

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

ORIGINAL

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438	
(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: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/20/14 and 5/21/14. Faulkton Senior Living was found not in compliance with the following requirements: F281, F323, F371, and F441.	F 000	<p><i>Appendix noted with an asterisk per 07/07/14 telephone to facility administrator. KR/DOH/MF</i></p> <p>F 281 This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <ol style="list-style-type: none"> Those resident's identified ^{9 and 13} Advair inhalers have been checked for remaining doses and the MAR marked with remaining doses effective 6/20/2014 All inhalers for residents currently in use have been checked for remaining doses and MAR's marked with remaining doses as of 6/20/2014 	
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: 22452 Based on record review and interview, the provider failed to ensure physicians' orders were followed for the administration of Advair (inhalation medication for breathing) for two of three sampled residents (9 and 13). Findings include: 1. Review of resident 9's April 2014 and May 2014 medication administration records (MAR) revealed: *Advair 100/50 one puff twice a day (BID). *There was documentation all the doses had been administered. Observation on 5/20/14 at 10:00 a.m. of resident 9's Advair inhaler revealed: *It had an opened date as 4/17/14. The inhaler contained sixty doses. *There should have been sixty-seven doses administered since 4/17/14.	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *BUC* TITLE Executive Director (X6) DATE 6/18/14

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.

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If continuation sheet Page 1 of 18

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F 281	<p>Continued From page 1</p> <p>*There were seven doses that remained in the Advair inhaler.</p> <p>2. Review of resident 13's April 2014 and May 2014 MARs revealed: *Advair 250/50 one puff BID. *There was documentation all the doses had been administered.</p> <p>Observation on 5/20/14 at 10:05 a.m. of resident 13's Advair inhaler revealed: *It had an opened date as 4/7/14. The inhaler contained sixty doses. *The inhaler was empty with the last dose administered on 5/20/14 at 8:00 a.m. *The Advair inhaler should have been empty on 5/6/14 when the sixty doses had been administered.</p> <p>3. Interview on 5/20/14 at 10:20 a.m. with licensed practical nurse F and registered nurse G regarding the above Advair inhaler discrepancies revealed they: *Could not explain why the Advair inhaler usage did not match what was documented as administered. *Thought maybe each of the residents might have had another Advair inhaler in-use at the same time. Sometimes when a resident was in the hospital or went to a clinic appointment a new inhaler was sent back to the facility with them. *Agreed both residents' Advair inhalers appeared to not have been administered as ordered by the physician.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St. Louis, Mo., 2005, page 419, revealed the physician was responsible for directing medical</p>	F 281	<p>3. Licensed staff will be re-educated by DNS to use of inhaler, administration of medication documentation and logging in remaining doses on the MAR after each dose is administered.</p> <p>4. The Director of Nursing(DNS) or her designee will check three inhalers two times per week for one month to ensure inhaler dosage left in inhaler matches documented dosage left on the MAR and then check three inhalers weekly for two months. The DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring.</p>	6-20-14

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F 281	Continued From page 2 treatment. Nurses were obligated to follow physicians' orders unless they believed the orders were in error or would harm clients.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure: *Chemicals were stored appropriately in multiple areas (utility rooms, janitor rooms, exercise room, kitchen nook area in the dining room, and on the 300 wing). *Straight edge razors used to shave the residents' faces had been disposed of in an appropriate manner. Findings include: 1. Random observations from 5/20/14 through 5/21/14 revealed multiple areas where chemicals were not stored or secured properly and had created the potential for harm. Those areas and chemicals had been: *Multiple spray bottles of Hyro Kleen disinfectant, carpet spotter, Bath Mate acid-free disinfectant cleaner, and Virex II 256 quaternary disinfectant stored on a shelf in the utility and storage rooms	F 323	F323 1. All identified chemicals were removed from accessible areas and away from resident care personal items on 6/3/14. Sharps container has been added to the bathing room for razor disposal. 2. All areas have been evaluated for safe storage of chemicals. 3. Clinical areas will have keypad locks applied to doors where chemicals may be stored by 7-10-2014. All staff will be re-educated to safe storage of chemicals, no storage of chemicals with resident care personal items and razor disposal into Sharps container by June 19 th , 2014 4. The Administrator/designee will audit safe storage of all chemicals including no storage with resident care personal items and use of Sharps containers for disposal of razors four times per week for one month and then three times per week for two months. The Administrator/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring.	7-10-14

