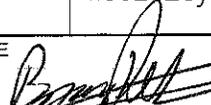


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2013
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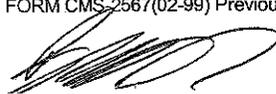
NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST PO BOX 479 LEMMON, SD 57638
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F 000	INITIAL COMMENTS Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/10/13 through 6/12/13. Five Counties Nursing Home was found not in compliance with the following requirements: F170, F252, F281, F363, F371, F431, and F441.	F 000	Addendums noted with an asterisk per 8/1/13 telephone to facility Emergency Permit Holder. CKV/SDDOH/JJ	
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on interview, the provider failed to deliver mail on Saturday to all residents. Findings include: 1. Group interview at 10:00 a.m. on 6/11/13 with 6 of 10 active participants revealed they had not received mail on Saturdays. They stated they had not received mail on a Saturday for a very long time. Interview at 3:00 p.m. on that same day with the director of social services (DSS) and administrator revealed they were not aware the mail was not received on Saturdays. The DSS stated she would call and check with the postal service. Continued interview at 3:45 p.m. on that same day revealed the DSS had contacted the	F 170	The activity staff will deliver mail to each resident on Saturdays. The local postmaster confirmed that they will resume delivery of the mail on Saturdays to the nurse's station. The activity staff will then deliver mail to each resident on Saturday. An ongoing checklist will be implemented for activity staff to record when the mail is being delivered on Saturday and will sign again when activity when activity staff delivers	7/6/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Board Chair	(X6) DATE 7/9/13
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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.

 7/26/13

JUL 29 2013 JUL 15 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 06/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2013
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<p>F 170</p> <p>F 252 SS=E</p>	<p>Continued From page 1</p> <p>postal service and was told the Saturday mail delivery had been canceled last Fall. Neither the DSS or administrator were aware the mail service had been canceled.</p> <p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to ensure the residents had an independent choice to use and enjoy the outdoor patio. Findings include:</p> <p>1. Observation at 10:15 am. on 6/11/13 revealed the outdoor furniture that was noted to have been in place on the patio on the previous survey was gone. Group interview at that same time with approximately half of the active participants revealed the current administrator had sold the furniture and there was no place to sit. Two random residents stated they had asked to go outside to the patio on nice days and were told "no". They stated they saw other residents go outside and it seemed to be a "double standard".</p> <p>Surveyor: 26632</p> <p>2. Interview on 6/11/13 at 3:00 p.m. with activity assistant H revealed:</p>	<p>F 170</p> <p>F 252</p>	<p>the mail to the residents. The audits will be completed weekly reported at QA quarterly monthly for the 1st 3 months and then quarterly by Act. Coordin.</p> <p>New furniture was purchased and in place on the deck on 6/14/13. Policy adapted to reflect that residents will be allowed to be out on the deck with reasonable expectations by staff and or residents. Activities/Social Services will monitor resident satisfaction monthly and report to Quality Assurance. quarterly.</p> <p>See above.</p>	<p>checklist and</p> <p>by BP 9/11/13 7/26/13</p> <p>6/14/13</p> <p>BP 6/12/13</p>
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F 252	Continued From page 2 *Residents like to be out on the deck when it was nice outside. *Residents could not be on the deck without supervision. *If a staff member was not able to be on the deck with a resident, the resident could not be on the deck alone. Surveyor: 28057 3. Interview on 6/12/13 at 9:30 a.m. with the administrator confirmed the patio furniture had been disposed of as it had no longer been safe for resident use. The plan had been to replace the old furniture with new furniture that would be safer for resident use. She believed at the earliest it would be the end of June of this year before new furniture would be purchased.	F 252	See above. Furniture purchased 6/14/13.	6/14/13 <i>BP</i> <i>7/24/13</i>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure one of three observed nurses administered an accurate amount of liquid potassium to one of two residents who received the medication. Findings include: 1. Observation on 6/11/13 at 7:25 a.m. revealed registered nurse (RN) D had used a graduated medication cup to measure 22.5 milliliters (ml) of	F 281	In-service completed on 7/2 and makeup completed on 7/3 for training on accuracy of Medication Administration. Weekly audits will be		

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

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F 281	Continued From page 3 liquid potassium to equal 30 millequivalants of potassium chloride for resident 1 as ordered and indicated on the June 2013 medication administration record. That medication cup had specified line markers for 20 ml and 25 ml of fluid. It had not contained a line marker for 22.5 mls of fluid. When she had poured the potassium into the medication cup she had filled the cup to a point between the 20 ml and the 25 ml markers. Interview at that same time with RN D confirmed the above observation to have been accurate when she had measured the potassium. She stated she would have had to use a syringe to measure it. Interview on 6/12/13 at 11:25 a.m. with the director of nursing confirmed using the graduated medication cup had not been accurate. Review of the provider's 2007 Medication Administration General Guidelines revealed liquid medications that required precise measurement were to have been measured by a device provided by the manufacturer or from a supplier. An oral syringe had been given as an example to ensure accurate measurements had been used to administer the medication.	F 281	completed times 1 month and then monthly to ensure accurate medication administration is completed. Audit results will be reported to Quality Assurance every month times 3 and then quarterly thereafter until 1 year is completed. Professional nursing staff was educated/ RN D attended. DON completes audits. DON will report to QA. *Resident 1 did have lab result reviewed and new dosage was ordered. 100% of residents with liquid medicine will be included in Audit to assure accuracy of medication is completed weekly times 1 month and monthly thereafter until QA committee recommends Audits cease. RN D was included in education of Proper Medication Administration. CKV/SDDOH/JJ	7/2/13 BP 7/24/13
F 363 SS=C	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance;	F 363		

