

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

ORIGINAL

PRINTED: 09/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579	
(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	F 000		
F 164 SS=D	<p>Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/25/14 through 8/27/14. White River HCC was found not in compliance with the following requirements: F164, F253, F441, and F514.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>F 164 SS = D</p> <p>1. Observation on 8/25/2014 at 17:17 revealed RN B had prepared medications on the top of the west medication cart. He then entered resident 11's room and left the open MAR unattended. During that time the MAR had been visible for anyone to read. Residents, unlicensed staff members, and visitors had been walking in that area. Administered resident 15's medications.</p> <p>Observation on 8/26/2014 from 11:45 a.m. through 11:50 a.m. revealed LPN C prepared medications for resident 11. She left the open MAR to administer the medications. The MAR had been visible for anyone to read. Unlicensed staff, residents and visitors had been in that area. That same practice occurred by her while she administered resident 15's medications.</p> <p>All residents being admitted to the White River Nursing Home and residents with an active order will be at risk.</p> <p>One on one education was held on 8/26/2014 with the LPN C and RN B, with verbalization of understanding of privacy/confidentiality of records defined by F164.</p> <p>Mandatory staff meetings was held on 8/29/2014 to review the above findings with all staff and departments related to privacy/confidentiality of records defined by F164. Appropriate questions were asked and verbalization of understanding was obtained. All staff will follow up on PRN</p>	

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

Carole M. Grigg

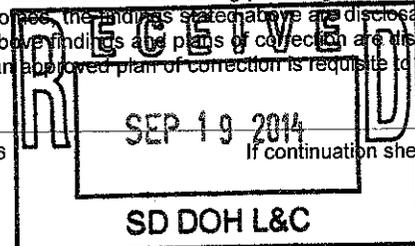
TITLE

Administrator

(X6) DATE

9/19/14

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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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to ensure confidentiality of the medication administration record (MAR) had been maintained during two of four medication administrations by one of two licensed practical nurses (LPN) Cand one of one registered nurse (RN) B for two observed residents (11 and 15). Findings include:</p> <p>1. Observation on 8/25/14 at 5:17 p.m. revealed RN B had prepared medications on the top of the west medication cart. He then entered resident 11's room and left the open MAR unattended. During that time the MAR had been visible for anyone to read. Residents, unlicensed staff members, and visitors had been walking in that area.</p> <p>Observation on 8/26/14 from 11:45 a.m. through 11:50 a.m. revealed LPN C prepared medications for resident 11. She left the open MAR to administer the medications. The MAR had been visible for anyone to read. Unlicensed staff, residents, and visitors had been in that area. That same practice occurred by her while she administered resident 15's medications.</p> <p>Interview on 8/26/14 at 2:10 p.m. with the director of nursing and the Minimum Data Set (MDS)assessment nurse confirmed they had expected the MAR to have been closed and not visible to anyone when staff had not been present.</p>	F 164	<p>basis if this concern is witnessed or observed at the time and DON / Administer/ or designated person in charge will be notified to follow up with staff member.</p> <p>The Administrator, Social Service Designee, Director of Nursing, MDS Coordinator, Charge Nurse and Pharmacy Consultant have reviewed and made revisions how the facility staff handles medical records and clarified the policy for privacy and confidentiality of records in the facility.</p> <p>The Director of Nursing will re-educate all staff on September 19, 2014 on the policy for privacy and confidentiality of records in the facility.</p> <p>The Medical Records or assigned designee will ensure that the policy of privacy and confidentiality of records in the facility will be maintained as defined by F164.</p> <p>Medical Records or designee will audit medication pass and medical records three times a day to include all nursing shifts weekly times 4 weeks then monthly times two month or until the policy of privacy and confidentiality of records in the facility is maintained as defined by F164.</p> <p>The results of audit F164 will be corrected instantly at the time of the audit with reeducation and then will be reported by Medical Records to the QA/PI monthly with further follow up as recommended by the interdisciplinary team.</p> <p>9-19-2014</p>	<p>9/19/14 cmg</p>
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F 164	Continued From page 2 Review of the provider's 2001 Med-Pass Release of Information policy stated "Resident records, whether medical, financial, or social in nature, are safeguarded to protect the confidentiality of the information."	F 164	F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services Based on observation, policy review, and interview, the provider failed to ensure 4 of 16 (3, 12, 13, 14) razors had been maintained in a clean and sanitary manner.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, policy review, and interview, the provider failed to ensure 4 of 16 (3, 12, 13, and 14) razors had been maintained in a clean and sanitary manner. Findings include: 1. Observation on 8/26/14 at 9:00 a.m. revealed a bin with mens' electric razors in individual plastic bags sitting on a table in the restorative therapy room. Another razor had been observed plugged into a charger in the restorative therapy restroom. Each razor had been labeled with the resident's name. Further inspection revealed four of the razors belonging to residents 3, 12, 13, and 14 had multiple hairs stuck in the clipper side of the razor (photo 1). Interview and observation on 8/26/14 at 4:30 p.m. with the director of nursing (DON) revealed she expected morning staff to clean and disinfect residents' razors by the end of their shift. The morning shift ended at 2:00 p.m. Oster spray disinfectant for grooming tools should have been	F 253	1.Observation on 8/26/2014 at 9:00 a.m. revealed a bin with men's electric razors in individual plastic bags sitting on a table in the restorative therapy room. Another razor had been observed plugged into a charger in the restorative therapy restroom. Each razor had been labeled with the resident's name. Further inspection revealed four of the razors belonging to residents 3,12,13,14 had multiple hairs stuck in the clipper side of the razor. All residents being admitted to the White River Nursing Home that have the potential to need to be shaved and residents that have razors will be at risk. One on one education was held on 8/27/2014 with the LPN E and Restorative Aide, with verbalization of understanding defined by F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services. Mandatory staff meetings was held on 8/29/2014 to review the above findings with all staff and departments related to defined by F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services. Appropriate questions were asked and verbalization of understanding was obtained. All staff will follow up on PRN basis if this concern is witnessed or observed at the time and DON / Administer/ or designated person in charge will be notified to follow up with staff member. The Administrator, Social Service Designee, Director of Nursing, MDS Coordinator, Restorative Charge Nurse, and Charge Nurse have reviewed and made revisions how the facility staff handles and cleans electric razors and clarified the policy defined by F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services.	

