

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

ORIGINAL

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/10/14 through 6/11/14. Avera Eureka Health Care Center was found not in compliance with the following requirements: F170, F323, and F441.	F 000	Addendums noted with an asterisk per 7/14/14 telephone to facility administrator. K6/SDDOH/ME	
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: 29162 Based on interview and policy review, the provider failed to ensure prompt delivery of outgoing mail and received mail for all residents. Findings include: 1. Group interview on 6/11/14 at 9:40 a.m. with eight randomly selected residents revealed: *They had not received their mail on Saturday. *They had been unaware they could have mail delivered on Saturday. *The residents wanted to have their mail delivered on Saturday. Interview on 6/11/14 at 1:45 p.m. with the activity director (AD) revealed: *On Monday, Tuesday, Wednesday, Thursday, and Friday the maintenance supervisor: -Took the residents outgoing mail to the post	F 170	THE DIETARY ASSISTED LIVING COOK WILL PICK UP MAIL ON THEIR WAY BACK FROM THE HOSPITAL AND PLACE MAIL BAG ON NORTH DESK IN THE BUSINESS OFFICE. AFTER REPORT, ONE OF THE NURSES WILL SORT OUT ANY RESIDENT MAIL TO BE DELIVERED TO RESIDENTS PER THEIR REQUEST UPON ADMISSION TO FACILITY. NURSE OR EVENING CNA'S WILL DELIVER MAIL TO RESIDENTS. ACTIVITY MANAGER WILL MONITOR PICKUP OF MAIL VIA CHECKLIST IN MAIL BAG* ACTIVITY MANAGER WILL REPORT FINDINGS TO QAPI COMMITTEE QUARTERLY FOR 6 MONTHS. *and the delivery of the mail to the residents K6/SDDOH/ME every week. K6/SDDOH/ME	7/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carmen Weber* TITLE *Administrator* (X6) DATE *7/7/14*

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.

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

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER avera eureka health care center		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 170	<p>Continued From page 1 office. -Picked up the facility mail from the post office. That mail included the resident's mail. *Activity staff delivered the residents' mail. *They did not deliver mail on Saturday, because: -It was not picked up from the post office. -Activity staff were not on duty to deliver the mail on Saturday. *On holiday weekends such as Mother's Day, Father's Day, Thanksgiving, and Christmas the maintenance director picked up the mail on Saturday. He gave the mail to a staff member on duty. Only resident mail that appeared to be holiday cards were delivered on those days. *She stated she had "talked to a couple of the residents and they didn't care if they got their mail on Saturday."</p> <p>Review of the provider's February 2011 Avera Eureka Health Care Center Resident Information booklet revealed: *All mail received through the United States Postal Service was to have been delivered to the resident or to their room. *Their mail was not to have been withheld from them.</p>	F 170		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323		

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

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Based on observation, interview, and policy review, the provider failed to ensure chemicals were kept secured on two of two observed housekeeping carts. Findings include:</p> <p>1. Random observations from 6/10/14 through 6/11/14 of two housekeeping carts revealed: *They had been observed by residents' rooms. *No housekeeping staff had been in attendance or monitoring their carts during any of the observations. *There had been a housekeeping cart located on the 200 wing. The cart had one spray bottle of Zephair air and fabric freshener hanging on the outside of the cart. *The housekeeping carts had been unlocked and contained the following chemicals: -One spray bottle of 3M Neutral floor cleaner. -One spray bottle of 3M Quaternary disinfectant cleaner. -One spray bottle of 3M glass cleaner. -One spray bottle of 3M bathroom cleaner. *Several unidentified residents had been observed walking past the housekeeping carts.</p> <p>Interview on 6/11/14 at 8:15 a.m. with housekeeping aide B confirmed the housekeeping carts should have been locked up when not in attendance or within sight of the housekeepers. No chemicals were to have been left on the outside of the cart.</p> <p>Interview on 6/11/14 at 1:15 p.m. with the housekeeping supervisor further confirmed the above interview with housekeeping aide B.</p>	F 323	<p>ALL HOUSEKEEPING CARTS WILL BE LOCKED AT ALL TIMES WHEN UNATTENDED. ALL CHEMICALS USED BY THE HOUSEKEEPING DEPARTMENT WILL BE STORED INSIDE THE CART AND LOCKED. ONCE EACH WEEK, HOUSEKEEPING STAFF WILL MONITOR [REDACTED] CARTS TO CHECK IF THEY ARE LOCKED WHEN CARTS ARE NOT ATTENDED. THEY WILL REPORT THEIR FINDINGS TO THE HOUSEKEEPING SUPERVISOR AND ALSO RECORD THEM ON A CART LOCK LOG LOCATED IN THE EAST JANITOR ROOM. HOUSEKEEPING SUPERVISOR WILL REPORT FINDINGS TO THE QAPI COMMITTEE QUARTERLY FOR 6 MONTHS.</p> <p><i>* each others KG/SDDH/MF</i></p>	7/7/14	