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

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F 363	Continued From page 4 and be followed. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and record review, the provider failed to follow the planned menu signed by the registered dietician. Findings include: 1. Observation on 6/11/13 at 7:20 a.m. of cook E revealed he had served sausage links to the residents. Review of the 6/11/13 menu revealed: *Fried eggs on the menu for breakfast. *The menu had been signed by the registered dietician. *Sausage links had not been on the menu for breakfast. Interview on 6/11/13 at 11:45 a.m. with cook E revealed: *Eggs had been on the menu for breakfast almost everyday. *He had wanted to change the menu for the resident's because he thought eggs were served too often. Interview on 6/11/13 with the certified dietary manager revealed the cook should have followed the planned menu that had been signed by the registered dietician.	F 363	In-service held on 7/2/13 for all Dietary Staff. to review policy regarding compliance. All menus are to be followed unless residents request, special event, or outage outate of item. If substitution is needed cook is required only use substitutions from approved list and to document reason for change, date of change and what was substituted according to FCNH policy and procedures. Audit will be done daily for 1 week starting 7/7/13 and monthly x-10 7/28/13 and monthly for 10 months. DCM or 1st cook will complete audit. DCM will report quarterly to QA Committee.	7/28/13 BD 7/26/13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		

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

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F 371	<p>Continued From page 5</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and record review, the provider failed to ensure: *Two of two cooks followed proper hand hygiene and glove-use techniques for two of two observed meal preparations and services. *A wall in the kitchen and the shelves in the dry storage area were maintained in good repair. *One of two handwashing sink faucets was in good working order. Findings include:</p> <p>1. Observation on 6/11/13 at 7:20 a.m. of cook E during the morning meal preparation and service revealed: *He had not washed his hands before donning gloves. *He placed one glove on his right hand and with that gloved hand he: -Touched plates. -Touched ready to serve food items. -Buttered and cut ready to serve food items. -Touched the food cart. -Served that food to the residents.</p> <p>Observation on 6/11/13 between 11:00 a.m. and</p>	F 371	<p>for all Dietary staff Inservice was held on 7/2/13 to review policy and Serv Safe guidance for proper usage of gloves when preparing foods. All food preparation must be as done so according to Serv Safe Guidelines. New policy was reviewed for storing of breads. Training will be held quarterly to educate staff of the proper usage of gloves, RD will do inservice in August. done by CDM and or RD quarterly. Monitoring will be completed daily x 1 week starting 7/27/13 by DCM or 1st cook then will be done monthly by CDM or 1st cook monthly. CDM will report quarterly to CA Committee.</p>	7/27/13 RB 7/26/13

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F 371	<p>Continued From page 6</p> <p>11:45 a.m. of cook G during the noon meal preparation revealed he donned gloves and with those gloved hands he:</p> <ul style="list-style-type: none"> *Touched multiple ready-to-serve food items that included bread, bologna, and cheese. *Touched multiple surfaces that included the countertop and a pair of scissors. *Removed those gloves, did not wash his hands, and donned new gloves. With those gloved hands he: <ul style="list-style-type: none"> -Put sandwiches into plastic baggies. -Took multiple cheese slices out of a plastic storage bag and rebagged them. <p>Observation on 6/11/13 of cook E during the noon meal revealed he:</p> <ul style="list-style-type: none"> *Donned one glove to his right hand and with that gloved hand he: <ul style="list-style-type: none"> -Served multiple resident plates. -Reached into and obtained bread from a bag to serve to residents. <p>2. Random observations from 6/10/13 through 6/12/13 of the kitchen and dry storage area revealed:</p> <ul style="list-style-type: none"> *A mound of ice was on the floor of the walk-in freezer (photo 9) and created an uncleanable and unsafe surface. *An approximate four inch by two inch area of the wall above the sanitizer for the three compartment sink was crumbling and had chipped paint. *Dry food storage shelves in the food storage room had multiple splintered and chipped wood surfaces (photo 8). *The handwashing sink near the walk-in cooler had a broken knob to turn the water on and off. That knob laid on top of the sink. 	F 371	<p>Will have HVAC people check. Freezer was defrosted and checked daily for build up.</p> <p>Maintenance will repair and paint wall. Wall repaired.</p> <p>Maintenance will cover with sheet steel or aluminum covers. Installed rubber edge covers.</p> <p>The skin will be removed as there is 2 handwash sinks. Sink repaired and repair wall.</p>	<p>7/20/13 BP 7/24/13</p> <p>7/25/13 BP 7/24/13</p> <p>7/16/13 BP 7/24/13</p> <p>7/17/13 BP 8/1/13</p>