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F 253	Continued From page 3 used after cleaning. This surveyor and the DON entered the restorative therapy room at the above time to inspect the razors. The DON picked up resident 3's razor to inspect it and removed the head of the razor. A mass of gray whiskers were observed inside. She had been unsure why the razors had not been cleaned that day.	F 253	The Director of Nursing will re-educate all staff on September 19, 2014 as defined by F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services. The Restorative Charge Nurse or assigned designee will ensure that the policy defined by F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services. Restorative Charge Nurse or designee will audit electric razor log at the beginning and end of the shift to correlate with razors cleaning to include the clipper side three times a week times 4 weeks then monthly times two month or until the Restorative Charge Nurse or assigned designee will ensure that the policy defined by F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services. The results of the audit by the Restorative Charge Nurse or assigned designee will ensure that the policy defined by F 253 SS = D (483.15(h)(2) Housekeeping & Maintenance Services will be corrected instantly at the time of the audit with reeducation and then will be reported by the Restorative Charge Nurse or assigned designee to the QA/PI monthly with further follow up as recommended by the interdisciplinary team.	
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	F 441	9-19-2014 F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens Based on observation, interview, and policy review, the provider failed to ensure two of two multiple use gluco meters (machine to check blood sugar levels) had been disinfected per facility policy by one to two licensed practical nurses (LPN) D and one of one registered nurse (RN) B for three of three resident (11, 16, 17) glucose testing performed. Findings to include: 1. Observation on 8/25/2014 at 16:05 p.m. revealed RN B had obtained resident 11's blood sugar, while obtaining that blood sugar he had placed the gluco meter on the dining room table without a barrier. That soiled gluco meter had then been brought back to the west wing medication cart and placed it on the cart without a barrier.	9/19/14

