

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

ORIGINAL

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221
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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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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32355 A recertification health survey for compliance with 42 CFT Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/24/15 through 3/25/15. Bryant Parkview Care Center was found not in compliance with the following requirements: F164, F281, F323, F363, F371, F431, and F441.</p> <p>F 164 SS=E 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</p>	F 000	<p>Addendums noted with an asterisk per 5/16/15 telephone to facility administrator. JKSDDOH/MF</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Lynelle Rust* TITLE *Administrator* (X6) DATE *4-16-15*

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.

APR 20 2015
If continuation sheet Page 1 of 42
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F 164	<p>Continued From page 1 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to ensure resident occupational, physical, and restorative therapy records had been stored securely to provide confidentiality in two of two unused resident rooms (105 and 210) used for storage. Findings include:</p> <p>1. Observation on 3/24/15 at 8:00 a.m. revealed: *Room 210 was not occupied. It was being used for storage of unused furniture and patient care equipment. *Placed on top of the built-in dresser were several papers for random inpatient and outpatient occupational and physical therapy records. There was also a medical history of a random patient. *The room also contained an unlocked file cabinet containing therapy records for inpatients and outpatients.</p> <p>2. Observation on 3/24/15 at 8:15 a.m. revealed: *Room 105 was not occupied. It was being used for storage of unused furniture items and patient care equipment. *A small trash receptacle had been placed on the sink area containing several papers including a provider's Care Plan Item/Task Listing Report. *The report listed: -All residents receiving a scheduled toileting program. -All residents receiving a dressing/grooming program. -All residents receiving a walking program.</p>	F 164	<p>Residents have the right to personal privacy and confidentiality of his/her personal and clinical records.</p> <ol style="list-style-type: none"> Inpatient and outpatient therapy papers were removed from temporary storage in room 210 during remodeling of therapy room to ensure confidentiality. Resident information was removed from small trash receptacle in room 105 to ensure confidentiality. <p>All staff was in-serviced on 4-16-15 on revised facility policy for confidentiality of personal and clinical records to include therapy services.</p>		

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F 164	Continued From page 2 -All residents receiving an active range of motion exercise program. 3. Interview on 3/25/15 at 9:50 a.m. with the director of nursing revealed: *The papers in the trash receptacle in room 105 should have been shredded rather than thrown away. *The therapy room was in the process of being remodeled. *The therapists were currently using room 210 as an office. *She had been unsure why the therapists had records sitting out. *Normally the file cabinet was stored in the therapy room. *The files had never been locked. *She agreed the residents' information had not been maintained in a confidential manner. Review of the provider's April 2014 Confidentiality of Information policy revealed: *The provider would safeguard all residents' records, whether medical, financial, or social in nature, to protect the confidentiality of the information. *Access to residents' medical records would be limited to authorized staff and business associates.	F 164	Confidentiality/privacy of personal and clinical record audits of unoccupied and storage rooms will be completed by DON/designee Daily x5, weekly x 2, and monthly x2 with results reported to the Administrator who will report to the Quarterly QAA x4 until advised to discontinue by QAA committee.	4-18-15	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281			

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F 281	Continued From page 3 Surveyor: 29354 Surveyor: 35237 A. Based on observation, interview, and policy review, the provider failed to ensure appropriate professional standards for infection control were followed for one of two licensed nurses (A) for: *One of one observed syringe driver (a syringe mixed with medications and sterile water used for continuous infusion of those medications) preparation and administration for a resident (5). *One of one observed administration of medication and nutrition through a gastric feeding tube (a tube inserted into the stomach to deliver liquid nutrients and medicines) for a resident (2) with a feeding tube. *One of one observed eye drop administration for a resident (2). *Two of two observed insulin administrations for a resident (12). Findings include: 1. Observation and interview on 3/24/15 at 12:03 p.m. with registered nurse (RN) A revealed she would be mixing medications into a 12 cubic centimeter (cc [unit of measurement]) syringe driver for resident 5. Without performing hand hygiene RN A took the supplies from the medication room. She then: *Placed the container with the supplies on top of the desk in the charting room. *Without disinfecting the top of the desk or without creating a clean field she: -Placed a piece of paper tape on the desk. -Took a pen from her pocket and wrote the names of the medications on the tape. -Added the sterile water and medications as directed. -Took the paper tape off the desk and placed it	F 281	----- Professional standards for infection control will be met for: A. Medical procedures for administration of syringe driver for Resident #5, gastric tube feeding for resident #2, eye gtt for resident #2 and insulin injection for resident #12 will be competed per facility policy. B. Will follow manufacture's recommendation for cleaning and disinfecting the glucometer after use for residents #3, 6, 12, and 13.		

