STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435029	A. Building B. Wing	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Rosebud Country Care Center	126 S Logan Ave Gregory, SD 57533

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45095 Based on observation, interview, record review, and policy review, the provider failed to implement Pull-Tab alarm assessments, reassessments of those alarm devices, update resident care plans to reflect the current use of those alarms, and notify the resident's family when the Pull-Tab Alarms were implemented for three of three sampled residents (10, 15, and 20). Findings include: 1. Observation and interview on 10/24/23 at 10:41 a.m. with resident 10 revealed: *He was lying in bed watching television. *A Pull-Tab alarm was attached to the bed and a garment clip was attached to his shirt. *He had a wheelchair and a walker in the corner of his room. *His feet were elevated, and he had heel protectors on both feet. *He stated that he had gone to the hospital after a fall for a broken hip, he had done some therapy afterwards and he had sores on his heels that were healing. Observation on 10/24/23 at 11:46 a.m. of resident 10 in the dining room during the lunch meal revealed: *The resident was sitting in a wheelchair at the dining room table eating lunch. *A Pull-Tab alarm was attached to the back of his wheelchair with a garment clip attached to the back of his shirt. Observation on 10/26/23 at 12:51 p.m. of resident 10 propelling his wheelchair back to his room from the dining room revealed: *He had a Pull-Tab alarm attached to the back of his wheelchair with a garment clip attached to the back of his shirt. Review of resident 10's medical record revealed: (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He was admitted on [DATE]. *Diagnoses included dementia and physical deconditioning. *He had a Brief Interview for Mental Status (BIMS) score of seven indicating severe impaired cognition. *He had a history of falls. *He had a fall with an injury on November 2022 that was listed on the provider's Matrix. *A 10/21/22 02:25 a.m. nurse note stated: Resident continues to be weak and unsteady with treatment for hyponatremia, has had a recent fall, resident found transferring and ambulating independently but due to unsteady gait, tab alarm has been placed for resident safety as he is not using call light for assist. *A 4/14/23 physician signed and dated facsimile (fax) requesting an order for a Pull-Tab alarm. *A 9/15/23 fall risk assessment revealed he was at high risk for falls and listed a Pull-Tab alarm as a fall prevention intervention. *No documentation was found regarding family or the resident's representative had been notified that the Pull-Tab alarm had been implemented. *A review of the care plan revealed there was no documentation of the Pull-Tab alarm documented on the care plan. Interview on 10/26/23 at 10:37 a.m. with the Minimum Data Set (MDS) Coordinator C regarding Pull-Tab alarms revealed: *The process to initiate a Pull-Tab alarm would have been completed due to falls and the fall risk assessment. *Pull-Tab alarms were often implemented by the nurses and at night. *The family member or representative had to have been notified when those Pull-Tab alarms were placed on the residents. *She was unable to locate any documentation in the resident's medical record that his family was notified about the placement of a Pull-Tab alarm. *She was unable to confirm that she had added the Pull-Tab alarm to the resident care plan. *The fall risk assessment dated [DATE], had the Pull-Tab alarm listed as an intervention but they had no Pull-Tab alarm-specific assessments that were completed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*There was no process to reassess the effectiveness of Pull-Tab alarms once they were implemented, they had no process in place to reassess if the Pull-Tab alarm was effective or ineffective for the resident. Interview on 10/26/23 at 11:57 a.m. with registered nurse (RN) D regarding Pull-Tab alarms revealed: *The nurse placed Pull-Tab alarms on residents when the nurse felt the resident was at high risk for falls and was unsafe. *She was unsure if a physician's order for the Pull-Tab alarms were needed but the physician was usually notified by a fax to let them know about the Pull-Tab alarms. *Generally, the family was notified by a phone call to let them know a Pull-Tab alarm was placed, which should have been documented in the residents medical record. *There was a section in the medical record to document when the family member or their representatives were notified, and documentation of those phone calls were probably missed. *Maybe it was not the policy to call, but she would have called them, so they were aware. *They would let the MDS nurse know in the report and may have written it in the care plan books when a Pull-Tab alarm was placed on a resident. *She was not sure if a re-evaluation was needed or if it had been completed to continue the use of a Pull-Tab alarm. *Once the Pull-Tab alarm was placed, they stayed. *She