

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
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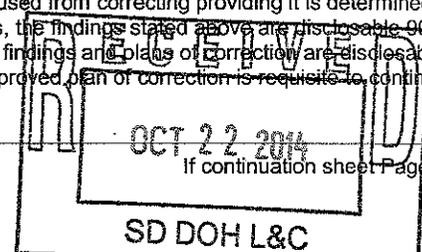
NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543
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F 000	<p><i>Addendums noted with an asterisk per 10/28/14 telephone to facility Chief operating officer. LA/SSA HBJ</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/30/14 through 10/1/14. Kadoka Nursing Home was found not in compliance with the following requirement(s): F323, F329, F371, F428, F441, and F520.</p>	F 000	F323 A mandatory in-service was held on Friday, Oct 17, 2014 at 0930 on the use of restraints and the facility policy and procedure on the use of restraints. The in-service was given by the DON and ADON. Use of grab bars and side rails was addressed and staff were educated on prevention of injury and potential risks of all residents.	
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> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, record review, and interview, the provider failed to ensure grab/positioning bars had been used in a safe manner to prevent potential injury for two of two sampled residents (8 and 11). Findings include:</p> <p>1. Observation on 9/30/14 at 12:15 p.m. through 10/01/14 at 4:00 p.m. revealed resident 8 and 11's beds had grab/positioning bars attached to them. Those grab/positioning bars had been at the head of the bed on both sides of the beds.</p> <p>a. Review of resident 8's complete medical record revealed she: *Had been admitted on 6/24/11.</p>	F 323	<p>The facility has removed the grab bars from the beds of resident 8 and 11. The ADON will initiate a monitoring tool to ensure the appropriate use of grab bars and care plan according to need with all residents that would benefit from a grab bar. A written tool assessment form will be used for all residents in the future that have a need for the use of grab bars/side rails and will be included on the care plan. The ADON will monitor for any requests, needs, tool initiation, and appropriate use weekly for 1 month, then monthly for 3 months, then quarterly at each resident's care plan review. The ADON will report the monitoring to the quarterly QI meetings on a quarterly basis until 100% compliance is achieved.</p>	<p>* [Redacted]</p> <p>LA/SSA HBJ</p> <p>10/22/14</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>CEO/ADMIN.</i>	(X6) DATE <i>10/22/14</i>
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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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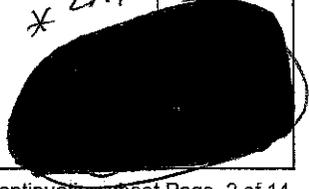
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F 323	<p>Continued From page 1</p> <p>*Had a diagnosis of dementia.</p> <p>*Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 8's updated 9/8/14 care plan revealed no mention of the use of the grab/positioning bar.</p> <p>b. Review of resident 11's complete medical record revealed she:</p> <p>*Had been admitted on 10/7/08.</p> <p>*Had a diagnosis of Alzheimer's disease (mental deterioration).</p> <p>*Had a history of falls.</p> <p>*Had no assessment for the use of the grab/positioning bar.</p> <p>Review of resident 11's revised 4/9/14 care plan revealed no mention of the use of grab/positioning bars.</p> <p>c. Interview on 10/1/14 at 10:10 a.m. with the administrator and the director of nursing confirmed safety assessments had not been completed for resident's 8 and 11. They confirmed the grab/positioning bars had not been care planned for either resident.</p> <p>A policy for care planning had been requested on 10/1/14 at 2:30 p.m. It had not been received by 10/1/14 at 4:00 p.m. when the survey ended.</p>	F 323		
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or</p>	F 329		