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

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 3 Review of the provider's January 2007 Hazardous and Toxic Substances policy revealed "All hazardous/toxic substances used in our facility will be stored as directed by the label and kept out of the reach of residents, family members, visitors, children, ect."	F 323			
F 441 SS=D	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	F 441	DON COUNSELED ALL CNA'S ON STAFF RELATIVE TO APPROPRIATE OPPORTUNITIES FOR HAND HYGIENE AND USE OF GLOVES (2 CNA'S OBSERVED DURING SURVEY NOT EMPLOYED AT THE TIME THE WRITTEN REPORT WAS RECEIVED). THIS COUNSELING WAS CONDUCTED ON 6/30/14, 7/1/14 AND 7/2/14. ALL CNA'S CURRENTLY EMPLOYED WERE REQUIRED TO SIGN A DOCUMENT STATING THEY RECEIVED AND REVIEWED HANDWASHING/GLOVE USE POLICY. THE DON AND MDS NURSE WILL MONITOR HAND HYGIENE PRACTICES THROUGH OBSERVATION 4X/WK FOR 4 WEEKS, THEN 2X/WK FOR 2 MONTHS, THEN ONCE A MONTH FOR 6 MONTHS WITH REPORTS SUBMITTED TO THE QAPI COMMITTEE EVERY QUARTER (OCTOBER 2014, JANUARY 2015, APRIL 2015 AND JULY 2015). IN ADDITION TO ABOVE, HAND GEL DISPENSERS WILL BE PLACED IN BOTH HALLWAYS.	7/31/14	

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

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 4</p> <p>direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained: *To prevent cross-contamination during and after the disinfecting of one of two whirlpool tubs (100 wing). *To prevent cross-contamination during and after personal care for one of three observed residents (2). Findings include:</p> <p>1. Observation on 6/11/14 at 9:30 a.m. of certified nursing assistant A during and after the disinfecting of the whirlpool tub on the 100 wing revealed: *She had prepared to disinfect the whirlpool tub after bathing a resident. *Without the use of gloves she had: -Removed a gel cushion for the chair and placed it in the bottom of the tub with the disinfectant solution. -Retrieved a large handled scrub brush and used the brush to scrub down the entire tub and chair.</p>	F 441		

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

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Touched several areas inside and outside of the tub during the scrubbing process. -Touched several personal care items for the residents while looking for a package containing razors. -Picked up several soiled towels, pushed open the privacy curtain, and opened the entrance door. -Opened a lid to a large wheeled bin and placed the towels inside of the bin. -Returned to the whirlpool room. <p>*She at that time sanitized her hands with a liquid gel hand sanitizer.</p> <p>Interview on 6/11/14 at 3:30 p.m. with the director of nursing (DON) confirmed sanitary precautions had been broken. There was potential for cross-contamination for any residents receiving a whirlpool tub bath and care after the disinfecting process of the tub.</p> <p>Review of the provider's undated Whirlpool Tub Bathing and Disinfecting Sequence revealed no procedure in place for hand sanitizing and glove use.</p> <p>2. Observation on 6/11/14 at 9:40 a.m. with CNA C during personal care for resident 2 revealed she had:</p> <ul style="list-style-type: none"> *Entered the resident's room to assist her with personal care. *Not washed or sanitized her hands prior to or upon entering the room. *Assisted the resident from her bed to the bathroom. *Assisted her with the cleansing of her upper torso (body) *Put on a pair of gloves and retrieved the resident's dentures from a cabinet in the 	F 441		
-------	---	-------	--	--