had not been in a situation when once the Pull-Tab alarm was placed it had ever been removed. *She believed that the Pull-Tab alarms resulted in fewer falls for residents. *She stated when she heard a Pull-Tab alarm go off, she was up and on the move. Interview on 10/26/23 at 1:02 p.m. certified nursing assistant (CNA) F regarding Pull-Tab alarms revealed: *CNAs notified the nurses if they felt a resident needed a Pull-Tab alarm, if they were at risk of falling, or if there was a safety concern. *The nurse might explain to the CNA to place the alarm, but the alarm would not have been placed unless the nurse directed it to have been placed. *Most of the residents that had Pull-Tab alarms would not have been able to have been asked for their permission as they were confused. *The nurse called the family to let them know the Pull-Tab alarm had been put on. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*They were told at the stand-up meetings when a new Pull-Tab alarm was placed for a resident. *She was not aware when a Pull-Tab alarm had been re-evaluated, once a resident had a Pull-Tab alarm, they continued with it. Interview on 10/26/23 at 1:21 p.m. with director of patient care B regarding Pull-Tab alarms revealed: *There was no resident or resident representative signature for the informed consent with the placement of Pull-Tab alarms for residents. *She knew the Pull-Tab alarms could have been a mental restraint, but the policy was old-school thinking and had not addressed those Pull-Tab alarms as a resident restraint. *Pull-Tab alarms were placed mostly at night because residents were restless, had dementia, and had gotten their days and nights mixed up, or because residents had a lot of falls, despite providing other interventions such as distractions, having residents in a common area, and activities. *They had no Pull-Tab alarm policy, but the [NAME] Hospital had one she would get for the surveyor's request for a Pull-Tab alarm policy. *They had no Pull-Tab alarm assessments, and had not performed any formal assessments for those alarms. *Her expectation was the use of an alternate method should have been attempted and documented prior to the placement of a Pull-Tab alarm. *She expected family and physicians to have been notified when a Pull-Tab alarm was placed, and that should have been documented in the resident's medical record. *She expected that Pull-Tab alarms would have been reassessed for continued use with the completion of the MDS, documented on the care plan, and reviewed with the family at the care plan meetings. 45683 2. Observation and interview on 10/24/23 at 3:03 p.m. with resident 15 in her room revealed: *She was seated in her wheelchair. *She enjoyed living at the facility. *She was not sure how long she had lived there. *Her family came to visit when they could. *She had a Pull-Tab alarm attached to the back of her wheelchair and one placed on her bed. *Her plan was to return home. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 15's medical record revealed: *She was admitted on [DATE] and her diagnoses included the following: -Vascular dementia with behavioral disturbance. -Paranoid type delusional disorder. -Major neurocognitive disorder. *Her BIMS score was 4 which indicated severe cognitive impairment. *She had a history of falls. *Her care plan goal was to have no injuries from falls. *Her discharge goal was to remain at the facility long-term. *The care plan documented Tab alarm to bed and wheelchair. *No documentation was found regarding family or family representative notification that those alarms were implemented. 3. Observation and interview on 10/25/23 at 9:43 a.m. with resident 20 in her room revealed she: *Was seated in her wheelchair. *Really enjoyed living here. *Thought she had lived there for a few months. *Had a Pull-Tab alarm attached to the back of her wheelchair. *Was not sure what the alarm was used for. Review of resident 20's medical record revealed: *She was admitted on [DATE] and her diagnoses included: -Alzheimer's. -Dementia without behaviors. -Anemia. -Depression. *Her BIMS score was 3 which indicated severe cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had fallen on 8/22/23 and again on 9/17/23. *She had a Fall Risk Assessment completed on 8/16/23 with a score of 4 indicating she was a high fall risk. *Her care plan goal was to have no injuries from falls. *No documentation was found regarding family or family representative notification that the bed/chair Pull-Tab alarm had been implemented. Review of the [Name of the provider] 3/2022 Patient Restraints policy revealed: * B. Alternatives to Restraints: Alternatives to restraints should be considered before restraint application. Some examples are: Frequent verbal instruction, bed alarm implementation, frequent observation, diversional activity, call light use re-explained, patient moved closer to the nurse's station, family at bedside, patient placed on fall risk precautions, sitter, reality orientation, mobility monitor implementation, one to one staffing, and rooms with video monitoring.