* LA / 150024 / JJ



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F 329	<p>Continued From page 2</p> <p>without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure a gradual dose reduction had occurred and medications had been reviewed after a fall for one of five sampled residents (1). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She had been admitted on 1/9/13. *She had the following diagnoses: -Vertigo (dizziness). -Hypertension (high blood pressure). -Coronary artery disease (reduced blood flow through the heart).</p>	F 329	<p>F329 Drug regimen is free from unnecessary drugs.</p> <p>The DON will contact the primary care provider to address Ambien and Zoloft referring to increased falls for resident 1 by October 3, 2014.</p> <p>The Ambien on Resident 1 has been reduced in half to 2.5 mgs hs on 10/3/2014 and we have asked the primary care provider to consider reducing Zoloft.</p> <p>The DON will continue to meet with Pharmacist for chart reviews on all residents on a monthly basis and fax the primary care provider the recommendations.</p> <p>The DON will keep a calendar to start tracking residents on any antipsychotic drugs, hypnotics, and antidepressants. The DON and Pharmacist will review the resident's medications every 6 months with the primary care provider to evaluate resident's use so no drug is used unnecessarily. The DON and Pharmacist will watch for excessive dose or excessive duration.</p> <p>The DON and Pharmacist will monitor resident's on any antipsychotic drugs, hypnotics, or antidepressants for side effects that would have a negative effect and could harm the resident in any way.</p>	

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10/1/14

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F 329	<p>Continued From page 3</p> <ul style="list-style-type: none"> -Atrial fibrillation (irregular heart beat). -Insomnia (unable to sleep). -Trans-ischemic attacks (mini-strokes). -Dementia (mental deterioration). -Frequent falls. -Depression. <p>*Review of the physician's order she had been taking Ambien (medication for sleep) 5 milligrams (mg) every night since admission. On 7/3/14 she had been started on Zoloft (antidepressant medication) 25mg every day for depression. She had five falls had occurred after the starting of the Zoloft. The medical record indicated falls had occurred on these days: -- 7/18/14, 7/31/14, 8/4/14, 8/19/14, and 9/11/14.</p> <p>*There had been no physician documentation to support the continued use of Ambien and Zoloft.</p> <p>Review of resident 1's 9/8/14 updated care plan revealed a problem area of at risk for falls because of history of falls and vertigo. There was an intervention of "Monitor effectiveness of psychotropics [mood altering medications] in relation to falls and report to MD."</p> <p>Review of the consulting pharmacist Monthly Drug Regimen Review record revealed on 7/23/13 the documentation "Suggest zolpidem on prn [as needed] rather than scheduled." From August 2013 through September 2014 the consulting pharmacist had documented "No recommendations."</p> <p>Review of American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults: The American Geriatrics Society 2012 Beers Criteria Update</p>	F 329	<p>An In-service meeting was held on 10/17/2014 with the DON, Pharmacy consultant, and nursing staff to review and revise the policy and procedure about medication review and drug regimen review.</p> <p>This will be monitored one time a week for 2 months and one time per month until 100% compliance and will be brought to quarterly Q.A. by the D.O.N.</p>		

* [Redacted Signature] 2A (Sedoth JJ)

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F 329	<p>Continued From page 4</p> <p>Expert Panel from The American Geriatrics Society, New York, 2012, DOI: 10.1111/j.1532-5415.2012.03923.x, revealed: **"Medication-related problems are common, costly, and often preventable in older adults and lead to poor outcomes." *Table 3 in that report indicated older adults were at risk when taking Zolofl and had history of falls. -The rationale for not using that medication was it produced ataxia (uncoordinated muscular movements), syncope (fainting), and additional falls. -The recommendation had been listed as "strong (benefits clearly outweigh risks and burden OR risks and burden clearly outweigh benefits.)"</p> <p>Review of Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., Lexi-Comp, Ohio, 2011, revealed: *Page 1622: side effects for Zolofl were dizziness, fatigue, headache, and insomnia. *Page 1903: side effects for Ambien were dizziness, disorientation, drowsiness, fatigue, and sleep disorders.</p> <p>Interview on 10/1/14 at 2:07 p.m. with the director of nursing and the assistant director of nursing confirmed they had not looked at the medications after residents' falls.</p> <p>Review of the provider's 7/1/14 Pharmacy Review Policy revealed it had not indicated when a gradual dose reduction would occur.</p> <p>Review of the provider's 5/29/14 reviewed Falls Assessment and Follow up Documentation policy revealed it had not indicated a review of recently taken medications after a fall.</p>	F 329		