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

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 6 bathroom.</p> <p>*Assisted her with the placement of her bottom dentures in her mouth.</p> <p>*Retrieved her pager and a piece of paper from her pants and shirt pocket. She had used them to answer a request from another staff member.</p> <p>*Assisted the resident with the placement of her upper dentures in her mouth.</p> <p>*Retrieved her pager and requested assistance with the resident.</p> <p>*Assisted CNA D with perineal (urinary and rectal area) care for the resident.</p> <p>*Removed her gloves and placed a gait belt around the resident's waist to assist her with walking.</p> <p>*Assisted her to the visiting area in the facility and helped her to sit in a chair.</p> <p>*Retrieved three pillows from a couch in the visiting area and used them to position the resident in the chair.</p> <p>*Retrieved a total lift (device used to assist residents with transfers) from the hallway and entered another resident's room.</p> <p>*She had not sanitized her hands before, during, or after personal care for resident 2.</p> <p>Interview on 6/11/14 at 3:45 p.m. with the DON regarding the above observation confirmed the sanitary precautions had been broken with the potential for cross-contamination for resident 2 and other residents receiving personal care. She had been auditing glove use and handwashing for several months.</p> <p>Review of the provider's May 2013 Handwashing and Glove Use policy revealed: **"Appropriate 15-20 second handwashing must be performed under the following conditions:" -"Before and after resident contact."</p>	F 441		

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

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 -"Before and after performing dressing care." -"After having prolonged contact with a resident." -"Upon completion of duty." **"The use of gloves does not replace handwashing. Hands must be washed or antiseptic hand solution applied after gloves removed." **"Gloves must be worn when performing the following tasks/procedures:" -"When performing personal resident care." -"When handling soiled linens.	F 441		

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

CRITICAL

PRINTED: 06/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER avera eureka health care center	STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 06/10/14. Avera Eureka Health Care Center 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 the deficiency identified at K029, K046, and K075 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 7/10/14 telephone to facility administrator. CH/SDDH/ME	
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: 18087 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas for the soiled linen room in the basement. Openings around pipe and conduit penetrations	K 029	8 INCH FLEX DUCT HAS BEEN REMOVED. THE WALL HAS BEEN COVERED WITH 5/8 GYPSUM BOARD AND THE WATER PIPES, VENT PIPES AND CONDUIT HAVE ALSO BEEN SEALED WITH FIRE BLOCK. *Maintenance staff performed the required work. The plant operations director reported the work completion to the QA committee. CH/SDDH/ME	6/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carmen Weber</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/7/14</i>
--	-------------------------------	----------------------------

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.

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

PRINTED: 06/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2014
NAME OF PROVIDER OR SUPPLIER avera eureka health care center			STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 1 above the lay-in ceiling in the soiled linen room were not sealed with an appropriate firestop material. A flex duct penetrating the one-hour fire-rated wall did not have a fire damper at the wall. Findings include: 1. Observation at 1:30 p.m on 6/10/14 revealed the soiled linen room in the basement had unsealed openings around pipe and conduit penetrations above the lay-in ceiling. The west wall also had an eight inch flex duct penetration for an unused ventilation system that did not have a fire damper in the wall.	K 029		
K 046 SS=D	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: 18087 Based on observation, testing, and interview, the provider failed to provide emergency lighting of at least one hour duration. The battery pack emergency lights in the kitchen did not work. Findings include: 1. Observation at 10:00 a.m. on 6/10/14 revealed two battery pack emergency lights in the kitchen. When tested the lights did not work. Interview with the director of plant operations at the time of the observation revealed those lights had not been maintained due to the emergency generator providing all the necessary emergency lighting.	K 046	EMERGENCY LIGHTING IN KITCHEN HAS BEEN ABANDONED. SWANSON ELECTRIC HAS BEEN CONTACTED TO REMOVE EMERGENCY LIGHTING BY 7/17/14. <i>*The plant operations director will report the completion of the work to the QA committee. CH/SDDH/MF</i>	7/17/14
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not	K 075		