BP 7/24/13

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

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FORM APPROVED
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F 371	Continued From page 7	F 371			
	Interview on 6/11/13 at 5:20 p.m. with the certified dietary manager revealed she: *Would have expected employees to wash their hands for 60 seconds or use hand sanitizer before donning gloves and after glove removal. *Agreed the walk-in freezer, dry storage shelves, and handwashing sink were in disrepair and needed repair.		Inservice held on 7/2/13. Repairs will be completed by 8/1/13.	7/2/13 7/26/13 8/1/13	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		BP 7/26/13	

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F 431	<p>Continued From page 8</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to maintain the security of medications from unauthorized personnel, residents, and visitors as evidenced by: *Unsecured access for one of one key in the facility for the cupboard that contained the schedule II and III medications awaiting destruction. *Random observation of two of four nurses leaving a medication cart unlocked in one of two hallways. Findings include:</p> <p>1. Observation and interview on 6/11/13 at 3:30 p.m. with registered nurse (RN) D while in the medication room revealed a locked cupboard door with a slot cut into the door. RN D confirmed that was where the schedule II and schedule III medications were stored until they were destroyed. She further confirmed the administrator had the only key to that cupboard.</p> <p>Interview on 6/12/13 at 9:30 a.m. with the administrator confirmed she had the only key in the facility to the cupboard where the schedule II and schedule III medications were stored until they were destroyed. She further confirmed she</p>	F 431	<p>Inservice completed on 7/2/13 and makeup completed on 7/3/13 for training on storage of medications. The key for the Schedule 2 and 3 medications has been given to the DON. The DON and Pharmacist have the keys to this cupboard to assure security of medication from unauthorized persons. Medication carts will be monitored daily times 1 week, weekly times 3 months and then monthly thereafter until 1 year is completed. Audit results will be reported to QA every month times 3 and then quarterly thereafter until 1 year is completed. Nursing staff educated and DON complete audits and report to QA</p>	7/2/13	

7/26/13

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 431	<p>Continued From page 9</p> <p>was not licensed by the State of South Dakota to administer medications to residents. She also confirmed the key had been kept in a drawer in her office. She admitted the office and drawer had not always been locked when she had been out of her office and in other areas of the facility.</p> <p>Surveyor: 26632</p> <p>2. Observation on 6/10/13 at 4:55 p.m. revealed the north medication cart was across from the nurses station. The medication cart was unlocked and the nurse was not present in the area. This surveyor was able to open the medication cart and access the medications it contained. After approximately three minutes the RN/Minimum Data Set coordinator came out of a resident room. She acknowledged she had left the medication cart unlocked and unattended. There were other staff in the hallway during that time.</p> <p>Surveyor: 32333</p> <p>3. Observation on 6/11/13 at 1:15 p.m. of the medication cart parked on the north hall revealed: *It had been unlocked. *No staff had been present. *Registered nurse D had walked out of a randomly observed resident room that had the door closed.</p> <p>Interview on 6/12/13 at 9:00 a.m. with the director of nursing revealed she had expected the medication cart to have been locked when staff giving medication were not in reach or range.</p> <p>Surveyor 28057 Review of the provider's 2007 Medication Storage policy revealed only licensed nurses, pharmacy</p>	F 431	<p>Same as above.</p> <p>Same as above.</p>	<p>7/2/13 BP 7/26/13</p> <p>7/2/13 BP 7/26/13</p>	

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F 431	Continued From page 10 staff, and those lawfully authorized to administer medications were allowed access to medication rooms, cabinets, and medication carts.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441			

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F 441	<p>Continued From page 11</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Surveyor: 26632</p> <p>A. Based on observation, interview, and policy review, the provider failed to ensure handwashing and glove use had been completed during personal care for one of one resident (11) observed. Findings include:</p> <p>1. Observation on 6/11/13 at 7:40 a.m. of certified nursing assistant (CNA) B while she assisted resident 11 from the toilet to her wheelchair revealed CNA B: *Entered resident 11's room from the hallway. *She then went into resident 11's bathroom. *She put on gloves without washing her hands. *She provided perineal care for resident 11. *She did not remove her gloves and then touched the resident's clothing, the standing-lift handles, and resident 11's wheelchair. *She removed her gloves and did not wash her hands. CNA F had been in the room and she then pushed resident 11 in her wheelchair to the dining room. CNA F had not worn gloves and touched the same surfaces that CNA B had previously touched with her contaminated gloves. Neither CNA B or F washed or sanitized their hands before they continued on to assist other residents.</p>	F 441	<p>Inservice completed on 7/2/13 and makeup completed on 7/3/13 for Infection Control measures including proper hand washing and glove usage. Weekly audits will be completed by Charge Nurses. Audit results will be reported to QA every month times 3 and then quarterly thereafter until 1 year is completed. Staff educated. DCN will complete audits and report to QA.</p>	7/2/13 <i>BP</i> <i>7/24/13</i>	