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F 371 F 371 SS=D	Continued From page 5 483.35(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 This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure food was prepared in a clean and sanitary environment in the kitchen during two of two observed meals by one of one cook (A). Findings include: 1. Observation on 9/30/14 at 5:15 p.m. in the kitchen revealed: *The fluorescent lights above the food preparation area had visible greasy lint along the top edges of the bulbs next to the ceiling. *The cupboard doors had been visibly soiled with a sticky dark deposit around and on the handles of the cupboard doors. *The refrigerator doors had been soiled with a film of sticky residue mainly around and on the handles of the doors. *An electric roaster pan stored on a cart between two refrigerators had spatters of a dried tan substance on the outside surface. *The two floor fans and the ceiling fan all had been visibly soiled with lint and a film of dirt/dust.	F 371 F 371	F-371 The fluorescent light in the preparation area, the cupboard doors, refrigerator doors, electric roaster, fans, shelves in the store room have all been cleaned and will be on the cleaning list for staff to clean. A policy has been developed for cleaning of these items and will be monitored by the dietary manager. Cleaning of the store room shelves will be monitored 1 time per month for 6 months or until 100% compliance. Cleaning of the stored roaster will be monitored 2 times per month then 1 time a month until 100% compliance. The cleaning of the cupboards will be monitored 2 times per month for 8 months then 1 time per month until 100% compliance. The cleaning of the refrigerator doors will be monitored 2 times a month for 6 months then 1 time per month until 100% compliance. The cleaning of the light fixtures will be monitored 2 times per month then 1 time per month until 100% compliance.		

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F 371	<p>Continued From page 6</p> <p>-It could be scraped off with a fingernail.</p> <p>*The shelves in the store room were painted wooden open shelving units.</p> <p>-Closed food items had been stored on those shelves including canned goods, boxed and bagged items.</p> <p>-The bottom shelves had a moderate amount of brushable dirt and lint on them and the items stored on those shelves.</p> <p>Interview on 10/1/14 at 10:30 a.m. with the dietary manager confirmed:</p> <p>*The above areas had visible lint and grime that had needed to be cleaned.</p> <p>*The roaster had been put away without cleaning the outside of it.</p> <p>*The fans might have to be replaced if they could not be gotten clean, as they had been cleaned about a week ago.</p> <p>*The dietary staff needed to do a better job of cleaning the surfaces in the kitchen.</p> <p>Review of the provider's policies listed below that had been received from the assistant director of nursing revealed:</p> <p>*The undated fan cleaning policy had stated the purpose was to maintain a sanitary environment in the kitchen.</p> <p>*The 7/22/04 refrigerator cleaning policy revealed it had not addressed the cleaning of the outside of the appliance.</p> <p>*None of the supplied policies had addressed the cleaning of the overhead lights and bulbs, the roaster, the cupboard doors, or the store room shelves.</p> <p>2. Observation on 9/30/14 at 5:15 p.m. in the kitchen during the supper meal service revealed cook A:</p>	F 371	<p>These will all be monitored by the DM and findings brought to the quarterly Q.A. team. A policy on wearing of aprons has been implemented and the DM will monitor the employee apron use for 2 times per week for 6 months then 1 time a month until 100% compliance and findings brought to the Q.A. Team by the DM.</p>		

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F 371	Continued From page 7 *Had been wearing gloves on her hands while she had served unwrapped ready-to-eat saltine crackers from the package sleeve onto the residents' plates. *Had been wearing a visibly soiled tee shirt and no apron over that shirt. *Had wiped her gloves on her soiled tee shirt and continued to serve the crackers without changing her gloves or washing her hands. *Had contaminated her gloves when she had wiped them on her soiled tee shirt. Interview on 10/1/14 at 10:30 a.m. with the dietary manager confirmed: *She agreed cook A's shirt had been soiled, and she should have been wearing an apron. *The gloves had been contaminated when she had wiped them on her soiled tee shirt. Review of the provider's undated Hand Hygiene and Glove use in the Kitchen and Handwashing policy revealed: *Hands were considered contaminated if they had touched an article of clothing. *If gloves became contaminated they had needed to be changed and hands washed.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F428 Drug Regimen Review, Report Irregular, Act on The drug regimen will continue to be reviewed by the Pharmacist and DON on a monthly basis. The DON will fax any recommendations that the Pharmacist has to the Primary Care Provider. The DON will keep a calendar to start tracking residents on any antipsychotic drugs, hypnotics, and antidepressants. The Pharmacist and DON will review the resident's medications every 6 months with the primary care provider to evaluate resident's use so no drug is used unnecessarily. We will watch for excessive dose or excessive duration. An In-service meeting was held on 10/17/2014 with the DON, Pharmacy consultant, and nursing staff to review and revise the policy and procedure about medication review and drug regimen review. The D.O.N. will monitor the pharmacist recommendation 1 each month for 3 months or until 100% compliance and will report to the quarterly Q.A team quarterly	