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F 323	<p>Continued From page 3 of the 200 wing.</p> <ul style="list-style-type: none"> -The doors had been left open. -There had been a sign taped between the two doors that read "Chemicals present. For the resident safety and protection it is mandatory that these doors be shut and locked at all times." -There had been several unidentified residents observed passing that area. *A plastic tub of Clorox germicidal wipes stored on a shelf in the utility room on 100 wing. The door had been left opened with no locking device attached to it or on the door handle. *Two spray cans of Zenatize disinfectant cleaner stored on a shelf in the janitor room on the the 100 wing next to multiple boxes of toothpaste, rolls of toilet paper, and a tube of body lotion. *A plastic tub of Clorox germicidal wipes stored in an unlocked cupboard in the exercise room. The room had been located off the dining room. There were no doors to the entrance area. An unidentified resident had been observed sitting at a table next to the entrance area multiple times. *A spray bottle stored under a sink in a kitchen nook area in the dining room. The spray bottle had been labeled Avery (bird) glass cleaner. The cabinet had been unlocked. There had been several unidentified residents observed passing that area. *A plastic tub of Clorox germicidal wipes stored in a holder attached to the vital sign machine in the commons area on 300 wing. There had been several unidentified residents who had passed by the vital sign machine. <p>Interview on 5/21/14 at 11:45 a.m. during an environmental walk through with the environmental services coordinator, administrator, and director of nursing (DON) confirmed the above findings. They agreed the</p>	F 323		

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F 323	Continued From page 4 chemicals should have been stored in a secured/locked area and not with resident's personal care items. Review of the provider's undated Safe Storage of Cleaning Chemicals policy revealed "All chemicals should be locked up when not in direct sight of employee." 2. Interview on 5/20/14 at 2:50 p.m. with certified nursing assistant B revealed she: *Was one of the bath aides. *Had shaved the womens' faces with a straight edged razor. *Had disposed of the razor into the garbage can after shaving them. *Had realized that was an inappropriate procedure. *Confirmed the razors should have been disposed of in a sharps container (enclosed container for used syringes with needles or sharp devices). Interview on 5/20/14 at 11:50 a.m. with the DON confirmed the disposable razors should have been placed inside a sharps container for destruction.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F371 1. All perished, non-dated, unlabeled foods were removed from the resident use refrigerator on 5/21/14. Staff identified C & D were re-educated to not handle food with bare hands. 2. Resident use refrigerators in individual rooms as well as facility resident use refrigerators were	

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F 371	Continued From page 5 This REQUIREMENT is not met as evidenced by: Surveyor: 12218 Based on observation and interview, the provider failed to: *Have a food expiration date system in place to ensure the safety of food stored in the resident use refrigerator in the dining room. *Ensure staff that assisted residents to eat did not touch ready-to-eat food with their bare hands. Findings include: 1. Observation on 5/20/14 at 4:45 p.m. of the resident use refrigerator in the dining room revealed the following unlabeled or outdated resident's personal food items had been saved to be eaten at a later date: *A covered plastic container with resident 9's name was written in ink on the lid, but no date was written in ink. When the container was opened it revealed a slice of carrot cake and a serving of cheesecake. The cheesecake was very moldy. *A white styrofoam container with resident 17's name written on it but no date. When the container was opened it revealed two chicken strips and a dinner roll. *A larger covered plastic container with resident 5's name written on it and the date of 5/16. That would be four days it had been in the refrigerator. It was not labeled as to what it was. When the lid was opened, it contained a large amount of what appeared to be chicken noodle casserole. Observation at the above time of the poster taped to the refrigerator revealed the following	F 371	checked to ensure items were labeled with contents, dated and within defined usage date. 3. Dietary Manager will review/revise procedure for storage of resident food items and educate Dietary, Community Life and Nursing staff to the procedure on 6-19-2014. Dietary Manager/designee will re-educate Community Life and Nursing staff on 6-19-2014 to proper food handling including no handling food with bare hands but to use utensils or gloves if necessary to handle food. 4. Dietary Manager/designee will audit resident use refrigerators for proper food storage four times per week for one month and then three times per week for two months. Audits will include visual check for items to be labeled with contents, dated and removal of any food items that had reached their expiration date. Dietary Manager/designee will audit meal service, for proper food handling at various meals four times per week for one month and then three times per week for two months. The Dietary Manager/designee will present data collected to the Quality Improvement Quality Assurance meeting for further	6-19-14