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F 441	<p>Continued From page 4</p> <p>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: 32572 Based on observation, interview, and policy review, the provider failed to ensure two of two multiple use glucometers (machine to check blood sugar levels) had been disinfected per facility policy by one of two licensed practical nurses (LPN) D and one of one registered nurse (RN) B for three of three resident (11, 16, and 17) glucose testing performed. Findings include:</p> <p>1. Observation on 8/25/14 at 4:05 p.m. revealed: RN B had obtained resident 11's blood sugar. While obtaining that blood sugar he had placed the glucometer on the dining room table without a barrier. That soiled glucometer had then been brought back to the west wing medication cart and placed it on the cart without a barrier.</p> <p>Observation on 8/25/14 at 4:50 p.m. revealed:</p>	F 441	<p>Observation on 8/25/2014 at 16:50 p.m. revealed LPN D had removed a plastic basket from the east medication cart.</p> <p>-The basket contained alcohol pads, gauze pads, band aids, lancets (skin sticking device), gluco meter test strips, and a gluco meter. The basket was carried down the hall, and went into resident 16's room , and placed the basket on the resident's dresser.</p> <p>-The glucose reading was obtained, removed the test strip, and placed the dirty gluco meter on top of the clean supplies in the basket.</p> <p>-The gluco meter was the picked up and placed it on a Kleenex.</p> <p>(At this time the gluco meter was disinfected, and the LPN D placed the wet gluco meter on the clean supplies.)</p> <p>-The gluco meter was then carried in the plastic basket with the supplies into resident 17's room.</p> <p>-The glucose test was obtained and the gluco meter was wrapped the gluco meter in the Kleenex she had used as a barrier.</p> <p>-The gluco meter was carried up the hallway to the east medication cart and laid it on the medication cart.</p> <p>-The gluco meter was cleaned and placed back in the basket.</p> <p>-The basket was placed back in the medication cart without cleaning it off (The basket had been placed on both residents bedside dressers and had not been cleaned prior to placing it in the medication cart.)</p> <p>All residents being admitted to the White River Nursing Home that have the potential to need to have a glucose test performed and residents that have glucose test ordered will be at risk.</p> <p>One on one education was held on 8/25 and 26/2014 with the LPN D and RN B, with verbalization of understanding defined by F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens.</p>	

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F 441	<p>Continued From page 5</p> <p>*LPN D had removed a plastic basket from the east medication cart.</p> <p>-That basket contained alcohol pads, gauze pads, bandaids, lancets (skin sticking device), glucometer test strips, and a glucometer.</p> <p>*She carried the basket down the hall, went into resident 16's room, and placed the basket on the resident's dresser.</p> <p>-She obtained the glucose reading, removed the test strip, and placed the dirty glucometer on top of the clean supplies in the plastic basket.</p> <p>-She then picked up the glucometer and placed it on a Kleenex.</p> <p>*At that time the glucometer was disinfected, and the LPN placed the wet glucometer on the clean supplies.</p> <p>*She then carried the plastic basket with the supplies into resident 17's room.</p> <p>-She performed the test and wrapped the glucometer in the kleenex she had used as a barrier.</p> <p>-She carried the glucometer up the hallway to the east medication cart and laid it on the medication cart.</p> <p>*She cleaned the glucometer and replaced it in the basket.</p> <p>*She placed the basket in the medication cart without cleaning the basket.</p> <p>That basket had been placed on both residents bedside dressers and had not been cleaned prior to replacing it in the medication cart.</p> <p>Interview on 8/26/14 at 2:10 p.m. with the director of nursing and the MDS nurse confirmed they would have expected:</p> <p>*The glucometer to have had a barrier when placed on unclean surfaces.</p> <p>*The glucometer to have been air dried before being returned it to the plastic basket in the</p>	F 441	<p>Mandatory staff meetings was held on 8/29/2014 to review the above findings with all staff and departments related to defined by F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens. Appropriate questions were asked and verbalization of understanding was obtained. All staff will follow up on PRN basis if this concern is witnessed or observed at the time and DON / Administer/ or designated person in charge will be notified to follow up with staff member.</p> <p>The Administrator, Social Service Designee, Director of Nursing, MDS Coordinator, and Charge Nurse have reviewed and made revisions how the facility staff handles glucose testing was done to develop and implement procedures utilizing universal precautions of glucose monitoring equipment personal protective equipment and hand washing practices by all employees and clarified the policy defined by F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens.</p> <p>The Director of Nursing will re-educate all staff on September 19, 2014 as defined by F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens.</p> <p>The Director of Nursing or assigned designee will ensure that the policy defined by F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens.</p> <p>The Director of Nurse or designee will audit glucose testing three times a week times 4 weeks then monthly times two month or until the Director of Nursing or assigned designee will ensure that the policy defined F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens.</p> <p>The results of the audit by the Director of Nursing or assigned designee will ensure that the policy defined by F 441 SS = D 483.65 Infection Control, Prevent Spread, Linens will be corrected instantly at the time of the audit with reeducation and then will be reported by the Director of Nursing or assigned designee to the QA/PI monthly with further follow up as recommended by the interdisciplinary team.</p> <p>9-19-14</p>	9/19/14	