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F 441	<p>Continued From page 12</p> <p>Interview on 6/12/13 at 10:40 a.m. with the director of nursing confirmed proper glove use and handwashing/sanitizing had not been completed during the above care.</p> <p>Review of the provider's revised August 2009 Personal Protective Equipment - Gloves policy revealed hands should have been washed after removing gloves.</p> <p>B. Based on observation and interview, the provider failed to keep clean linen covered for protection while in transit for two of two clothes racks. Findings include:</p> <p>1. Observation at 10:40 a.m. on 6/11/13 revealed a clean linen clothes rack in transit in the hallways. The clean clothes were partially covered with an old bedspread that covered about half of the clothes (photo 4). Interview at that same time with the housekeeping and laundry supervisor confirmed that finding. She stated they had used the old bedspreads to cover the clean clothes for about a year. She stated she had another rack that was used in the same manner.</p> <p>C. Based on random observation, testing, and interview, the provider failed to ensure sanitary conditions were kept for:</p> <ul style="list-style-type: none"> - Two of two bathing rooms. - The stopper chain for the whirlpool. - The plastic lip of the roll-in floor for the shower. - Boxes of gloves and water cups for the medication carts. - Ventilation grates in the soiled and clean linen storage rooms. 	F 441	<p>Two pieces of machine washable material will be fit for each clothing racks with the dimensions of 60 x 124 inches; which will include one end will be secured with Velcro closure, for each covering. The Laundry Supervisor as well as the laundry aide will be monitoring daily; assuring that the linen material covers 100% of all clothing on racks before they are in transit down north and west wing hallways. The Housekeeping Supervisor will be reporting QA/QI committee quarterly. The date of this correction will be 8/1/13.</p> <p>Maintenance replaced with new plastic coated cable in place of chain.</p> <p>Housekeeping to add cleaning vents to daily check lists.</p>		

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F 441	Continued From page 13 Findings include: 1. Random observation from 9:00 a.m. to 3:00 p.m. on 6/12/13 revealed: a. The approximate three foot by four foot non-slip surfaces for the shower room and whirlpool room were embedded with dirt and debris and had scratches and tears along the edges. The original grey color was now a grey-black color (photos 5 and 7). Interview with CNA C at the time of the observation confirmed that finding. She stated it had begun to look worse every year. She revealed it was embarrassing to show visitors and family the nice whirlpool room with the "ugly" floor. Continued interview with the NAs A and B also confirmed the above findings. They stated they would clean and sanitize the floor but thought it needed either a good scrubbing or be repainted to look nice again. b. Decorative loop chain was used to keep the rubber stopper in place for the whirlpool tub. That chain laid in the bottom of the tub in two to three six inch loops. Closer observation revealed that chain was not stainless steel and had begun to rust. Interview with CNA C at the time of the observation confirmed that finding. She stated the original cord had broken a few months ago and the maintenance man had used that chain to access the stopper. She stated it was hard to scrub clean and the resident feet would get tangled in the long loops. Continued interview with the NAs A and B also confirmed the above findings. They also stated the chain was hard to clean and agreed the residents feet would get caught in the loops. Interview with the maintenance supervisor (MS)	F 441	Maintenance will remove paint and install adhesive backed non-slip strips. Maintenance to build a cable for tub plug. Cable is stainless wrapped in vinyl for easy cleaning. Completed 7/18/13	8/15/13 7/30/13 BP 7/26/13	8/15/13 7/18/13 BP 7/26/13

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

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F 441	Continued From page 14 at 3:00 p.m. on that same day revealed he was aware of the chain. He stated the old cord had broken and the new cord sent by the company was not long enough. He stated he had not reordered a longer cord. c. The plastic lip of the roll-in shower floor had an approximate six inch crack on the right side (photo 2). The crack was pliable and could harbor water and bacteria. Continued observation at 3:00 p.m. on that same day revealed that crack had been sealed with globs and layers of caulking that would be uncleanable (photo 6). Interview the MS at that same time revealed he had repaired the crack. d. Three boxes of gloves and two boxes of water cups were stored on a piece of plywood in the clean utility room on the west unit. Interview with the MS at the time of the observation confirmed the finding. He agreed those boxes of resident care items should be stored higher off the floor to protect from contamination. e. The ventilation grates in the soiled linen and clean linen storage rooms were layered with dirt, dust, and debris (photos 1 and 3). The dirt, dust, and debris created a fuzzy look to the grates. Interview with the MS at the time of the observations confirmed those findings. He stated he was not aware those grates needed to be cleaned. He stated he kept an "eye" on the ventilation grates in resident rooms but had not checked other rooms.	F 441	New plastic coated cable was installed Maintenance to fix and repair properly Tub/shower called in for estimate to repair shower base. Have been removed. Cleaning was completed by housekeeping. Maintenance will check monthly and reports will be given to Safety Committee and a log will kept in PMS *MS will complete Audits of all items listed (pages 13 and 14) weekly times 1 month and monthly thereafter. Results will be reported to QA committee monthly X 3 months and quarterly thereafter until QA committee recommends Audits cease. CKV/SDDOH/JJ	6/18/13 9/30/13 8/1/13	BP 7/26/13 BP 7/26/13