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F 371	<p>Continued From page 6</p> <p>instructions:</p> <ul style="list-style-type: none"> *Personal resident food items placed in this refrigerator MUST contain the following: <ul style="list-style-type: none"> -1. Resident's name. -2. Date it was placed there. *All food items must not exceed the expiration date. *The kitchen staff will dispose of any perishable items that are deemed unsafe for use or outdated due to Federal guidelines. *Signed by the food service director. <p>Interview with the dietary manager (food service director) on 5/20/14 at 5:00 p.m. and a re-examination of each container revealed:</p> <ul style="list-style-type: none"> *She was shocked there was any food in the resident use refrigerator that was old enough to have mold. *She checked resident 9's container and found a date of 4/20 scratched on the lid but not in ink. *She stated any food brought in and saved in that refrigerator were supposed to have been given to either the charge nurse or the kitchen staff for labeling and dating. *Her staff that delivered snacks to that refrigerator was supposed to have checked the food items in the refrigerator. *She had not assigned any specific position to be responsible to check the food items. *She had not assigned how often each day that refrigerator should have been checked for resident's food items. *She had not been in the habit of checking that refrigerator herself. *She did not have a definite system in place for: <ul style="list-style-type: none"> -Who checked the food items in that refrigerator and how often. -Who the food items were to be given to before they had been placed in the refrigerator. 	F 371	<p>recommendations regarding system changes and continued monitoring.</p>	

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F 371	<p>Continued From page 7</p> <p>-How the food was labeled when placed in the refrigerator.</p> <p>-How long the food was kept and was labeled with an expiration date.</p> <p>*She stated any cooked leftovers were not to be kept longer than three days.</p> <p>Review of the undated policy for Food From Outside Sources revealed: *Policy: "Food from outside sources is discouraged due to problems with food safety and infection control, as well as control of therapeutic diet orders." *Procedure: "All food brought in is checked by the charge nurse or the food service manager. It must be placed in a plastic ontainer with tight fitting lid. It is recommended that only enough food be brought in for that visit." *Procedure: "Food brought in should be labeled with the individual's name and dated if it must be stored."</p> <p>Surveyor: 32355 2. Observation on 5/20/14 at 11:45 a.m. of activity assistant C revealed: *She had been assisting resident 16 with his meal. *He had a sandwich on his plate. *He had been unable to pick up the sandwich on his own. *She had picked up the sandwich multiple times to assist him to take a bite. *She had not been wearing gloves when handling his sandwich.</p> <p>Interview on 5/21/14 at 11:00 a.m. with activity assistant C confirmed she should not have touched the sandwich with her bare hands. She</p>	F 371		

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F 371	Continued From page 8 should have worn gloves or retrieved a knife to cut the sandwich into pieces. Surveyor: 22452 3. Observation on 5/20/14 at 12:10 p.m. of CNA D revealed she: *Took a sandwich out of a baggie with her bare hands and put it on resident 14's place mat. *Picked up the sandwich off of the place mat with her bare hands and put it on a paper plate. Interview at that time with CNA D revealed she should have had gloves on before she handled the sandwich.	F 371		
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	F 441	F441 1. Employees identified as A, B, F and E were re-educated to the identified infection control practice. Outdated treatment supplies and the biohazard containers were removed from the clean medical supplies room. 2. Policies and procedures related to handwashing, gloving, storage of clean linen, disinfection of tub, residents bathed with indwelling catheters, carrying of clean linens, sorting and handling or soiled linen, contact time for disinfectant use in bathrooms, storage of biohazard containers, washing machine temperature and use of bleach were reviewed/revised. VSS, the company that provides laundry chemicals provided clarification of the current chemicals and how to dispense on 6-9-14. Adjustments to	