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F 281	<p>Continued From page 4</p> <p>onto the syringe filled with the medications.</p> <ul style="list-style-type: none"> -Discarded the used supplies in the garbage can. -Put the other supplies in the container. -Put that container in the medication room. -Signed out the medications on the controlled substance record. *Pushed the medication cart to the resident's room. *Took a roll of tape from the top drawer of the medication cart. *Went into the resident's room. *Removed the old syringe from the machine and disconnected it from the tubing that was attached to the catheter in the resident's skin. *Connected the new syringe to the tubing and began administering the medication. *Left the resident's room. *Signed out the medications in the electronic medical record. *She did not perform hand hygiene during the above observation. *She stated she was instructed on the procedure for the syringe driver by the hospice nurse. <p>Interview on 3/24/15 at 4:05 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *The syringe driver training would have been done by the hospice nurse. *She did not have a copy of the training or proof that all nurses had been trained on it. *Hospice would have the policy for the syringe driver. It should have been in the resident's chart but was not there currently. <p>Review of the provider's undated Syringe Driver procedure revealed to "Assemble equipment and plan for as clean technique as possible."</p> <p>2. Observation on 3/24/15 at 12:20 p.m. with RN</p>	F 281	<p><i>*DNS A & B JKISDD/MF</i></p> <p>All staff, including professional nursing staff, was in-serviced on 4/16/15 on Professional standards for infection control for:</p> <p>A.</p> <ol style="list-style-type: none"> 1. Hospice policy and procedure for syringe driver's preparation and administration to include hand hygiene (handwashing, glove usage) A copy will be placed on hospice residents charts. 2. Policy and procedure for setup (surface prep) and administration of medication and nutrition through tube feeding to include hand hygiene (Hand washing, Glove usage) 	

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F 281	<p>Continued From page 5</p> <p>A during resident 2's administration of medication and nutrition through the feeding tube revealed: *Without performing hand hygiene she: -Entered the resident's room. -Set the supplies on the resident's bedside table without creating a clean field. -Applied gloves. -Administered the medication and nutrition as directed through the feeding tube. -Removed her gloves and washed her hands for approximately five seconds.</p> <p>3. Observation on 3/24/15 at 5:42 p.m. with RN A during resident 2's eye drop administration revealed she: *Entered the resident's room. *Had not performed hand hygiene. *Had not applied gloves. *Used her bare hands to pull down the resident's right lower eye lid and administered the eye drop. *Then washed her hands for approximately five seconds.</p> <p>4. Observation on 3/24/15 at 10:52 a.m. with RN A during resident 12's insulin administration revealed she: *Prepared the ordered amount of insulin in the syringe at the medication cart in the hallway. *Applied gloves. *Grabbed the insulin syringe and supplies. *Entered the resident's room. *Administered the insulin. *Exited the room. *Discarded the supplies and her gloves at the medication cart. *Documented the administration. *Had not performed hand hygiene before or after the procedure.</p>	F 281	<p>3. Policy and procedure for setup and administration for eye gtt's to include hand hygiene. (Handwashing, glove usage) a. Policy and procedure for insulin administration to include hand hygiene. (Handwashing, glove usage)</p> <p>4. Policy and procedure for manufacturer's recommendation for cleaning and disinfecting the glucometer after use to include set up and cleaning.</p>	