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F 428	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider's consultant pharmacist failed to make recommendations for gradual dose reduction and address the rationale for the medications for one of ten sampled residents (1). Findings include: 1. Review of resident 1's monthly pharmacy consultant drug regimen review reports from July 2013 through September 2014 revealed: *On 7/23/13 "Suggest zolpidem (Ambien) on prn [as needed] rather than scheduled." *After 7/23/13 the consulting pharmacist had documented "No recommendations." *There had not been documentation if medications had been caused the increased resident falls.	F 428			
F 441 SS=E	Refer to F329, finding 1. 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	F 441	F441 A Mandatory in-service was held on Friday, Oct 17, 2014 at 1000 on the policy and procedure of disinfection of the whirlpool tub in normal working order and when the disinfectant wand is out of working order, and the proper cleaning and storage of nail clippers. Education of staff responsibility was addressed and deficiencies were discussed. The policy "Cleaning of Resident Whirlpool Tub/Shower" was reviewed, rewritten, and initiated on 10/1/2014. * [REDACTED] LA/SD00H/JJ Education for instructions of use with and without the dis-infecting wand has been provided and demonstrated to nurses and CNAs that give baths. * [REDACTED] LA/SD00H/JJ	11/20/17	

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F 441	<p>Continued From page 9 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</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: 32333 Based on observation, interview, record review, label review, and policy review, the provider failed to ensure: *There had been a procedure to disinfect one of one whirlpool tub and the whirlpool tub had been disinfected after each use by one of one observed certified nursing assistant (CNA) (B). *A multiple resident-use nail clipper that had been stored in the tub room had been cleaned</p>	F 441	<p>F441 Cont'd</p> <p>The ADON will initiate a monitoring tool by Oct 22, 2014 and monitor the disinfection of the whirlpool tub 3 random times per week for 1 month, then 1 random time weekly for 1 month, then monthly until 100% compliance is achieved. The ADON will report this at the quarterly QI meeting on a quarterly basis.</p> <p>The policy and procedure of the "Cleaning and Storage of Nail clippers" was reviewed. The nail clippers located in the locked cupboard were removed and cleaned per policy. Personal nail clippers were inventoried and purchased if unaccounted for all residents. All individual resident nail clippers will be labeled and stored for safe keeping by Oct. 22, 2014. Education has been provided to all staff that use resident nail clippers.</p>		