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F 441	<p>Continued From page 9</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if 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 education and processes were in place for: *The handling and delivering of clean linens to the bathing room by one of one laundry aide (A). *Separating of soiled linens by one of one laundry aide (A). *The washing of linens in one of three washing machines by one of one laundry aide (A). *Disinfecting of a whirlpool bathing tub by one of one certified nursing assistants (CNA) (B). *Bathing of all residents with a catheter (tube inserted into the bladder to assist with draining) by one of one CNA (B). *Glove use and sanitizing between the residents' rooms by one of one housekeeper (E). *The use of a disinfectant per manufacturer's recommendations by one of one housekeeper (E). *Disposing of multiple treatment supplies in one of one medical supply room.</p>	F 441	<p>add appropriate chemicals to all wash cycles were made 6/9/14.</p> <p>3. Environmental Services Director will re-educate all laundry staff and DNS will educate nursing staff to revised policies and procedures for the identified areas in number two by 6-19-2014.</p> <p>4. Environmental Services Director/designee will audit each identified area for compliance three time per week for one month and then two times per week for two months. Environmental Services Director/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring.</p>	6-19-14

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F 441	<p>Continued From page 10</p> <p>*The storage for two of two biohazardous waste containers located in the medical supply room.</p> <p>*The storage of clean linens underneath a sink in one of two kitchen nook areas in the dining room. Findings include:</p> <p>1. Observation on 5/20/14 at 2:20 p.m. of laundry aide A revealed: *She had been pushing a cart into the bathing room on 300 wing. *The cart had contained multiple clean linens. *She had removed multiple clean towels from the cart. *She held those clean towels next to her chest and abdomen while opening a cupboard in the bathing room. *She laid those towels on a shelf inside of the cupboard.</p> <p>Interview on 5/20/14 at the time of the observation with laundry aide A revealed the towels would have been used for all residents taking a bath.</p> <p>Interview on 5/21/14 at 11:45 a.m. with the director of nursing (DON)/infection control nurse confirmed the laundry aide should not have held the clean towels next to her body. That process had soiled the linens.</p> <p>2. Interview on 5/21/14 at 10:10 a.m. with laundry aide A regarding the separating of soiled linens revealed: *After she had retrieved all the soiled linens from the three wings she would have separated them into bins. *She would not have used gloves while retrieving the soiled linens or while sorting them.</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD 57438	
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F 441	<p>Continued From page 11</p> <p>Interview on 5/21/14 at 11:48 a.m. with the DON/infection control nurse confirmed the laundry aide should have worn gloves when retrieving and sorting of soiled linens.</p> <p>The provider's January 2010 Linen Handling policy and procedure had not mentioned glove use with soiled linens nor with delivery of clean linens.</p> <p>3. Observation on 5/21/14 at 10:15 a.m. of the laundry room revealed: *Two commercial and one regular washers. *There had been two buttons located next to the regular washer. *One button had been labeled detergent and the other bleach.</p> <p>Interview on 5/21/14 at the time of the above observation with laundry aide A revealed: *The regular washer had been used to wash housekeeping and dietary linens and residents' linens exposed to infectious diseases. *She would have pushed the buttons located next to the washer for the detergent and bleach to be added to the wash water. *She had no knowledge of whether she needed to add bleach to the water or not. *She had no knowledge of the temperature of the water going into the washer. *She would not have used the bleach on the housekeeping linens as they already contained chemicals. *She would not have used the bleach on the residents' linens if they were colored.</p> <p>Interview on 5/21/14 at 11:50 a.m. with the DON/infection control nurse, administrator, and environmental services coordinator revealed:</p>	F 441		

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F 441	<p>Continued From page 12</p> <p>*They confirmed the washer had been used for dietary, housekeeping, and infectious disease linens.</p> <p>*They would have expected bleach to be added to all the linens during washing.</p> <p>*The water going into the regular washer was on the same system as the kitchen water.</p> <p>*The regular washer water temperature had not been tested seperately from the kitchen water.</p> <p>Review of the daily maintenance logs for April 2014 revealed the kitchen water temperature had been between 150 to 168 degrees Fahrenheit (F). The temperature had been over 160 degrees F ten times in a thirty day window of time.</p> <p>Review of the provider's undated Linen Laundry Temps and Germicidal Agents policy and procedure revealed: **"Purpose to destroy microorganisms in the laundry supply." **"Procedure for linen laundering temperatures is set above 160 degrees F for a 25 minute wash." *Water temperatures were to have been set between 71 and 77 degrees F when using bleach.</p> <p>4. Observation on 5/20/14 at 2:40 p.m. of certified nursing assistant (CNA) B revealed: *She had been preparing to disinfect the whirlpool tub after bathing a resident. *She had not been wearing gloves. *With those ungloved hands she had: -Removed the the gel cushion from the whirlpool chair and placed it inside of the whirlpool tub for disinfecting. -Grabbed the handle on the whirlpool tub door and closed it. -Turned on several knobs to add the disinfectant and water to the tub.</p>	F 441		

