

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER The Neighborhoods at Brookview		STREET ADDRESS, CITY, STATE, ZIP CODE 2421 Yorkshire Dr Brookings, SD 57006	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>45683</p> <p>Based on observation, interview, and call light log report review, the provider failed to ensure call lights were answered promptly for one of two sampled residents (29) who used the call light to alert staff of assistance needs. Findings include:</p> <ol style="list-style-type: none"> 1. Observation and interview on 5/29/24 at 3:55 p.m. with resident 29 revealed: <ul style="list-style-type: none"> *She stated she had waited for over an hour on a few occasions in the last few months for staff to respond to her call light. 2. Interview on 5/30/24 at 3:35 p.m. with administrator A regarding call light times revealed: <ul style="list-style-type: none"> *They had budgeted to replace the call light system next year. *It took more deliberate review to utilize the information because of the age of the system. *He was not sure if they could determine staff response times for individual room call lights. 3. Interview on 5/31/24 at 8:32 a.m. with director of nursing B regarding call light times revealed: <ul style="list-style-type: none"> *The goal was for staff to have answered call lights within an average of five minutes. *She had printed off the requested rooms call light times. *It would have been very labor-intensive to review call light response times by individual rooms. 4. Review of resident 29's call light report from 3/1/24 to 5/30/24 revealed: <ul style="list-style-type: none"> *There were 82 times when over 20 minutes had passed until the staff responded to her call light. *The longest call light response wait time was one hour and 21 minutes. 5. Interview on 5/31/24 at 1:12 p.m. with certified nursing assistant H regarding call lights revealed: <p>(continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*He had a walkie-talkie that notified him when a call light was activated.</p> <p>*He would also get notified when a call light was answered.</p> <p>*The goal was to answer all call lights within five minutes.</p> <p>6. Interview on 5/31/24 at 2:33 p.m. with nursing supervisor I regarding call light times revealed:</p> <p>*The goal was to average less than five minutes for call lights to be answered by staff.</p> <p>*They reviewed call light times during monthly quality assurance meetings.</p> <p>*If they noticed an issue, they would have reviewed call light response times more closely.</p> <p>47416</p> <p>7. Interview on 5/31/24 at 3:18 p.m. with the DON B regarding the quality assurance and performance improvement (QAPI) program and call light response times revealed:</p> <p>*The QAPI committee met monthly.</p> <p>*The medical director attended quarterly.</p> <p>*They had a performance improvement plan (PIP) in place for call light times.</p> <p>*Call light reports were emailed to administration weekly for review.</p> <p>*The goal was for staff to answer a resident's call light within 5 minutes.</p> <p>*The report can be compiled by resident room but must be counted manually for an average time to be calculated.</p> <p>*They have had problems with the current call light system, but it was to be updated soon.</p> <p>A call light policy was requested on 5/31/24 DON B stated they did not have a call light policy.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45683</p> <p>Based on observation, interview, expiration date cheat sheet review, and policy review, the provider failed to properly label and store:</p> <p>*Juice cartons in two of six kitchenette refrigerators.</p> <p>*Food items in one of one main kitchen walk-in cooler.</p> <p>Findings include:</p> <p>1. Observation and interview on [DATE] at 9:14 a.m. with nutrition and food service worker E in the Ash Boulevard neighborhood kitchenette revealed:</p> <p>*A side-by-side refrigerator with several fruit juice cartons on the top two shelves.</p> <p>*A grape juice carton in the refrigerator was dated [DATE] and [DATE].</p> <p>*Food service worker E explained the first date was when the carton was opened.</p> <p>-The second date on the carton is considered the expiration date once it was opened.</p> <p>-Sometimes the juice is still good after one week.</p> <p>-She would taste the juice to ensure it was still good before serving it if it was after the expiration date.</p> <p>-She agreed the grape juice was expired.</p> <p>2. Interview on [DATE] at 9:52 a.m. with food service worker F revealed:</p> <p>*When they open any food or beverage product, they write the date on it so they know when it was opened.</p> <p>*They count out seven days and write that date on it and that is the expiration date.</p> <p>3. Observation and interview on [DATE] at 10:38 a.m. with nutrition and food service worker G in the Birch Way neighborhood kitchenette revealed:</p> <p>*A side-by-side refrigerator with several fruit juice cartons on the top two shelves.</p> <p>*A grape juice carton in the refrigerator was dated [DATE] and [DATE].</p> <p>*An apple juice carton in the refrigerator was dated [DATE] and [DATE].</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*She stated they label resident food and drink items when they are opened.</p> <p>-They put a second date on the package dated a week later that would be considered the expiration date.</p> <p>-Items would be discarded after the expiration date.</p> <p>*She agreed the cartons of grape juice and apple juice had expired and should have been thrown away.</p> <p>4. Observation on [DATE] at 2:02 p.m. in the walk-in cooler in the main kitchen revealed:</p> <p>*An open package of smoked [NAME] cheese wrapped in plastic cling wrap dated ,d+[DATE] and ,d+[DATE].</p> <p>*A package of bacon bits wrapped in plastic cling wrap dated ,d+[DATE] and ,d+[DATE].</p> <p>*Three unopened gallons of vitamin D milk with a best by date of [DATE].