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F 281	<p>Continued From page 6</p> <p>5. Observation on 3/24/15 at 5:00 p.m. with RN A during resident 12's insulin administration revealed she:</p> <ul style="list-style-type: none"> *Had not performed hand hygiene or applied gloves. *Prepared the insulin at the medication cart in the hallway. *Entered the resident's room with insulin and supplies. *Administered the insulin. *Exited the room. *Discarded the supplies at the medication cart. <p>6. Interview on 3/25/15 at 1:40 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *She would have expected appropriate infection control to be maintained by the staff. *It would have included appropriate hand hygiene and glove use. <p>Review of the provider's undated Standard Precautions policy revealed:</p> <ul style="list-style-type: none"> ***1b. Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such..." ***1c. In the absence of visible soiling of hands, alcohol based hand rubs are preferred for hand hygiene." ***1d. Wash hands after removing gloves." ***2a. Wear gloves (clean, non-sterile) when you anticipate direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material." ***2g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other 	F 281	<p><i>*including RNS A #B,</i></p> <p>Professional nursing audits for nursing procedures on syringe drivers, tube feedings, eye gtt administration, insulin administration and cleaning of glucometer after use will be completed by DON/designee daily x5, weekly x2, monthly x2 with results reported to the Administrator who will report to the Quarterly QAA x4 until advised to discontinue by QAA committee</p> <p><i>*to include the following residents 2, 3, 5, 12, and 13;</i></p> <p><i>JKSDOH/MF</i></p>	4-18-15
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F 281	<p>Continued From page 7 residents or environments."</p> <p>Review of the provider's undated Handwashing/Hand Hygiene policy revealed: **2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." **7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" -"b. Before and after direct contact with residents." -"c. Before preparing or handling medication." -"i. After contact with a resident's intact skin." -"j. After contact with blood or bodily fluids." -"m. After removing gloves." **9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as best practice for preventing healthcare-associated infections." **10. Single-use disposable gloves should be used:" -"b. When anticipating contact with blood or body fluids." *Procedure for washing hands: -"1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 15 seconds (or longer)..."</p> <p>B. Based on observation, interview, manufacturer's recommendation review, and germicidal cleaning wipe label review, the provider failed to ensure two of two licensed nurses (A and B) followed manufacturer's recommendations for cleaning and disinfecting the glucometer (machine used to test sugar</p>	F 281		
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F 281	<p>Continued From page 8</p> <p>levels in the blood) after use for six of six observed glucometer tests for residents (3, 6, 12, and 13). Findings include:</p> <p>1. Observation on 3/24/15 at 10:32 a.m. during resident 6's glucometer test with RN A revealed she: *Placed the glucometer on the resident's night stand in his room. *Picked up the glucometer and tested his blood sugar. *Brought the glucometer back to the medication cart. *Wiped it for approximately two seconds with a Sani-cloth disposable wipe. *Placed it on top of the cart.</p> <p>2. Observation on 3/24/15 at 10:38 a.m. during resident 3's glucometer test with RN A revealed she: *Assisted the resident by wheeling his wheelchair with the glucometer in her hand to his room. *Tested his blood sugar with the glucometer. *Brought the glucometer back to the medication cart. *Wiped it for approximately five seconds with a Sani-cloth wipe. *Placed it on top of the cart.</p> <p>3. Observation on 3/24/15 at 10:52 a.m. during resident 12's glucometer test with RN A revealed she: *Set the glucometer down on the arm rest of the resident's recliner in his room. *Picked up the glucometer and tested his blood sugar. *Brought the glucometer back to the medication cart. *Wiped it for approximately five seconds with a</p>	F 281			

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F 281	<p>Continued From page 9</p> <p>Sani-cloth disposable wipe. *Placed it on top of the cart.</p> <p>4. Observation on 3/24/15 at 11:05 a.m. during resident 13's glucometer test with RN A revealed she: *Tested the resident's blood sugar with the glucometer. *Assisted the resident by wheeling her wheelchair with the glucometer in her hands to the dining room. *Returned to the medication cart with the glucometer. *Wiped it for a approximately five seconds with a Sani-cloth disposable wipe. *Placed it on top of the cart.</p> <p>5. Observation on 3/25/15 at 10:35 a.m. during resident 6's and at 10:42 a.m. during resident 3's glucometer tests with RN B revealed she: *Tested first resident's 6's blood sugar and then resident 3's blood sugar with the same glucometer. *She wiped the machine approximately three seconds with a Sani-cloth disposable wipe between the resident's. *Brought the glucometer back to the medication cart in the hallway. *Wiped the machine for approximately three seconds with a Sani-cloth disposable wipe. *Placed it on top of the cart.</p> <p>6. Observations during the above glucometer tests revealed RNs A and B used the same glucometer for all of the above residents.</p> <p>Interview on 3/25/15 at 1:40 p.m. with the DON revealed she would have expected the glucometer to have been cleaned per the</p>	F 281		

