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

ORIGINAL

PRINTED: 10/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	

(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: 16385 An initial Medicare health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/22/14 through 9/24/14. Aurora Brule Nursing Home was found not in compliance with the following requirements: F221, F431, and F441.	F 000	The preparation of the following plan of 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 on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the foregoing statement, the facility states that with respect to:	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, record review, interview, and policy review, the provider failed to ensure periodic assessments had been completed for one of one sampled resident (2) who had positioning bars on her bed. Findings include: 1. Observation on 9/22/14 at 3:45 p.m. revealed resident 2 was laying on her bed with two positioning bars up on both sides of the top half of her bed. Review of resident 2's medical record revealed: *No assessment had been completed for the use of the positioning bars. *There were no physician's order for those positioning bars. *The positioning bars had not been documented on her care plan.	F 221	Resident 2's medical record was reviewed to ensure proper physician involvement periodic assessments for the use of positioning bars had been completed so that the residents rights of being free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the residents medical symptoms were intact. All other residents medical records were reviewed to ensure that proper physician involvement and periodic assessments for the use of positioning bars had been completed so that the residents rights of being free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the residnets medical symptoms were intact.	10/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-14-14

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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OCT 16 2014
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

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F 221	Continued From page 1 Interview on 9/22/14 at 3:10 p.m. with licensed practical nurse (LPN) A regarding positioning bars on resident 2's bed revealed: *Positioning bars were not being assessed unless they were side rails. *No assessments were being done on positioning bars. *She was not aware all positioning bars needed to have been assessed. Interview on 9/22/14 at 3:30 p.m. with LPN A, registered nurse B, and the social services designee regarding positioning bars on resident 2's bed revealed no assessments were being done on positioning bars. Observation on 9/23/14 at 5:10 p.m. revealed resident 2 was laying on her bed with two positioning bars up on both sides of the top half of her bed. Interview on 9/23/14 at 5:45 p.m. with the director of nursing and the social services designee regarding positioning bars on resident 2's bed revealed: *They confirmed there was not an assessment completed on the positioning bars. *They agreed the positioning bars needed to have been assessed. Interview on 9/24/14 at 8:10 a.m. with certified nursing assistant/restorative care C regarding resident 2's positioning bars on her bed revealed: *The positioning bars had been put on the beds after she had returned from the hospital on 7/22/14. *The positioning bars had not been assessed by therapy department staff.	F 221	The Director of Nursing and interdisciplinary team reviewed and revised the policies and procedures regarding the use of restraints to ensure proper physician involvement and the completion of initial and quarterly assessments. All staff will be educated on the reviewed and revised policies and procedures regarding the use of restraints to ensure proper physician involvement and the completion of initial and quarterly assessments. The Director of Nursing or designee will audit once a month for three months all residents who are using restraints to ensure proper physician involvement and the completion of initial and quarterly assessments. The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.	

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NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	

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F 221	Continued From page 2 Review of the provider's undated Restraints Assessment policy revealed: *Prior to a restraint having been applied, a physical restraint assessment would have been performed. *The policy had not specified a positioning bar as a restraint.	F 221		
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	The two medication carts were observed to ensure that all fentanyl patches are appropriately disposed of and an account of all controlled drugs is maintained and periodically reconciled. The Director of Nursing and Interdisciplinary team reviewed and revised the policies and procedures of controlled medication reconciliation and the policies and procedures of medication disposal so that they include the counting and reconciliation of all controlled medications and the appropriate destruction of Fentanyl patches in a designated locked box where only the director of nursing has access to. All staff responsible for the tasks of controlled medication reconciliation were re-deucated on proper procedures.	10/24/14

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NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	

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F 431	Continued From page 3 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on medication cart observation, interview, and policy review, the provider failed to: *Ensure scheduled controlled (non-schedule II [drugs that are regulated by pharmacies due to high potential for abuse]) medications located in two of two medication carts were regularly accounted for. *Appropriately dispose of Fentanyl patches (controlled narcotic pain medicine delivered through the skin) in one of one east hall. Findings include: 1a. Medication cart observation and interview on 9/23/14 at 5:00 p.m. and on 9/24/14 at 9:30 a.m. of both medication carts with the director of nursing (DON) revealed: *The medications were to have been administered to residents according to a physician's order. *The medications were delivered from the pharmacy and were placed in a locked container in the medication cart until needed. At that time, they would have been moved into the drawer in the resident's personal section to have been dispensed by the nurse. *There was no system to account for non schedule II, controlled medications that were admisnistered regularly.	F 431	The Director of Nursing or designee will audit the counting and reconciliation of all controlled medications once a week for 4 weeks and twice a month for two more months to ensure an account of all controlled medications. The Director of Nursing or designee will audit the disposal of Fentanyl patches weekly for three month to ensure the proper disposal and destruction of Fentanyl patches. The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.	