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F 441	Continued From page 6 medication cart. *The plastic basket to have been cleaned prior to returning it to the medication cart. Review of the provider's 2001 Med-Pass Glucometer Cleaning policy revealed: *The purpose was "To ensure a clean and safe environment, reduce the risk of infection transmission through multi-resident equipment use." **"The meter must be cleaned between each resident use. If the meter is 'set down' in a resident room without establishing a clean work area, each surface the unclean machine touches must be disinfected with each use, in addition to the meter disinfecting."	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, policy review, and	F 514	F 514 SS = D (483.75(l)(1) Resident records-complete/accurate/accessible) 1. Based on record review, policy review, and interview, the provider failed to document two of none residents (6 and 9) weekly skin assessments. Finding include: 1a. Review of resident 6's physician orders revealed an order dated 10/16/13 for weekly skin assessments. Review of her licensed nurse weekly skin assessment from 5/1-14 through 8/27/14 revealed: -The 5/21/14 skin assessment stated she had a skin tear to her right lower leg. -The 5/28/14 skin assessment had not been signed off on her medical administration record(MAR). -The 6/4/14 skin assessment had been left blank but had been signed off on her (MAR). -A 6/4/14 nurse's treatment note stated her skin had been assessed and was intact with no open areas noted.		

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F 514	<p>Continued From page 7</p> <p>interview, the provider failed to document two of nine residents (6 and 9) weekly skin assessments. Findings include:</p> <p>1a. Review of resident 6's physician's orders revealed an order dated 10/16/13 for weekly skin assessments. Review of her licensed nurse weekly skin assessments from 5/1/14 through 8/27/14 revealed: *The 5/21/14 skin assessment stated she had a skin tear to her right lower leg. *The 5/28/14 skin assessment had been left blank. *The 5/28/14 skin assessment had not been signed off on her medical administration record (MAR). *The 6/4/14 skin assessment had been left blank but had been signed off on her MAR. *A 6/4/14 nurse's treatment note stated her skin assessment had been completed. No information about the condition of her skin had been noted. *A 6/11/14 nurse's treatment note stated her skin had been assessed and was intact with no open areas noted.</p> <p>b. Review of resident 9's physician's orders revealed a current order dated 4/22/11 for weekly skin assessments. Review of her licensed nurse weekly skin assessments from 5/1/14 through 8/27/14 revealed: *The 5/26/14 skin assessment had been left blank and had not been signed off on her MAR. *There had been no mention of the condition of her skin in the May nurse's treatment notes.</p> <p>c. Interview on 8/25/14 at 5:25 p.m. with the director of nursing revealed she expected the resident's skin assessment sheets to have been filled out every time a skin assessment had been</p>	F 514	<p>1b. review of resident 9's physician's orders revealed a current order dated 4/22/11 for weekly skin assessments. Review of her licensed nurse weekly skin assessments from 5/4/14 through 8/27/14 revealed:</p> <p>-The 5/26/14 skin assessment had been left blank and had not been signed off on her MAR.</p> <p>-There had been no mention of the condition of her skin in the May nurse's treatment notes.</p> <p>All residents being admitted to the White River Nursing Home will need nursing assessments and residents that have a change in condition will be at risk.</p> <p>One on one education was held with the LPN and RN verbalization of understanding defined by F 514 SS = D (483.75(1)(1) Resident records-complete/accurate/accessible).</p> <p>Mandatory staff meetings was held on 8/29/2014 to review the above findings with all staff and departments related to defined by F 514 SS = D (483.75(1)(1) Resident records-complete/accurate/accessible). Appropriate questions were asked and verbalization of understanding was obtained. All staff will follow up on PRN basis if this concern is witnessed or observed at the time and Medical Records/DON / Administer/ or designated person in charge will be notified to follow up with staff member.</p> <p>The Administrator, Social Service Designee, Director of Nursing, MDS Coordinator, Medical Records and Charge Nurse have reviewed and made revisions how the facility staff handle Resident records-complete/accurate/accessible) was done to develop and implement procedures by all employees and clarified the policy defined by F 514 SS = D (483.75(1)(1) Resident records-complete/accurate/accessible).</p>		