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

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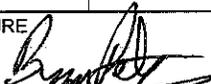
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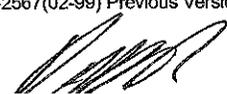
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 6/10/13 through 6/12/13. Five Counties Nursing Home (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/12/13 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K029, K033, K044, K046, K062, K076, K144, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 8/1/13 telephone to facility Emergency Permit Holder.</p> <p style="text-align: right;">CKV/SDDOH/JJ</p>	
K 028 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and record review, the</p>	K 028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Board Chair	(X6) DATE 7/9/13
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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.

JUL 15 2013

 7/26/13

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K 028	Continued From page 1 provider failed to maintain clear door widths of at least 32 inches for one smoke barrier located on the first floor of the original building (between the original building and the 1962 addition). Findings include: 1. Observation on 6/11/13 revealed the cross-corridor doors between the original building and the 1962 addition were only 30 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report dated 4/18/12 revealed those doors were the original doors. The building meets the FSES. Please mark an "F" in the completion date column.	K 028		F	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain proper separation of two of two hazardous areas (soiled linen storage	K 029	*Door was repaired to soiled linen room by Maintenance by 7/31/13. Maintenance Supervisor will report findings of PMP monthly to QA committee until QA committee recommends Audits cease. CKV/SDDOH/JJ		

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K 029	Continued From page 2 room and boiler room). Findings include: 1. Observation and testing at 1:45 p.m. on 6/12/13 revealed the self-closing 90 minute rated door to the soiled linen storage room located next to the laundry room would not close and latch into the frame. Interview with the maintenance supervisor (MS) at the time of observation and testing confirmed that finding. He revealed he was just made aware that door would not close and latch on its own. He stated he did not have a preventative maintenance program to check for life safety issues in the facility. 2. Observation at 1:50 p.m. on that same day revealed the 2 hour rated self-closing boiler room door was propped in the open position with a broom. Interview with the MS at the time of observation confirmed that finding. The MS was aware that a rated door could not be propped open, but revealed someone had probably done so as the room grew very warm.	K 029 K029	Maintenance will adopt state provided Preventative Maintenance Program and a check list for all doors will be implemented for once a month inspection. EMP started. Door will not be propped open and will be monitored by MS and reported quarterly to QA.	9/30/13 8/1/13 7/26/13
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. The	K 032		7/1/13 7/26/13

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K 032	Continued From page 3 basement had only one means of egress. Findings include: 1. Observation at 1:30 p.m. on 6/12/13 revealed the basement was not provided with two means of egress. One exit stairwell was the only means of egress from the basement. Review of the previous survey dated 4/18/12 confirmed that finding. The building meets the FSES. Please mark an "F" in the completion date column.	K 032	There is a ladder to the roof hatch on south end of boiler room.	<i>BJ</i> <i>7/26/13</i>
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain the one hour fire resistive rating for one of two (southwest) exit stair enclosures. Findings include: 1. Observation and testing at 2:15 p.m. on 6/12/13 revealed the 60 minute rated self-closing stairwell door to the southwest stairs and loading dock would not securely latch against the frame. A gap of approximately 1/4 to 1/2 inch ran the entire length of the edge of the door where	K 033	Maintenance will adjust this door and it will be under close watch with the monthly inspection of all doors. Repaired 7/22/13.	<i>9/30/13</i> <i>7/22/13</i> <i>7/26/13</i>

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K 033	Continued From page 4 sunlight could be seen. Interview with the maintenance supervisor at the time of the testing confirmed that finding. He stated he had just started in January of this year and was not aware of the all the codes or preventative maintenance for life safety measures in the facility.	K 033	Repaired. Door will be monitored by Maintenance monthly and logged in RMP book. MS will report to Safety.	7/22/13.
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, record review, and interview, the provider failed to maintain a minimum clear space of 22 inches between the swing of the door and the newel post in the southwest stair enclosure. Findings include: 1. Observation at 9:00 a.m. on 6/11/13 and record review of the previous survey report dated 4/18/12 revealed the first floor door swung into the southwest stair enclosure. That door in the open position restricted the egress to 17 inches measuring from the latch side of the door leaf to the stair newel post. The building meets FSES. Please mark an "F" in the completion date column.	K 034	*MS will report to Safety/QA committee monthly until QA committee recommends Audits cease. CKV/SDDOH/JJ	<i>BP</i> <i>7/26/13</i>
K 044 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5	K 044		F