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

PRINTED: 06/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 075	Continued From page 2 exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper containment of soiled linens. The soiled linen utility room was used for holding soiled linens overnight and was not provided with one-hour fire-rated construction. Findings include: 1. Observation at 10:50 a.m. on 6/10/14 revealed the soiled linen utility room was approximately 60 square feet in area and was used to hold soiled linens in an eighty-nine gallon wheeled plastic cart. The room was equipped with 20 minute fire-rated doors and did not meet the required one-hour fire-rating to hold soiled linens in a container larger than thirty-two gallons. Interview with the administrator at 3:00 p.m. that same day revealed the soiled linens were taken to the basement soiled linen holding room for processing by laundry staff several times a week. The eighty-nine gallon soiled linen cart would remain in the unrated soiled utility room overnight on occasion.	K 075	THE 89 GALLON SOILED LINEN CART HAS BEEN REMOVED AND WILL NO LONGER BE KEPT IN THE SOILED LINEN UTILITY ROOM. STAFF WILL NOW USE A CART SMALLER THAN 32 GALLONS IN THE SOILED LINEN UTILITY ROOM. LAUNDRY SUPERVISOR WILL CHECK THE SOILED LINEN UTILITY ROOM 1X WEEK FOR 6 MONTHS TO MAKE SURE ONLY 1 SMALL CART IS KEPT IN THE ROOM. LAUNDRY SUPERVISOR WILL REPORT FINDINGS TO THE QAPI COMMITTEE QUARTERLY FOR 6 MONTHS.	7/7/14	

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

PRINTED: 06/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435078	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2014
--	---	---	---

NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

--	--	--	--	--

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10618	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER avera eureka health care center	STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE PO BOX 40 EUREKA, SD 57437
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

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 6/10/14 through 6/11/14. Avera Eureka Health Care Center was found not in compliance with the following requirements: S166 and S296.

S 000

S 166

44:04:02:17(1-10) OCCUPANT PROTECTION

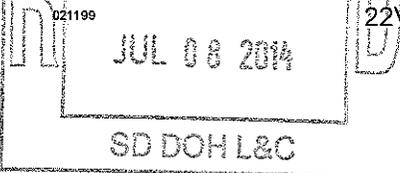
The facility must take at least the following precautions:
 (1) Develop and implement a written and scheduled preventive maintenance program;
 (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents;
 (3) Provide a call system 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;

S 166

ALARMS WILL BE ACTIVATED ON ALL EIGHT EXIT DOORS (INCLUDING THE MAIN ENTRANCE AND EAST EXIT DOOR) AT ALL TIMES. DOOR ALARM POLICY WILL BE CHANGED TO REFLECT THIS. STAFF INFORMED OF THE CHANGES DURING DAILY REPORT AND IN THE WEEKLY WHAT'S NEW NEWSLETTER. ADMINISTRATOR WILL CHECK DOOR ALARMS 1 X WEEK FOR 6 MONTHS TO ENSURE THAT ALARMS ARE ON AND POLICY IS BEING FOLLOWED. ADMINISTRATOR WILL REPORT FINDINGS TO THE QAPI COMMITTEE QUARTERLY FOR 6 MONTHS.