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

PRINTED: 09/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579	
(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 514	Continued From page 8 done. The boxes should all have been checked, and the condition of the resident's skin written down in notes. Review of the providers 2008 charting and documentation policy revealed "All observations must documented in the resident's clinical records." Changes in the resident's condition or other pertinent resident related information should have been recorded. Documentation should have included care-specific details including the assessment data, the signatures and title of the individual documenting the information.	F 514	The Director of Nursing will re-educate all staff on September 19, 2014 as defined by F 514 SS = D (483.75(1)(1) Resident records-complete/accurate/accessible). The Medical records or assigned designee will ensure that the policy defined by F 514 SS = D (483.75(1)(1) Resident records-complete/accurate/accessible). The Medical Records or designee will audit Medical Administration Records and Treatment Administration Records will be audited three times a week times 4 weeks then monthly times two month or until the Medical Records or assigned designee will ensure that the policy defined by F 514 SS = D (483.75(1)(1) Resident records-complete/accurate/accessible). The results of the audit by the Medical Records or assigned designee will ensure that the policy defined by F 514 SS = D (483.75(1)(1) Resident records-complete/accurate/accessible) will be corrected instantly at the time of the audit with attempt to contact employee with reeducation and then will be reported by the Medical Records or assigned designee to the QA/PI monthly with further follow up as recommended by the interdisciplinary team. 9-19-2014	9/19/14

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

ORIGINAL

PRINTED: 09/04/2014
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
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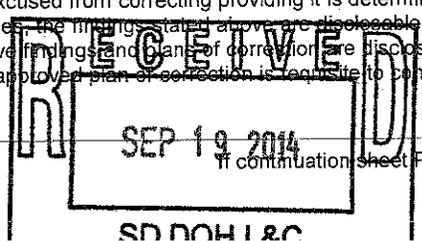
NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/27/14. White River Health Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		
K 062 SS=F	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: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had the required quarterly flow testing performed during the previous twelve months. Record review of the previous fourteen months' fire sprinkler system inspections revealed quarterly flow testing documentation was not available. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports revealed the quarterly	K 062	K062 The administrator established a file log to ensure the quarterly automatic sprinkler system flow testing is completed by an outside contractor and documented. The quarterly flow testing was completed on 9/15/14. The administrator will monitor that the flow testing is completed and report to QA monthly.	9/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carole Mcgregg</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/19/14</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 plan of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579	
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K 062	Continued From page 1 flow testing documentation was not available. A five-year required internal obstruction inspection had been performed on 11/22/13. Interview with the maintenance director at the time of the record review indicated he was aware of the quarterly flow testing requirements. The same deficiency was written for the 6/25/13 inspection survey. This deficiency affects all 52 residents of the facility.	K 062		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a remote alarm in a continuously occupied location to indicate when the generator system was in a trouble status in accordance with NFPA 99 Section 3-4.1.1.15 (see attachment). The generator battery terminals were not covered. The generator battery was 33 months old. Findings include: 1. Observation at 8:45 a.m. revealed the 15 kilowatt propane-fueled Onan generator was located in the boiler room in the service wing. Interview with the maintenance director at the	K 144	K144 MS purchased new battery and terminal covers for generator on 9/11/14. ADM ordered annunciator/fault alarm for generator on 9/11/14. MS will audit generator during weekly load exercise. Results of audits will be reported to QA monthly x3, then quarterly thereafter. MS will audit annunciator status weekly and report to QA committee monthly x 3, then quarterly thereafter.	9/19/14