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NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	

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F 431	Continued From page 4 Interview with the DON during the above dates and times revealed she agreed there was no system in place to reconcile scheduled controlled medication. Review of the provider's revised 5/29/14 Management & Storage of Controlled Substances policy revealed: *"All controlled substances will be recorded on a controlled Drug Administration Record." *"All schedule II-V controlled substances will be reconciled at the start of each shift by on-coming and off-going nurses." b. During the above medication review of both medication carts with the DON it was revealed to this surveyor that: *Fentanyl patches had been discarded in the sharps containers (where needles and syringes were placed for safety after use) attached to the side of the medication cart. *When the containers were full they had been removed from the cart and placed in the east hall soiled utility room. *That room was accessible to all staff. Interview with the DON and registered nurse (RN) B on 9/24/14 at 9:30 a.m. regarding the storage of discarded Fentanyl patches revealed they agreed: *All staff had access to the sharps containers placed in the east soiled utility room. *The Fentanyl patches would have been easily accessible to all staff. Review of the provider's 11/8/12 Medication Destruction Policy and Procedure revealed the Fentanyl patches were to have been placed in the sharps container. It had not addressed where the	F 431		

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NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	

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F 431	Continued From page 5 sharps container should have been placed to limit access to staff. Review of the provider's revised 5/29/14 Management & Storage of Controlled Substances policy revealed all schedule II-V controlled medications were to have been accessible only to nursing, pharmacy, or designated personnel by the provider.	F 431		
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 direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	The multiple use curlers in the barber shop were observed to ensure they were cleaned and sanitized between resident use and the sink in the beauty shop was also observed to ensure there wasn't any resident use linens stored next to the plumbing as to prevent the development and transmission of disease and infection. All other multiple use curlers were observed to ensure they were cleaned and sanitized between resident use and all other resident accessible sinks were observed to ensure there wasn't any resident use linens stored next to the plumbing as to prevent the development and transmission of disease and infection.	10/24/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

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F 441	Continued From page 6 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, South Dakota Cosmetology checklist, and policy review, the provider failed to: *Ensure multiple use curlers were cleaned and sanitized between resident use in one of one beauty shop. *Ensure resident use linen was not stored under the sink next to the plumbing in one of one beauty shop. Findings include: 1. Random observations during the day on 9/22/14 and on 9/23/14 of the beauty shop revealed: *Two plastic tubs filled with hair curlers. -Those curlers contained hair and debris. *One stack of resident use towels in the cupboard next to the sink. -The towels had been touching the plumbing pipes allowing for contamination from debris and bacteria to occur. Interview on 9/23/14 at 3:30 p.m. with the director of nursing revealed: *It was their expectation the beauty shop curlers	F 441	The Administrator, Director of Nursing, and interdisciplinary team reviewed and revised the policies and procedures regarding infection prevent and control to ensure they include the cleansing and sanitizing of multiple use curlers after each resident use and that the policies also state not storing resident use towels by the plumbing under resident use sinks so as to prevent the development and transmission of disease and infection. All staff and any individuals coming into our facility that provide a service to the residents will be educated on the reviewed and revised policies and procedures about infection prevent and control. The Director of Nursing or designee will audit the cleaning and sanitizing of the multiple use curlers weekly for four weeks and twice a month for two more months as to prevent the development and transmission of disease and infection.	

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F 441	Continued From page 7 were cleaned and disinfected between resident use. *It was their expectation no resident care items were to be stored under the sink in the beauty shop. Phone interview on 9/24/14 at 4:30 p.m. with licensed beautician D regarding the beauty shop revealed: *She had not regularly cleaned and disinfected multiple-use curlers between resident use and had been unaware she needed to clean and sanitize the curlers. *She was unaware she could not store resident use items under the sink next to plumbing. Review of the 2007 South Dakota Cosmetology Commission's Salon Self Inspection Checklist, items 25-27, accessed on 9/29/14, http://dlr.sd.gov/bdcomm/cosmet/documents/ccsalonself07.pdf, revealed multiple-use items should be cleaned and disinfected between use and free of hair and debris. Review of the provider's July 2014 Beautician Services Policy revealed no mention of how to care for and clean resident use items.	F 441	The Director of Nursing or designee will audit all resident use sinks to ensure there isn't any resident use towels around the plumbing twice a month for one month and once a month for two more months as to prevent the development and transmission of disease and infection. The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.	

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

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K 000	INITIAL COMMENTS Surveyor: 14180 An initial Medicare survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/24/14. Aurora Brule Nursing Home was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10-14-14

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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	10709		09/24/2014

NAME OF PROVIDER OR SUPPLIER: AURORA BRULE NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 408 S JOHNSTON ST, WHITE LAKE, SD 57383

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S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/22/14 through 9/24/14. Aurora Brule Nursing Home was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 10-14-14

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