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F 441	<p>Continued From page 13</p> <p>-Retrieved a large handled brush and scrubbed the interior of the whirlpool tub and chair. *She had not washed her hands after the above process. *With unwashed hands she had opened a clean linen cart containing residents' clothing.</p> <p>Interview on 5/20/14 at the time of the above observation with CNA B she confirmed she: *Should have worn gloves during the disinfecting process of the whirlpool tub. *Should have washed her hands prior to opening the clean linen cart. *She would not have always worn gloves during the disinfecting process of the tub. *The gloves and chemicals had caused irritation to her hands.</p> <p>Interview on 5/21/14 at 11:55 a.m. with the DON/infection control nurse revealed: *She had recently reviewed the whirlpool tub disinfecting process with the above CNA. *She would have expected CNA B to wear gloves. *She would have expected CNA B to wash her hands when done disinfecting the whirlpool tub.</p> <p>Review of the provider's undated manufacturer's recommendations for the whirlpool tub disinfecting process had not mentioned glove use. No other policy or procedure had been available from the provider.</p> <p>Surveyor: 34030 Preceptor: 32355 5. Interview on 5/20/14 at 2:24 p.m. with CNA B revealed she: *Bathed residents with a Foley (urine) catheter submerged in a whirlpool tub. *Clamped the catheter tubing, so that it was</p>	F 441		

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F 441	<p>Continued From page 14</p> <p>closed off from the collection bag, then covered the collection bag with a plastic bag. She then hung it over the edge of the tub. *Had been taught that was an acceptable practice.</p> <p>Observation and interview on 5/21/14 at 10:00 a.m. with CNA F revealed she: *Had resident 1 who had a Foley catheter in the whirlpool tub. *Stated "I'm just going to give her a shower this time. Isn't that what you told us we should do?" *Normally had been giving resident 1 a submerged bath once a week.</p> <p>Interview on 5/21/14 at 12:00 noon with the DON revealed: *She agreed proper bathing technique had not been followed. *No policy or procedure existed for this.</p> <p>6. Interview on 5/21/14 at 11:00 a.m. with housekeeping aide E revealed: *She had used a disinfectant to spray on all of the surfaces in the resident's bathrooms. *The disinfectant she had used was Bath Mate Acid-free washroom cleaner. *She would not have allowed the disinfectant to stay on the surfaces for any length of time. *She had worn gloves for the cleaning of all the residents' rooms. *She would not have changed her gloves until after she had cleaned "A few rooms." *She would not have sanitized or washed her hands when she had changed her gloves.</p> <p>Interview on 5/21/14 at 12:05 p.m. with the DON/infection control nurse, administrator, and environmental services coordinator revealed:</p>	F 441		

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F 441	<p>Continued From page 15</p> <p>*They had not been aware housekeeping aide E had not been allowing contact time for the disinfectant on all bathroom surfaces.</p> <p>*They had not been aware housekeeping aide E had not been changing her gloves and washing/sanitizing her hands between the cleaning of the residents' rooms.</p> <p>*Confirmed sanitary precautions had been broken, and there was potential for cross-contamination for any residents after the disinfecting and cleaning of their rooms.</p> <p>*The DON/infection control nurse had no audits available for the monitoring of the housekeeping department and the cleaning of the residents' rooms.</p> <p>Review of the Bath Mate Acid-free washroom cleaner manufacturer's recommendations revealed the disinfectant should have remained on all surfaces for five to ten minutes.</p> <p>Review of the provider's December 2011 Procedure for Handwashing revealed no process in place for the housekeeping department.</p> <p>7. Observation on 5/20/14 at 1:45 p.m. of the clean medical supply room revealed: *Multiple treatment supplies was located inside of the cupboards. *There had been outdated treatment supplies in the cupboards. Those supplies had been: -Multiple boxes of abdominal gauze pad dressings dated 12/9/12. -Eight Allevyn (dressing for wounds) adhesive dated 2012. -One box of cotton tipped applicators dated August 2013. -Two full boxes of DuoDerm (dressing for wounds) dated October 2012.</p>	F 441		