LA/ScooH/DJ

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543	
(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 10 appropriately after each use. *Maintain an effective infection control program to include goals and interventions. *Appropriate personal protective equipment had been worn by one of one staff member (C) in the laundry. Findings include:</p> <p>1. Observation and interview on 10/1/14 at 9:30 a.m. of CNA B while she cleaned the whirlpool tub revealed: *The hand sprayer that dispensed the disinfectant had not been working. *She used a spray bottle with Mastercare disinfectant to spray the surfaces of the tub. *After she sprayed the tub with the disinfectant she immediately filled the tub with "two gallons of water." *She then waited ten minutes to allow the appropriate time for disinfection. *She had diluted the disinfectant when she added the water to the tub.</p> <p>Review of the handwritten label on the spray bottle revealed Mastercare 0.5 ounces (oz) to 1 quart (qt) of water.</p> <p>Review of the Mastercare manufacturer's label revealed 2 oz of Mastercare to 1 gallon of water.</p> <p>Interview on 10/1/14 at 2:50 p.m. with the director of nursing revealed the whirlpool tub should have been disinfected after each resident use. The sprayer on the whirlpool tub had been broken for at least two weeks. They had no procedure to follow while the whirlpool tub had been broken.</p> <p>2. Review of the provider's July and August 2014 Medical Staff and Infection Control Report reports</p>	F 441	<p>The ADON will monitor 3 times weekly for 1 month the appropriate storage and random cleaning of resident nail clippers, then 1 time weekly for 1 month, then 1 time monthly until 100% compliance is achieved. The ADON will report this to the Quarterly QI meeting on a quarterly basis.</p> <p>F441 Cont'd The DON will initiate a tracking and trending method to effectively monitor the Infection Control Program by Oct 22, 2014. The DON will complete a monthly tracking and trending flowsheet and report on the Infection Control Program at the Quarterly QI meetings. The ADON will monitor the usage of the tracking and trending flowsheet monthly for 3 months, then quarterly until 100% compliance is achieved. This will be reported to the quarterly QI meetings on a quarterly basis.</p>	

* [Redacted Signature] LA/SDD/H/JS

* [Redacted Signature] LA/SDD/H/JS

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F 441	<p>Continued From page 11 revealed they had no documentation of the organisms that had caused the infections in the facility.</p> <p>Interview on 10/1/14 at 10:15 p.m. with the director of nursing (DON) and the assistant (A)DON regarding the infection control program revealed:</p> <ul style="list-style-type: none"> *They confirmed they had not been documenting the organisms in the infection control reports. *They were not tracking and trending the infections to determine the cause or to identify a pattern in infections. *They had not determined any interventions or goals regarding infections. *There were no documented monitoring tools to ensure staff had appropriate education regarding infection control. *They agreed the above listed items should have been included in their infection control program. <p>3. Observation on 10/1/14 at 10:00 a.m. in the tub room revealed:</p> <ul style="list-style-type: none"> *A locked cabinet with multiple residents' items inside of it. *A multiple resident-use nail clipper had been on the shelf. *Those nail clippers had skin and nail debris on them. <p>Interview on 10/1/14 at 2:50 p.m. with the DON and the ADON revealed the nail clipper should have been cleaned after each resident use. However staff should have been using the resident's own personal nail clippers.</p> <p>3. Interview on 9/30/14 at 3:50 p.m. with laundry staff personnel C revealed she:</p> <ul style="list-style-type: none"> *Did not wear a gown when she sorted soiled 	F 441	<p>F-441 Continued.</p> <p>An in-service was held with all housekeeping and laundry personnel on infection control. Discussed cleaning procedures and how to clean and do linen not to spread the infections with in the facility or to the outside. All laundry staff will wear gowns and gloves when sorting dirty linen and then will take off the gown and gloves and wash hands before handling clean linen. The wearing of gowns and gloves at appropriate time will be monitored 1 time a week for 2 months, then one time a month till 100% compliance. The head of housekeeping will monitor and will bring findings to the quarterly Q.A team meetings.</p>	

including laundry staff C. LA/SPOOH/BJ

** LA/SPOOH/BJ*

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F 441	Continued From page 12 laundry. *She did not have any gowns in the laundry room at that time. *She stated they did not have any gowns to wear to sort the soiled laundry, they only had gloves. Interview on 10/1/14 at 2:50 p.m. with the DON and the ADON revealed: *Laundry staff should have worn gowns when they had sorted the soiled laundry. *They did have gowns in a storage room in the facility. *Laundry staff person C had not liked to wear a gown.	F 441	F-520 The Administrator of PHS will make sure that the Medical Director or a physician will attend all quarterly Q.A. meeting held at the facility. The policy will be revised so that it can be the Medical Director or a Physician who will attend the meetings. The other member of the Q.A. committee will remain the same. The attendance of a physician will be monitored by the C.O.O. one time a quarter for one year. At this time we will be in 100% compliance.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		