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K 044	Continued From page 5 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain one of two sets of 90 minute horizontal exit doors. An astragal plate was missing for one of the doors. Findings include: 1. Observation and testing at 2:45 p.m. on 6/12/13 revealed a gap of approximately 1/4 inch between the 90 minute rated cross-corridor horizontal exit doors in the north unit. Those doors were in the two hour fire-resistive wall between building 01 and building 02. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. He stated he understood the need for the astragal plate. He stated he was not aware of all the codes and did not have a preventative maintenance program to check for life safety issues in the facility.	K 044	Maintenance to install astragal in north corridor fire doors. Astragal is on order for Direct Supply and these doors also will be inspected on the Preventative Maintenance Program once a month. MS intalled plate and doors will be inspected by Maintenance and logged in EMP. MS will report to Safety monthly. *Maintenance Supervisor will report to Safety/ QA committee monthly until QA committee recommends Audits cease. CKV/SDDOH/JJ	9/30/13 7/30/13
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain emergency lighting of at least one and a half hours in duration for the following areas: west stairwell of the third floor, basement storage room, generator shed and transfer switch, boiler room, and old boiler room. Findings include:	K 046		

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K 046	Continued From page 6 1. Random observation and testing from 1:30 p.m. to 3:00 p.m. on 6/12/13 revealed the battery powered emergency lights did not illuminate when tested at the following locations: west stairwell of the third floor, basement storage room, generator shed and transfer switch, boiler room, and old boiler room. Interview with the maintenance supervisor at the time of testing and observations confirmed those findings. He revealed he did not have those emergency lights on a preventive maintenance schedule. He stated he had just started at the facility in January of this year and was not aware of all the codes or preventative maintenance needed for life safety measures in the facility.	K 046	Maintenance to add this to preventative maintenance plan as per state program off website Lights were replaced. Installed new batteries. Maintenance is responsible for repair of lights. Have started a RMP to check lights and batteries on a monthly basis. Report will be given to Safety monthly.	9/30/13 7/30/13 BP 7/26/13
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required quarterly flow tests for two of four quarters (second and third) in 2012. Findings include: 1. Review of the provider's automatic sprinkler system quarterly flow test inspection reports revealed quarterly flow tests were not conducted the second and third quarter of 2012. Interview	K 062	*MS will report to Safety/QA committee monthly until QA committee recommends Audist cease. CKV/SDDOH/JJ	
		K062	Quarterly flow tests have been started and current up to 4th quarter. Most tests were by done MS. Will do quarterly testing and log into MPS. Maintenance to add to preventative maintenance check list quarterly and report to Safety Committee.	BP 7/26/13 9/30/13 7/30/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2013
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K 062	Continued From page 7 with the maintenance supervisor at the time of the record review revealed he was aware quarterly flow tests must be conducted on the automatic sprinkler system. He stated he had just started in January of this year and could not find the records for all the preventative maintenance tests completed in 2012.	K 062	*MS will report to Safety/ QA committee monthly until QA committee recommends Audits cease. CKV/SDDOH/JJ	
K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to restrain four of four portable oxygen cylinders in a secured position in the oxygen storage room. Findings include:</p> <p>1. Observation on 6/11/13 at 9:00 a.m. revealed four E size oxygen cylinders unrestrained in the oxygen storage room. Interview at 2:50 p.m. on 6/12/13 with the maintenance supervisor confirmed those findings. He stated staff were aware oxygen tanks must be restrained at all</p>	K 076	<p>Audits will be completed to ensure that all oxygen cylinders are in the appropriate storage. Report to QA quarterly MS will report to Safety quarterly.</p> <p>7/25/13 7/26/13</p>	