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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579		
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K 144	Continued From page 2 time of the observation confirmed the generator/boiler room would not be a continuously occupied space. A generator requires a monitored generator annunciator, covered battery terminals, and a battery not more than 30 months old. * There was no annunciator at a continuously occupied space (nurse station, for example) that would indicate when the generator was in a trouble status. * The generator battery terminals were not covered. * The maintenance supervisor stated the generator battery was installed in December 2011 (33 months ago). Generator batteries are recommended for replacement at 24-30 months from installation. Interview with the maintenance supervisor confirmed those conditions. This deficiency affects all 52 residents at this facility.	K 144			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 43A089	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 8/27/2014
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD
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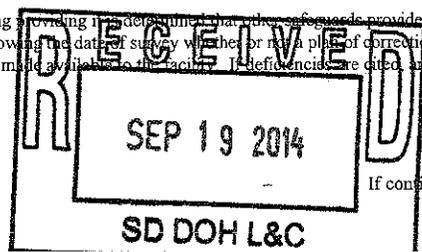
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 038	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1</p> <p style="text-align: right;">K038</p> <p>Delayed egress signage was ordered by ADM on 9/9/14. Signage was received and posted On 9/15/14. 9/19/14</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>Based on observation, testing, and interview, the provider failed to ensure one of eight exits (east wing) were readily accessible at all times. Findings include:</p> <p>1. Observation at 9:45 a.m. on 8/27/14 revealed the eight building exits were each equipped with a device that would magnetically lock the door. Testing of the locked doors revealed they were all delayed egress magnetic locks. The exit door for the east wing did not have the required delayed egress signage on the door. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he had put the signage on all the magnetically locked doors previously. This deficiency affected one location required to have delayed egress signage.</p>
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K 076	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>Based on observation and interview, the provider failed to restrain two randomly observed portable oxygen cylinders in a secured position in the chapel. Findings include:</p>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting according to the requirements 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 when 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 on approved plan of

The above isolated deficiencies pose no actual harm to the residents



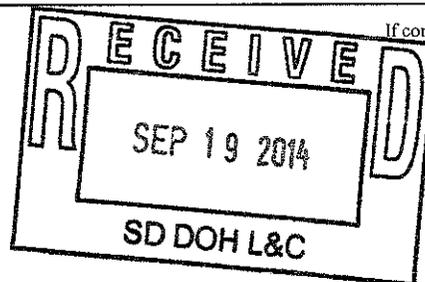
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 43A089	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 8/27/2014
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<p>K 076</p>	<p>Continued From Page 1</p> <p>1. Observation at 9:15 a.m. on 8/27/14 revealed two 'e' size oxygen cylinders unrestrained in the storage room in the chapel area. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He further revealed staff were aware oxygen cylinders could not be stored unsecured. This deficiency could affect the safety of one of several storage areas.</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>K076 NFPA 101 Life Safety Code Standard</p> <p>Based on observation and interview, the provider failed to restrain two randomly observed portable oxygen cylinders in a secured position in the chapel. Findings include:</p> <p>Observation at 9:15 on 8/27/14 revealed two 'E' sized oxygen cylinders unrestrained in the storage room in the chapel area. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He further revealed staff were aware oxygen cylinders could not be stored unsecured. This deficiency could affect the safety of one of several storage areas.</p> <p>All residents being admitted to the White River Nursing Home that may need to utilize oxygen therapy will be at risk.</p> <p>The Administrator, Social Service Designee, Director of Nursing, MDS Coordinator, Medical Records, Maintenance Supervisor and Charge Nurse have reviewed and made revisions to how the facility staff handle K076 NFPA 101 Life Safety Code Standard. Based on observation and interview, the provider failed to restrain two randomly observed portable oxygen cylinders in a secured position in the chapel.</p> </div> <div style="width: 45%;"> <p>The Director of Nursing will re-educate all staff on September 19, 2014 as defined by K076 NFPA 101 Life Safety Code Standard that the provider failed to restrain two randomly observed portable oxygen cylinders in a secured position in the chapel.</p> <p>The Maintenance supervisor or assigned designee will ensure that the policy defined by K076 NFPA 101 Life Safety Code Standard that the provider failed to restrain two randomly observed portable oxygen cylinders in a secured position in the chapel.</p> <p>The Maintenance supervisor or designee will audit oxygen tank rooms three times a week times 4 weeks then monthly times two month or until the Maintenance or assigned designee will ensure that the policy defined K076 NFPA 101 Life Safety Code Standard that the provider failed to restrain two randomly observed portable oxygen cylinders in a secured position in the chapel.</p> <p>The results of the audit by the Maintenance supervisor or assigned designee will ensure that the policy defined by K076 NFPA 101 Life Safety Code Standard that the provider failed to restrain two randomly observed portable oxygen cylinders in a secured position in the chapel will be corrected instantly at the time of the audit with attempt to contact employee with reeducation and then will be reported by the Maintenance supervisor or assigned designee to the QA/PI monthly with further follow up as recommended by the interdisciplinary team.</p> <p>9-19-2014</p> </div> </div>
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9/19/14