7/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carmen Weber</i>	TITLE <i>DETECTIVE Administrator</i>	(X6) DATE <i>7/7/14</i>
--	---	----------------------------



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10618	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE PO BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 166	<p>Continued From Page 1</p> <p>(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 metal vent pipe for exhaust.</p> <p>This Rule is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure two of eight exit doors (main entrance and east exit doors) had an activated audible alarm or was attended at all times. Findings include:</p> <p>1. Random observations and testing from 6/10/14 through 6/11/14 of the main entrance/exit door revealed: *From 8:00 a.m. through 6:00 p.m. the alarm had not been activated. *The door had been unattended. *There had been several unidentified residents independently walking past the door. *The building and main entrance door was located by a heavily traveled highway.</p> <p>2. Random observations and testing from 6/10/14 through 6/11/14 of the east exit door revealed: *From 8:00 a.m. through 6:00 p.m. the door had been unlocked and easily pushed open. *No alarm had been heard upon opening the</p>	S 166		

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10618	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE PO BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 166	<p>Continued From Page 2</p> <p>door. *The door had been located by the entrance to the basement. The basement door had no locking device attached to it. *The door had been unattended and exited to the back of the facility.</p> <p>Interview on 6/10/14 at 3:00 p.m. with the director of nursing revealed: *The main entrance/exit door: -Had been unlocked with the alarming device inactivated during the day time hours. -Would have been locked with the alarming device activated at 5:00 p.m. *They had a Wanderguard alarm system that would have activated the alarm. Not all residents wore a Wanderguard bracelet. *Any resident who had been determined as an elopement risk by the provider would have been wearing a Wanderguard bracelet. *Any resident who had not been an elopement risk and did not wear a Wanderguard bracelet was able to go outside. There had been no process in place to monitor when those residents had exited through the door. *The doors were not monitored at all times. *The staff were to have frequently monitored the main entrance/exit door during the hours upon inactivation of the alarm.</p> <p>Interview on 6/11/14 at 1:00 p.m. with the plant operations manager revealed: *He had been aware the above doors had been unlocked and inactivated during the day time hours. *He had informed the administration staff several times those doors needed to be locked or have an alarming device attached to them and activated at all times.</p> <p>Review of the provider's May 2011 Wanderguard</p>	S 166		

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10618	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE PO BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 166	Continued From Page 3 in Conjunction with Door Alarms policy revealed: *The above hours of inactivation. *No procedure in place to ensure those residents without a Wanderguard bracelet had been secure and accounted for.	S 166		
S 296	44:04:07:07 Director of dietetic services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved the Dietary Managers Association, must enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Dietary Managers Association, or successfully completed equivalent training as determined by the Health Department. The dietetic manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each...resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian must approve all menus, assess the nutritional status of...residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the...residents must be on duty daily over a period of 12 or more hours in nursing facilities... This Rule is not met as evidenced by: Surveyor: 28057	S 296	DIETARY MANAGER WILL COMPLETE THE CERTIFIED DIETARY MANAGER COURSE BY 7/31/14. FACILITY POLICY WILL BE CHANGED TO REFLECT THAT THE DIETARY MANAGER WILL COMPLETE THE DIETARY MANAGER CERTIFICATION COURSE WITHIN 18 MONTHS OF EMPLOYMENT.	7/31/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10618	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/11/2014
NAME OF PROVIDER OR SUPPLIER AVERA EUREKA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 J AVENUE PO BOX 40 EUREKA, SD 57437		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 296	<p>Continued From Page 4</p> <p>Based on interview and policy review, the provider failed to ensure the dietary manager had completed a dietary manager course within eighteen months of being hired. Findings include:</p> <p>1. Interview with the dietary manager on 6/10/14 at 4:50 p.m. confirmed she had been hired in November 2012. She further confirmed she had not completed the dietary manager certification course. She believed she had completed about three fourths of the course. She had requested two extensions from the university where she had been enrolled at for that course.</p> <p>Interview on 6/11/14 at 10:35 a.m. with the administrator confirmed the dietary manager had been hired on 11/5/12. She had believed the requirement for completion of the dietary manager certification had been two years. She agreed the dietary manager had not completed the certification as required.</p> <p>Review of the provider's revised 3/25/14 Dietary policy and procedures revealed it had been expected the dietary manager would complete continuing education. It had not addressed the need for nor completion of a dietary manager certification course.</p>	S 296			