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F 281	Continued From page 10 manufacture's recommendations. Review of the User Instruction Manual for the Assure Platinum glucometer machine revealed "Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicidal wipe. To use a wipe, remove from container and follow product label instructions to disinfect the meter." Review of the Sani-cloth germicidal disposable wipe label revealed instructions to disinfect included: **"Unfold a clean wipe and thoroughly wet surface." **"Allow treated surface to remain wet for a full two (2) minutes." **"Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time."	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 35121 A. Based on observation, interview, and record review, the provider failed to ensure proper interventions were put into place to prevent falls for one of five sampled residents (1). Findings	F 323		

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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
F 323	<p>Continued From page 11 include:</p> <p>1. Random observations on 3/24/15 from 7:30 a.m. through 6:15 p.m. and on 3/25/15 from 7:30 a.m. through 5:00 p.m. revealed resident 1 was in his wheelchair. His upper body was leaning to his right side with his right shoulder past the right wheelchair handle bar.</p> <p>Review of resident 1's medical record revealed he:</p> <ul style="list-style-type: none"> *Was admitted on 7/20/11. *Had a diagnosis of a stroke with paralysis (not able to move) of his left side. *Had a score of fifty-five on the Morse Fall Scoring system (a score of forty-five or higher indicated a high risk for falls). <p>Review of resident 1's 6/9/15 Minimum Data Set (MDS) assessment revealed:</p> <ul style="list-style-type: none"> *A score of twelve out of fifteen on the Brief Interview for Mental Status assessment (BIMS). *A BIMS score of twelve showed moderate cognitive (mental) impairment. *He required assistance of two or more people with bed mobility, transfers, locomotion (moving from one place to another), dressing, toilet use, and bathing. *He had fallen twice since the 12/8/14 MDS. <p>Interview on 3/25/15 at 11:13 a.m. with the social services designee regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *Physical therapy had helped with the ordering of a new wheelchair for resident 1. *Staff had been instructed to remind him to sit up straight in his wheelchair. *She stated: <ul style="list-style-type: none"> - "His memory may be impaired." - "We need to do something." 	F 323	<p>The facility will ensure that residents are free of accident hazards to include:</p> <ul style="list-style-type: none"> 1.Safe positioning of Resident #1 in w/c., taking into consideration his ability to move about with care team re-evaluating interventions. Note: MDS assessment date 6/9/15 2 a.Chemical, hazardous materials and equipment have been secured with removal of propped open door to maintenance room. 2 b.Germicidal wipes were removed from therapy room and dietary desk. Laundry Policy for Safety precautions, general Has been revised. 	

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F 323	<p>Continued From page 12</p> <p>*She agreed the interventions in place were not working.</p> <p>Interview on 3/25/15 at 11:40 a.m. with the director of nursing revealed she agreed:</p> <p>*The wheelchair had not corrected resident 1's leaning.</p> <p>*Staff reminders to resident 1 to sit up straight in his wheelchair were not working.</p> <p>Surveyor: 32355</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure chemicals, hazardous materials, and equipment were secured from resident access in four of four observed areas (maintenance room, therapy room, dietary manager's (DM), and laundry room. Findings include:</p> <p>1. Random observations from 8:40 a.m. through 4:45 p.m. on 3/24/15 of one of one maintenance store room revealed:</p> <p>*The entrance door had been unlocked and propped open with a bungy cord.</p> <p>*No staff had been observed in the room or the surrounding area.</p> <p>*The following items were observed inside of this room:</p> <ul style="list-style-type: none"> -Multiple one gallon cans of paint. -Multiple tubes of caulk. -Nails. -Screws. -Various types of equipment for repair work. -Multiple chemicals labeled hazardous. -Electric saw. -Electrical and extension cords. <p>Interview on 3/25/15 at 2:00 p.m. with the</p>	F 323	<p>3. Smoking Safety for resident #3 will be followed according to facility policy to not carry a lighter. Lighter was removed from resident. ✓</p> <p>All staff was in-serviced on 4/16/15 on positioning of residents, security of chemicals, hazardous materials, & equipment and policy on resident smoking.</p> <p><i>* Audits on smoking for resident #3 will be completed by DON/designee daily x 5, weekly x 2, monthly x 2, with results reported to the administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee. JK/SDDOH/ME</i></p>	