(Handwritten signature and date)
11/20/14

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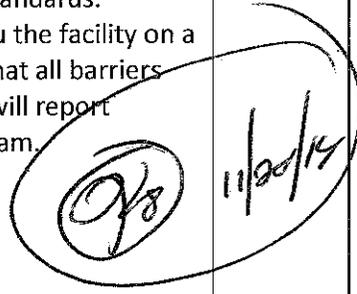
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/01/2014
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F 520	<p>Continued From page 13</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy review, the provider failed to ensure a physician or the medical director had attended the quality assurance (QA) meetings on a quarterly basis. Findings include:</p> <p>1. Interview and record review on 10/1/14 at 2:25 p.m. with the chief operating officer confirmed the medical director had not come to every QA meeting. They had met on a quarterly basis. She reviewed the log in sheets for the QA meetings for the past twelve months. He had only attended the January 2014 meeting and no others for those twelve months.</p> <p>Review of the provider's undated Quality Improvement policy revealed the medical director was one of the members of that program. It had stated the meetings would be quarterly or more frequent if a need had arisen sooner.</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543
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(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
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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 10/1/14. Kadoka Nursing Home 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 K025, K050, and K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 025 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the smoke tightness for one of one smoke barrier wall (near the nurses station). Findings include:	K 025	K-025 The smoke wall by the nurses station has been sealed with fire retardant caulk so as to maintain a smoke barrier. This was completed by the maintenance person on 10/13/2014. The halls and all barrier walls will be monitored by the maintenance person 1 time a month to be in compliance with Life Safety Code Standards. The C.O.O. will walk thru the facility on a quarterly basis to see that all barriers are in compliance and will report quarterly to the Q.A. team.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/ADMIN.	(X6) DATE 10/20/14
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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 30 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.

DISCLOSED
OCT 22 2014
If continuation sheet Page 1 of 4
SD DOH L&C

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K 050	Continued From page 2 what to do. She did not rescue the resident from the room. The nurse then returned and pulled the manual fire alarm pull station. The fire alarm summoned other nurses to respond to the scene, and they began closing all the corridor doors to contain the smoke and fire. A different nurse responded to the resident's room with a fire extinguisher. She tested the door for heat, opened the door, and discovered the resident had not yet been rescued. That nurse then relocated the resident to the opposite smoke compartment. The nurses confirmed the fire was extinguished, and a code red all clear was called over the paging system. Interview with the head of maintenance revealed that rescuing of residents was not a usual problem during fire drills. She believed the responding nurse was probably nervous due to the inspection.	K 050		
K 211 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	K-211 The ABHR station above the mercury thermostat near the nursing station and the ABHR in the conference room above a light switch have been relocated. The maintenance person has walked thru the facility and moved any ABHR stations that were installed over an ignition source. When new ABHR stations are installed the maintenance person will be aware of code pertaining to these stations and install them accordingly. This will be monitored by the C.O.O. monthly and brought to the quarterly Q.A. team.	

Handwritten signature and date 10/20/14

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K 211	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to properly install alcohol based hand rub (ABHR) containers at two randomly observed locations (near nurses station and in the conference room). Findings include: 1. Observation beginning at 10:30 a.m. to 1:00 p.m. on 10/1/14 revealed the provider utilized ABHR stations throughout the facility. Further observation when touring the facility revealed one randomly observed ABHR station that was installed above a mercury thermostat near the nurses station. ABHR stations should not be installed above or adjacent to an ignition source. Observation in the conference room revealed the same condition over a light switch. Interview with the head of maintenance at the time of the observations confirmed those findings. She revealed she was unaware of that requirement.	K 211		

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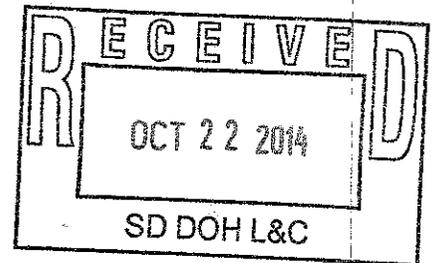
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/01/2014
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NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W KADOKA, SD 57543
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S 000	<p>Initial Comments</p> <p>Surveyor: 32572 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/30/14 through 10/1/14. Kadoka Nursing Home was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Yart Ron

TITLE

CEO/Admin.

(X6) DATE

11/20/14