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/27/2014
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579
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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/25/14 through 8/27/14. White River Health Care Center was found not in compliance with the following requirement: S206, S210, and S402.	S 000	Addendums noted with an asterisk per 9/19/14 telephone from facility DON. KJ-SDDH/ME	
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.	S 206		

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

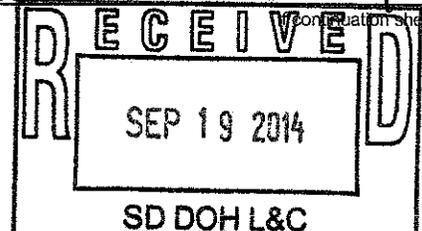
Carole M Gruger

TITLE

Administrator

(X6) DATE

9/19/14



South Dakota Department of Health

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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 28057</p> <p>Based on record review and interview, the provider failed to ensure five of five newly hired sampled employees (B, E, F, G, and H) received all ten of the state required orientation programs. Findings include:</p> <p>1. Review of employees (B, E, F, G, and H) orientation documentation in their employee records revealed:</p> <ul style="list-style-type: none"> *They had all been hired by the provider between 5/5/14 through 8/6/14. *All five of the above employees had no documentation to support training had been provided for the proper use of restraints and dining assistance, nutritional risks, and hydration needs of residents. *Employees G and H had no documentation to support training had been provided for emergency procedures and preparedness. *Employees G and H had no documentation to support training had been provided for infection control and prevention. *Employees F and H had no documentation to support training had been provided for accident prevention and safety procedures. *Employee H had no documentation to support training had been provided for incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *Employees E, G, and H had no documentation to support training had been provided for care of residents with unique needs. *All of the above missing training had been required by the South Dakota Department of Health during orientation and annually thereafter. <p>Interview on 8/27/14 at 10:30 a.m. with the</p>	S 206		
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
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S 206	<p>Continued From page 2</p> <p>director of nursing (DON) and the laundry/housekeeping supervisor confirmed: *The DON had oriented her staff on the ten required topics. *She had not been able to find documentation to support all ten topics had been provided to the above employees. *No further documentation was offered by the DON before the surveyors had exited. *The DON had oriented only nursing staff, but no other departments to include housekeeping. *The laundry/housekeeping supervisor had not provided orientation on the ten required topics to employee H. -He had not known the ten topics had been required.</p> <p>Review of the provider's undated Employee Handbook under the heading "Orientation" revealed it had not addressed the need for orientation of the ten required topics listed in the SD DOH orientation program.</p>	S 206	<p>S206</p> <p>The BOM will review all staff hired within the last 4 months for completion of "orientation checklist". The Department Supervisor will review the "orientation checklist" with their staff member. The "orientation checklist" will be initialed by both the Department Supervisor and staff member. The BOM will audit the progress of orientation completion and report results to the QA committee monthly x 3, then quarterly thereafter.</p> <p>The BOM will audit each new employee weekly x 4 and monthly x 3 for completed orientation checklists. He will report to the ADM weekly x 4 and monthly x 3. Audit results will be shared with QA committee monthly by the BOM with further follow up as recommended by the committee.</p>	
S 210	<p>44:04:04:06 EMPLOYEE HEALTH PROGRAM</p> <p>The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable</p>	S 210	<p>*that had included all ten required topics. KJ/SDDO/HIME</p>	9/19/14