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F 441	<p>Continued From page 16</p> <p>-One box of four by four gauze dressings dated November 2013.</p> <p>*Two large cardboard boxes with red biohazardous bags inside of the them. One of the boxes contained multiple containers for biohazard sharps (for used needles, lancets, and razors) wastes. Those containers had been full of sharps and were waiting for destruction.</p> <p>Interview on 5/21/14 at 12:10 p.m. with the DON/infection control nurse revealed: *The DON had not been aware of the outdated treatment supplies. *She had assigned two CNAs to clean the room and check for outdated supplies. *There was not a scheduled time for when the CNAs were to have cleaned the medical supply room. *She had not been aware the biohazardous containers should not have been located in the clean medical supply room. *She had agreed the biohazardous containers needed to be moved to a different area.</p> <p>8. Observation on 5/20/14 at 10:40 a.m. in the dining room revealed a kitchen area with a sink. Underneath the sink were multiple clean towels.</p> <p>Interview on 5/21/14 at 12:15 p.m. with the DON/infection control nurse revealed she had not been aware the towels were being stored under the sink. She agreed the towels should not have been stored underneath the sink and had been a potential for cross-contamination.</p> <p>Review of the provider's January 2010 Infection Preventionist job description revealed: **"Consults on infection risk assessment, prevention, and control strategies including</p>	F 441		

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F 441	Continued From page 17 transmission based precautions and isolation." **Implements evidence-based infection prevention and control practices including those mandated by regulatory and licensing agencies and guidelines from the Centers for Disease Control and Prevention." **An essential element of the Facility Infection Control Program is the development and revision of written Policies and Procedures. The policies represent the foundation of the program and they must conform to current standards of practice and/or address specific facility concerns." Surveyor: 34030	F 441		

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ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435084	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/20/2014
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/20/14. Faulkton Senior Living (Building 01) 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 deficiencies identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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: 32334 Based on document review, observation, and interview, the provider failed to maintain the automatic sprinkler system in reliable operating condition in two randomly observed locations (sprinkler riser and dishwash area). Findings include: 1. Document review on 5/20/14 of the automatic fire sprinkler system inspection reports revealed a comment in regards to issues with that sprinkler system. The inspection performed by Western	K 062	K062 Quote to repair the identified malfunctioning valve and sprinkler head was received on 6-4-14. The work will be scheduled and completed by Western States Fire Protection. Environmental Services Director will report outcome and any recommendations to Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring.	7-10-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Executive Director

(X6) DATE

6/18/14

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.

JUN 30 2014

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K 062	<p>Continued From page 1</p> <p>States Fire Protection revealed a malfunctioning 4 inch valve on the system riser when trying to test the back flow preventer. A comment was made on the report indicating that valve should be replaced. Interview with the maintenance supervisor during document review revealed that valve had not been replaced.</p> <p>2. Observation at 2:45 p.m. on 4/29/14 revealed a dishwasher area in the kitchen. Further observation revealed heavy corrosion on one randomly observed sprinkler head in that dishwasher area. Interview with the maintenance supervisor at the time of the observation confirmed that condition.</p> <p>This deficiency has the potential to affect six of six smoke compartments.</p>	K 062			

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10619	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL STREET FAULKTON, SD 57438
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S 000	Initial Comments Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/20/14 through 5/21/14. Faulkton Senior Living was found not in compliance with the following requirements S166 and S206.	S 000	Addendums noted with an asterisk per 07/07/14 telephone to facility administrator. KR/SDDH/IME	
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	S166 The front entrance door will be locked at all times beginning on 6-20-14. The change will be updated in the Environmental daily checks. The Administrator will report to the Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring. * Staff were educated on door alarms at the mandatory all staff meeting on 6/19/14. KR/SDDH/IME * Environmental services does a walk-through 3 times a week checking door alarms for 3 weeks and then weekly for one month. Environmental services will report to QA. KR/SDDH/IME	6-20-14

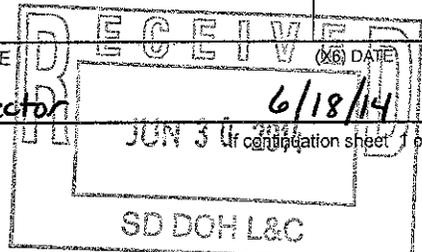
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