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F 323	<p>Continued From page 13</p> <p>administrator and the maintenance supervisor revealed they had been aware the entrance door was kept unlocked and propped open while he had been working. They agreed that had created a potential for harm to the residents.</p> <p>2. Observation on 3/24/15 at 9:00 a.m. of the therapy room revealed the entrance door was unlocked and open to allow resident access. A plastic tub of Germicidal Super-Sani wipes had been observed on an open shelf. There had been no staff in that room or area. Several unidentified residents walked past that room.</p> <p>3. Random observation on 3/24/15 from 9:30 a.m. through 5:45 p.m. of the dietary manager's desk revealed: *Her desk was located in the back area of the dining room. *There had been partitions surrounding her desk to allow for privacy. *A plastic tub of Germicidal Super-Sani wipes was sitting on the desk. It had been unsecured from resident access. *Resident 11 assisted with soiled linens in that area during every meal.</p> <p>4. Observation on 3/25/15 at 7:50 a.m. of the laundry room revealed: *The entrance door leading into the soiled linen area had been unlocked. *Inside of the soiled linen area were the following unsecured chemicals: -One spray bottle of Germicidal Foaming cleaner. -One can of odor eliminator. -One tub of Germicidal Sani-clothes. -One can of stainless steel cleaner. -Six bottles of Shout Stain remover. -Seven gallon jugs of Clorox.</p>	F 323	<p>Audits on positioning of any residents in w/c with altered positioning concerns will be completed by DON/Designee daily x5, weekly x2, monthly x2 with results reported to the Administrator who will report to the quarterly QAA x4 until advised to discontinue by QAA committee</p> <p>Secured chemical, hazardous material and equipment audits for areas with items accessible to residents will be completed by Housekeeping/Laundry Supervisor/designee daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	4-18-15	

* [Redacted Signature] JKSDCHIME

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F 323	<p>Continued From page 14</p> <p>-One bottle of Neutralizer cleaner. *All the labels attached to those chemicals revealed "Danger, keep out of the reach of children."</p> <p>Interview on 3/25/15 at the time of the observation with the laundry and housekeeping supervisor revealed: *The soiled linen area had always been unlocked. *She agreed that created a potential for harm to the residents.</p> <p>5. Interview on 3/25/15 at 2:10 p.m. with the administrator, housekeeping, and laundry supervisor confirmed all chemicals should have been locked-up and secured from resident access.</p> <p>Review of the provider's April 2013 Location of Hazardous Chemicals revealed no procedure for the proper securing and storage of chemicals to ensure no resident access.</p> <p>Surveyor: 32331 C. Based on observation, interview, record review, and policy review, the provider failed to ensure their policy and procedure was followed for one of two residents (3) who smoked cigarettes. Findings include:</p> <p>1. Review of resident 3's medical record revealed: *He had diagnoses that had included diabetes (a disease involving blood sugar control), depressive disorder (mood disorder), and epilepsy (a brain disorder). *A Smoking Safety Screen assessment had been completed on 2/17/15. The following areas were</p>	F 323			

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F 323	<p>Continued From page 15 reviewed on the assessment:</p> <ul style="list-style-type: none"> -Cognition (mental ability). -Vision. -Dexterity (hand and eye coordination). -Frequency of smoking. -Safety with smoking. <p>*The interdisciplinary team decision regarding smoking revealed:</p> <ul style="list-style-type: none"> -He was able to have stored cigarettes and a lighter. -He required supervision due to a diabetes diagnosis and fluctuations (changes) in his blood sugar levels. -He was safe to smoke with supervision. <p>*A physician's progress note on 1/22/14 revealed:</p> <ul style="list-style-type: none"> -He had burned his fingers on his wheelchair with his smoking. -He shook a lot. <p>Review of resident 3's 3/9/15 care plan revealed:</p> <ul style="list-style-type: none"> *He was a smoker. *Could smoke with supervision only, every two hours on the even hour. *He was to have worn a smoking apron. *Smoking supplies were stored by the resident and the nurse. *Clothing and skin were to have been observed for signs of cigarette burns. *He was not able to go outside to smoke when his blood sugar level was below 70 milligrams/deciliter (mg/dl). <p>Interview on 3/24/15 from 4:00 p.m. through 4:20 p.m. with resident 3 in his room revealed:</p> <ul style="list-style-type: none"> *He enjoyed smoking cigarettes. *His hands were shaky, and he had difficulties holding his cigarette at times. *He pointed to a burn hole in the pants he was wearing. 	F 323		