South Dakota Department of Health

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S 210	<p>Continued From page 3</p> <p>disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 28057 Based on record review, document review, and interview, the provider failed to ensure five of five newly hired sampled employees (B, E, F, G, and H) had been evaluated by a health professional to determine they were free from a reportable communicable disease. Findings include:</p> <p>1. Review of employees B, E, F, G, and H's employee files revealed: *They had all been hired by the provider between 5/5/14 through 8/6/14. *There had been no documented health evaluation reviewed and signed by a health professional in their employee files.</p> <p>Review of the provider's undated Employee Handbook Employee Health revealed: *All new employees had been required to make arrangements for a physical examination. *The medical director would furnish the examination at the facility or the employee could go to a physician of their choice at their own expense.</p> <p>Interview on 8/26/14 at 6:05 p.m. with the administrator confirmed she had not known a health professional had needed to sign the employee health evaluations. She agreed the above staff had not had a health assessment evaluation completed by a health professional.</p>	S 210 S210	<p>1. The BOM will review all staff hired within the last 6 months for health assessment completion. The Director of Nursing or designated health care professional will review the health assessment with each staff member. The health assessment will be signed by the Director of Nursing or designated health care professional. The BOM will audit current staff health assessments for updates/signatures and report results to QA monthly x 3, then quarterly thereafter.</p> <p>2. The BOM will audit each new employee weekly x 4 and monthly x 3 for a completed health care assessment. He will report to the DON weekly x 4 and monthly x 3. Audit results will be shared with QA committee monthly by the DON with further follow up as recommended by the committee.</p>	9/19/14
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579
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S 402	Continued From page 4	S 402		
S 402	<p>44:04:13:41 Lighting</p> <p>All spaces occupied by people, machinery, and equipment within buildings, the approaches to the buildings, and parking lots must have artificial lighting approved by the department...Residents' bedrooms must have general lighting of at least 10 footcandles (0.929 lumens per square meter) and night lighting. Where task illumination is required, a light with an intensity of at least 30 footcandles (2.79 lumens per square meter) at the work surface must be provided for each...resident. At least one luminaire for night lighting must be switched at the entrance to each...resident room...Residents' reading lights and other fixed lights not switched at the door must have switch controls convenient for use at the luminaire. All switches for control of lighting in ...resident areas must be of the quiet operating type. Illumination of at least 100 footcandles (9.29 lumens per square meter) must be provided at the medication set-up area. Illumination of at least 50 footcandles (4.65 lumens per square meter) must be provided at the activity room work tables. Illumination of at least 30 footcandles (2.79 lumens per square meter) must be provided in dining areas, physical and restorative therapy, and at bathing facilities.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and testing, the provider did not install sufficient lighting fixtures in one randomly observed room (the activities room) to</p>	S 402	<p>S402</p> <p>MS installed two additional 4 foot fluorescent lights in the activities room on 9/18/14. MS will audit all lighting and report findings to QA committee monthly x 3 then quarterly thereafter</p>	<p>9/19/14 amg</p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10710	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET POST OFFICE BOX 310 WHITE RIVER, SD 57579
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S 402	Continued From page 5 furnish 50 foot candles of illumination at the work table. Findings include: 1. Observation at 9:45 a.m. on 8/27/14 revealed the activities room had two overhead four foot long double flourescent lamp fixtures. Testing of the lighting with a light meter at the time of the observation revealed the room had only 15 foot candles of illumination at the activities table. Interview with the maintenance supervisor at the time of the observation confirmed the low light level. He was unaware of the minimum lighting requirement for activities.	S 402		