, and U) and one vaccinated employee (V). -10/27/21 for two unvaccinated staff persons (F and R) and 3 staff persons of unknown vaccination status, (V, W, and X). -10/29/21 for one unvaccinated staff person (J) and one staff person of unknown vaccination status (X). -10/31/21 for one unvaccinated staff person of unknown vaccination status (X). -11/1/21 for one unvaccinated staff person (F) and one staff person of unknown vaccination status (Y). *Review of provider's Staff/Resident Testing During COVID-19 Pandemic policy revealed: -Policy: ACRC [Alcester Care and Rehab Center] policy on staff testing for COVID-19 to prevent spread of infection into facility. -Purpose: Appropriately implement safe infection control procedures. a. Administrator will document county positivity rate every week. i. If positivity rate is 5-10% the facility will test unvaccinated staff once a week. ii. If the positivity rate is above 10%, the facility will test unvaccinated staff 2x [times] a week. iii. If the positive rate returns to a lower rate, the facility must remain resting [testing] at the same frequency for 2 weeks. 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 revealed: *Unvaccinated staff were to be tested based off county level positivity rates. *Healthcare personal (HCP), residents and families were to be notified of an outbreak in the facility. *An outbreak consisted of: -One resident or HCP *A person should be designated as the infection control person to oversee the COVID-19 effort and management of infection control program.