BNZ

Executive Director

6/18/14



SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 166	Continued From Page 1 (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. This Rule is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure the main entrance/exit door had an activated audible alarm or was attended at all times. Findings include: 1. Random observations and testings on 5/20/14 through 5/21/14 of the main entrance/exit door revealed: *From 8:00 a.m. through 5:30 p.m. the alarm had not been activated. *The door had been unattended. *There had been several unidentified residents independently walking past the door. Interview on 5/20/14 at 10:53 a.m. with the administrator 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 sometime during the evening and through the night.	S 166		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 166	<p>Continued From Page 2</p> <p>*She had not been able to provide a specific time frame for the above.</p> <p>*They had a Wanderguard alarm system that would have activated the alarm. Not all residents wore a Wanderguard bracelet.</p> <p>*Any resident who had been determined as an elopement risk by the provider would have been wearing a Wanderguard bracelet.</p> <p>*Any resident who had not been an elopement risk and did not wear a Wanderguard bracelet were held responsible by the provider to sign themselves out upon going outside. Those residents had not always remembered to sign themselves out.</p> <p>*The main entrance/exit door was not monitored at all times.</p> <p>*The staff were to have frequently monitored the main entrance/exit door during the hours upon inactivation of the alarm.</p> <p>Review of the provider's undated Door Alarm System policy and procedure revealed: **Guidelines: All doors will have a door alarm system with an electrically activated audible alarm on all unattended exit doors. Other exterior doors will be locked or alarmed." **Alarms will be armed at all times with the following exception: Main entrance doors where family and visitors enter the facility during the busy daytime hours may be disarmed provided all of the following are met: there is reasonable expectation that staff can frequently monitor the door during hours of disarmament." **The front door will be unlocked during daytime hours Monday-Sunday during daytime hours. There will still be an active alarm for residents at risk for elopement. Once the door is locked all visitors will need to enter using a doorbell system." **Times of disarmament may be adjusted according to staffing levels, shift changes,</p>	S 166		

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10619	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL STREET FAULKTON, SD 57438
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S 166	Continued From Page 3 seasons, change in weather, or ect."	S 166		
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs. This Rule is not met as evidenced by: Surveyor: 12218 Based on record review and interview, the provider failed to ensure the annual required in-service training sessions for dining assistance, nutritional risks, and hydration needs of the residents had been offered to all the staff. Findings include:	S 206	S206 Contracted Dietician will provide inservice on necessary topics on 6/19/14. This training will be added to the annual training schedule and will be provided by the Dietician or Dietary Manager. Dietary Manager will report to Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring.	6/19/14

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S 206	<p>Continued From Page 4</p> <p>1. Review of the annual required in-service agendas for 2013 revealed: *Dining assistance, nutritional risks, and hydration of residents had not been presented. *Dining assistance included observation and awareness of resident eating requirements, assistance with encouragement, substitutions to be offered, feeding precautions to prevent choking and swallowing difficulties, types of fluids to use to prevent choking, changes in eating abilities and time requirements, necessity of encouraging residents to feed themselves or assist in feeding, social atmosphere of the dining room, room trays, and reheating of foods. *Nutritional risks usually included dangers of weight loss and weight gain, risks of nutrient deficiency, awareness of diet requirements such as dysphagia (difficulty in swallowing), diabetic, protein, lactose (allergy to dairy products), gluten (allergy to foods containing oats, wheat, barley and rye grains), fluid restrictions, nutrient requirements, poor eating habits, and importance of meal/food consumption records, and awareness of the residents at nutritional risk. *Hydration included prevention of dehydration, fluid requirements, foods high in liquids, ways to get the resident to drink more fluids, signs and symptoms of dehydration, medications causing loss of fluids or constipation, and environmental influences.</p> <p>Interview on 5/21/14 at 11:15 a.m. with the certified dietary manager and at 2:30 p.m. with the director of nursing confirmed: *The in-service had not been included in their annual required staff in-services. *They were unaware of the above requirement for nutrition and dining assistance. *They had a list of in-services outlined that had been given, but it did not include the above</p>	S 206		

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S 206	Continued From Page 5 requirements.	S 206		