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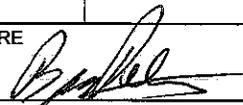
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2013
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K 144	Continued From page 9	K 144		
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to furnish permanent wiring for five randomly observed rooms. Multiple-tap adaptors were in-use in resident rooms 10, 11, 38, 42, and 48. Findings include:</p> <p>1. Observation from 9:00 a.m. to 10:30 a.m. on 6/12/13 revealed multiple-tap adaptors in-use in place of permanent wiring in resident rooms 10, 11, 38, 42, and 48.</p> <p>Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated he had been told when he started in January of this year power strips were not allowed. He stated he had replaced the power strips with multiple-tap adaptors.</p>	K 147	<p>Maintenance stated that we took all power strips out and told residents that they may provide their own adaptors. No adaptors will be used at all, and adaptors were removed.</p> <p>Maintenance will monitor rooms for non-compliant adaptors monthly and logged into RMP. Report to Safety Committee monthly.</p> <p>*MS will report findings monthly to QA committee until committee recommends audits cease.</p> <p>CKV/SDDOH/JJ</p>	<p>9/30/13. 7/30/13</p> <p><i>Handwritten initials and date: MS 7/26/13</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2013
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K 000	INITIAL COMMENTS Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 6/10/13 through 6/12/13. Five Counties Nursing Home (building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K046, K062, K144, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 8/1/13 telephone to facility Emergency Permit Holder. CKV/SDDOH/JJ	
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain emergency lighting of at least one and a half hours in duration for the following areas: west stairwell of the third floor, basement storage room, generator shed and transfer switch, boiler room, and old boiler room. Findings include: 1. Random observation and testing from 1:30 p.m. to 3:00 p.m. on 6/12/13 revealed the battery powered emergency lights did not illuminate when tested at the following locations: west stairwell of the third floor, basement storage room, generator	K 046	P.M.P. has been started, lights were replaced by MS. Installed new batteries. Maintenance will be responsible for repair of lights. P.M.P. will be logged for light & batteries. This will be reported to Safety Committee on a monthly basis. Maintenance to add this to preventative maintenance plan as per state program off website	7/30/13 9/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Board Chair	(X6) DATE 7-9-13
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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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NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVENUE WEST PO BOX 479 LEMMON, SD 57638
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K 046	Continued From page 1 shed and transfer switch, boiler room, and old boiler room. Interview with the maintenance supervisor at the time of testing and observations confirmed those findings. He revealed he did not have those emergency lights on a preventive maintenance schedule. He stated he had just started at the facility in January of this year and was not aware of all the codes or preventative maintenance needed for life safety measures in the facility.	K 046	*MS will report findings monthly to QA committee until committee recommends audits cease. CKV/SDDOH/JJ	
K 062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required quarterly flow tests for two of four quarters (second and third) in 2012. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system quarterly flow test inspection reports revealed quarterly flow tests were not conducted the second and third quarter of 2012. Interview with the maintenance supervisor at the time of the record review revealed he was aware quarterly flow tests must be conducted on the automatic sprinkler system. He stated he had just started in January of this year and could not find the records for all the preventative maintenance tests</p>	K 062	<p>Report will be given to Safety Committee on a quarterly basis. Quarterly flow tests are complete for month of July. Most tests were done by MS, some done by Maintenance Staff. Will continue to do flow testing quarterly and record it in our preventative maintenance program</p> <p>Maintenance can provide complete 2013 and 4th quarter 2012 reports and is now part of the life safety preventative maintenance program adopted from state website</p> <p>*MS will report findings monthly to QA committee until committee recommends audits cease. CKV/SDDOH/JJ</p>	<p>7/30/13</p> <p>9/30/13</p> <p><i>BD</i> <i>7/26/13</i></p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 06/12/2013
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K 062	Continued From page 2 completed in 2012.	K 062			
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, record review, and interview, the provider failed to document testing of the generator under load 30 minutes each month. Findings include: 1. Observation at 9:00 a.m. on 6/12/13 of the generator storage shed revealed a clip board with generator maintenance notes. Review of the maintenance records revealed the facility kept track of weekly generator run times for exercising the generator for approximately 10 minutes. No documentation could be provided to show the generator had been run under load for at least 30 minutes each month. Interview with the maintenance supervisor at the time of the record review revealed he had no documentation indicating the generator had been exercised under load each month. Further interview with the maintenance supervisor revealed he was unaware of the requirement for generator testing and for keeping records of the testing.	K 144	Maintenance will get training as to run generator under load and will update check list for preventative maintenance program Training will be completed to run generator under load. Generator test for 30 min. with load and keep record in RMP log book. Maintenance will report to Safety Committee monthly. *MS will report findings monthly to QA committee until committee recommends audits cease. CKV/SDDOH/JJ	9/30/13 7/30/13 BP 7/26/13	

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K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to furnish permanent wiring for five randomly observed rooms. Multiple-tap adaptors were in-use in resident rooms 10, 11, 38, 42, and 48. Findings include:</p> <p>1. Observation from 9:00 a.m. to 10:30 a.m. on 6/12/13 revealed multiple-tap adaptors in-use in place of permanent wiring in resident rooms 10, 11, 38, 42, and 48.</p> <p>Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated he had been told when he started in January of this year power strips were not allowed. He stated he had replaced the power strips with multiple-tap adapters.</p>	K 147	<p>Maintenance will remove improper multi-tap adaptors and monitor on a weekly basis to ensure this type of multi-tap adapter is not used</p> <p>Maintenance will remove improper multi-tap adaptors and monitor on a monthly basis to ensure this type of multi-tap adapter is not used. A report will be logged in RMP book monthly. Maintenance will report to Safety Committee on a monthly basis.</p> <p>*MS will report findings monthly to QA committee until committee recommends audits cease.</p> <p>CKV/SDDOH/JJ</p>	9/30/13	7/30/13 7/26/13