</p> <p>5. Interview on [DATE] at 1:41 p.m. with nutrition and food supervisor D in the main kitchen revealed:</p> <p>*They had an expiration date cheat sheet to follow for the expiration dates for food and beverage items once opened.</p> <p>*The cheat sheet was not all-inclusive.</p> <p>*She thought the smoked [NAME] cheese was categorized with parmesan cheese and expired 30 days after it was opened.</p> <p>*She stated the three gallons of milk had another seven days past the best by date according to the label.</p> <p>-She went into the main kitchen walk-in cooler.</p> <p>-Looked at a gallon of milk label.</p> <p>-There was nothing on the label that indicated milk was good for seven days past the best by date.</p> <p>*She would have expected staff to have labeled food items when opened and to have followed the expiration dates on the cheat sheet.</p> <p>*She agreed staff should not have been tasting juice to ensure quality if it had been open more than seven days.</p> <p>*She stated the juice cartons and bacon bits were past their expiration date and should have been discarded.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. Review of the provider's [DATE] Expiration Date Cheat sheet revealed:</p> <p>*Milk-2%, Whole date on package, up to 7 days past date on package.</p> <p>*Cheese-Parmesan date on package, 30 days once opened.</p> <p>*If not listed 7 days.</p> <p>7. Review of the provider's [DATE] Sanitation in Food Handling policy revealed:*Storage of perishable items .</p> <p>7. Opened packages of commercially packaged foods are bagged, dated and immediately frozen and stored in the Main Kitchen Freezer. Staff can then pull individual packages as needed and date them 5 days from the date they pulled them to expiration.*D. Expired/Outdated Product</p> <p>Any product expired or outdated will be removed from shelf/refrigeration/etc. and properly disposed of.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>32332</p> <p>A. Based on observation, interview, and policy review, the provider failed to ensure appropriate glove use and hand hygiene had been performed during one of two residents (44) observed catheter care and personal care by certified nursing assistant (CNA) J.</p> <p>Findings include:</p> <p>1. Observation and interview on 5/30/24 at 8:35 AM of catheter care for resident 44 by CNA J revealed:</p> <p>* CNA J had a gown and gloves on when the surveyor entered resident 44's room.</p> <p>*With those gloved hands she:</p> <p>-Held a pen, moved the call light, and bedding, and touched the sink faucets.</p> <p>-Prepared for catheter care by opening a wet wipe packet, removing wipes, and cleansing the resident's perineal area, including the the area around the catheter entrance with no-rinse soap and water.</p> <p>-Stated she cleansed around the catheter with no-rinse soap and water, and cleansed only at the entrance of the catheter tubing.</p> <p>-Removed the resident's brief and cleansed her buttocks and rectum with wet wipes.</p> <p>*With those same gloved hands she walked to the bathroom, opened and closed a cabinet two times, and removed a clean brief and skin cream from the cabinet.</p> <p>-Applied the skin cream on the resident's buttocks, removed the glove from her right hand, and put a clean glove on the right hand, and without washing her hand she put a clean glove on her right hand.</p> <p>-She did not remove the soiled glove from her left hand.</p> <p>--She then put lotion on her legs, and removed both gloves.</p> <p>2. Interview on 5/31/24 at 3:30 p.m. with director of nursing (DON) B regarding the observed glove use and lack of hand hygiene revealed CNA J should have washed her hands or used hand sanitizer before she had put gloves on, and after she had removed gloves.</p> <p>3. Review of the provider's October 2013 Infection control program policy regarding hand hygiene revealed:</p> <p>*Hand hygiene:</p> <p>-Was the single most important method of preventing the spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Removes dirt, organic and inorganic materials, and transient microorganisms.</p> <p>-During patient care was necessary to remove microcontamination from recent contact with infected, colonized patients or environmental sources.</p> <p>*The use of gloves was not a substitute for hand hygiene.</p> <p>*Care givers should perform hand hygiene:</p> <p>-Before and after contact with the patient or environment.</p> <p>-After contact with a source of microorganisms.</p> <p>-After removing gloves, masks, or other protective gear.</p> <p>*Alcohol-based hand sanitizer should have been used in conjunction with soap and water and not the sole source of hand hygiene.</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure residents' clean laundry had been covered when delivered to resident's rooms by one of one CNA (J) observed during laundry pass.</p> <p>Findings include:</p> <p>1. Observation and interview on 5/31/24 at 9:30 a.m. with CNA J while walking down Elm hall with a laundry cart revealed:</p> <p>*The cart had a place to hang clothing on hangers.</p> <p>*The cart was not covered and left the laundry at risk of contamination.</p> <p>*CNA J stated she had worked for the provider for over two years and had never heard anyone state the laundry was to have been covered while it was in the hallway.</p> <p>2. Interview on 5/31/24 at 3:00 p.m. with CNA K regarding covering the residents' laundry while delivering the laundry sometimes the CNAs cover it, and sometimes they had not covered it.</p> <p>3. Interview on 5/31/24 at 3:30 p.m. with the DON B regarding delivering resident laundry revealed she did not know the laundry had been delivered uncovered. The laundry should have been covered.</p> <p>4. Review of the provider's revised March 2024 Infection Control Practices policy revealed:*Staff could use a clean cart to deliver laundry and would leave the cart outside of the room to ensure appropriate hand hygiene.</p> <p>*If the carts were not used staff will carry laundry away from their uniforms so it did not contaminate the clean laundry.</p> <p>*Staff would cover laundry during deliveries.</p>		