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10641	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2013
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NAME OF PROVIDER OR SUPPLIER FIVE COUNTIES NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 405 6TH AVE. WEST PO BOX 479 LEMMON, SD 57638
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S 000	Initial Comments Surveyor: 28057 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/10/13 through 6/12/13. Five Counties Nursing Home was found not in compliance with the following requirements: S153, S166, S192, and S290.	S 000		
S 153	44:04:02:10 PLUMBING Facility plumbing systems must be designed and installed in accordance with SDCL 36-25-15 and 36-25-15.1. Plumbing must be sized, installed, and maintained to carry required quantities of water to required locations throughout the facility. Plumbing may not constitute a source of contamination of food equipment or utensils or create an unsanitary condition or nuisance. This Rule is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to maintain the vacuum breaker on the janitor floor sink in one of two housekeeping closets on the north unit. Findings include: 1. Observation at 4:00 p.m. on 6/11/13 revealed a hose laid in the bottom of the sink of the housekeeping closet on the west side of the north unit. Closer observation revealed the vacuum breaker for that sink was broken. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was not aware the vacuum breaker was broken.	S 153		
		S153	Staff was educated to keep hose off drain floor. MS informed Housekeeping, Maintenance & Dietary in meeting 6/18/13. MS to report to Safety monthly. Will log in FMP log. The vacuum breaker was repaired.	6/26/13 6/18/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: **Board Chair** (X6) DATE: **7-9-13**

[Handwritten signature] 7/26/13
JUL 15 2013
JUL 15 2013

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 166	Continued From Page 1	S 166	*S153 continued...	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed; (7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized	S 166	MS will monitor plumbing fixtures monthly to ensure they are in good working order. MS will report monthly X 3 months and quarterly thereafter to QA committee. CKV/SDDOH/JJ	

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 166	Continued From Page 3 aware how the door alarms should work. He stated he had just started here in January of this year. The administrator provided the surveyor with a undated current version of a door monitor policy. The policy addressed monitoring of residents with Wanderguards but no policy actually addressed the monitoring of the door alarms. 2. Observation at 1:45 p.m. on 6/12/13 revealed the housekeeping closet on the north end of the north unit had paper towels and toilet paper in storage. Closer observation revealed the unshielded bulb in that room was not shatterproof. Interview with the MS at the time of the observation confirmed that finding. He stated he was not aware that light bulb needed a light shield or a shatterproof coating. 3. Interview at 2:30 p.m. on 6/12/13 with the MS revealed he had started a PM program for repairs and general maintenance of the facility. He stated he did not have a PM program for the life safety code measures within the facility.	S 166	Report revised Revised door policy in place. Policy attached, all staff has been made aware of changes by department supervisors. New Policy turned in by DON. Bulb has been replaced, with shatter proof vynal coated bulb. <i>*MS will monitor light fixtures to ensure they are in good working order and report findings to QA Monthly X3 months and quarterly thereafter. CKV/SDDOH/JJ</i> Preventative maintenance program in place by 7/30/13 Reported quarterly to QA. by MS *MS is responsible for PMP.	7/25/13 <i>BP 7/26/13</i> 6/14/13 <i>BP 7/26/13</i> 7/30/13 <i>BP 7/26/13</i>
S 192	44:04:02:19 PHYSICAL PLANT CHANGES A facility must submit any proposed change by new construction, remodeling, or change of use of an area to the department. Any change must have the approval of the department before it is made. This Rule is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider did not submit a proposed change of room use for resident room 23. Findings include:	S 192	CKV/SDDOH/JJ	

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 192	Continued From Page 4 1. Observation at 8:00 a.m. on 6/11/13 revealed resident room 23 was used as a therapy room. Interview with the maintenance supervisor at 3:30 p.m. on that same day confirmed that finding. He stated that room had been changed before he started to work in January of this year. He was unaware if the administrator had notified the Department of Health before changing the room. He stated he was unaware of the requirement to submit plans for review before changing the use of a room.	S 192	SD Department of Health will be notified of all physical plant changes.	*7/31/13
S 290	44:04:07:02.04 FOOD SUPPLY An on-site supply of nonperishable foods adequate to meet the requirements of planned menus for three days must be maintained. This Rule is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and record review, the provider failed to maintain a three day emergency menu and three day supply of non-perishable foods. Findings include: 1. Random observation on 6/11/13 of the non-perishable food supply revealed an inadequate supply to meet a three day planned menu. Interview on 6/11/13 at 5:20 p.m. with the certified dietary manager confirmed she did not have an adequate supply of non-perishable foods for a three day planned menu nor a three day non-perishable food menu.	S 290	*On 7/24/13 DON notified engineer at SDDOH of current room change, by phone. Administrator will be responsible for prior notification of SDDOH of future room changes prior to change occurring. Administrator will report all building/room changes to QA committee quarterly X 1 year. CKV/SDDOH/JJ Non-perishable food supply according to new emergency menu has been purchased and staff was educated on service 7/2/13. Menus approved by dietician. S290 CDM is responsible to order non-perishable food supply according to new emergency menu that has been approved by dietician. All Dietary staff has been educated at inservice on 7/2/13. CDM or 1st cook will review supply weekly when ordering from food supplier, monitoring will be done monthly by CDM or 1st cook	CKV/SDDOH/JJ 7/2/13