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F 323	<p>Continued From page 16</p> <p>*He had needed assistance with smoking, because he had burned his clothes in the past. *He needed to wear a smoking apron when he smoked.</p> <p>Observation during the above interview with resident 3 revealed he had: *A pack of cigarettes in the front pocket of his shirt. *A Bic lighter in the side pocket of his sweatshirt.</p> <p>Interview on 3/24/15 at 4:30 p.m. with certified nursing assistant (CNA) J regarding resident 3's smoking revealed: *He had needed staff assistance with his smoking due to his weakness. *He had tremors and had the potential of dropping his cigarettes when he smoked. *Sometimes she had to help him hold the cigarette. *He used the lighter by himself to light his cigarette.</p> <p>Observation and interview on 3/24/15 at 4:40 p.m. with CNA K regarding resident 3 revealed: *He had gone outside with her to smoke a cigarette. *He was wearing a smoking apron. *He was able to take a cigarette and a lighter from his pockets and light his cigarette. *She stated he needed to have a staff person with him when he smoked for safety reasons.</p> <p>Interview on 3/25/15 at 8:30 a.m. with the director of nursing regarding resident 3's smoking cigarettes revealed: *He had a smoking assessment quarterly or more often as needed. *He was not independent with his smoking</p>	F 323			

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F 323	Continued From page 17 privileges. *He had needed direct supervision when he smoked. *The provider's policy for resident smoking without independent smoking privileges had included: -Residents may not have or have kept any type of smoking articles except when under direct supervision. *She agreed the provider's policy had not been followed with his current storage of cigarettes and a lighter in his room. Review of the provider's April 2012 Smoking Policy-Residents policy revealed: *Safe resident smoking practices were to have been established and maintained. *Smoking articles for residents without independent smoking privileges were to not to have or have kept: -Any types of smoking articles. -Except when they were under direct supervision.	F 323			
F 363 SS=E	Surveyor: 32332 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by:	F 363			

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F 363	<p>Continued From page 18 Surveyor: 32331 Based on observation, record review, interview, and policy review, the provider failed to serve the pureed consistency diet correctly at three of three observed meals for two of two sampled residents (1 and 9) who were on pureed consistency diets. Findings include:</p> <p>1. Observation and interview with the dietary manager on 3/24/15 at 11:10 a.m. in the kitchen revealed: *Pureed chicken was the only pureed food item prepared in the steam table. *She stated resident 1 was on a pureed consistency diet.</p> <p>Observation on 3/24/15 from 11:10 a.m. through 11:15 a.m. in the kitchen revealed resident 1 received one-third cup of pureed chicken, one-half cup non-pureed cornbread stuffing, one-half cup non-pureed creamed corn, and no bread.</p> <p>Observation on 3/24/15 from 11:30 a.m. through 12:25 p.m. in the dining room revealed: *Resident 1 had consumed one hundred % of his solid foods. *Resident 1 had coughed once during the noon meal. *Resident 1 was observed during the noon meal to have a significant lean to his right side while seated in his wheelchair.</p> <p>Observation and interview on 3/24/15 at 5:10 p.m. with cook F at the evening meal in the kitchen revealed: *Beef stew was the only pureed food item prepared in the steam table. *She stated resident 1 was on a pureed</p>	F 363	<p>-----</p> <ol style="list-style-type: none"> 1. The facility will meet the nutritional needs of residents with their menus/diets. Resident #1 and #9 will have appropriate consistency for a pureed diet per physician order. 2. All staff including dietary staff, was in-serviced by Registered Dietician and Dietary Manager on 4/16/15 of facility policy on preparation, and serving of a pureed consistency diet. 	
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F 363	<p>Continued From page 19 consistency diet.</p> <p>Observation on 3/24/15 from 5:12 p.m. through 5:20 p.m. in the kitchen revealed resident 1 received two-third cup of pureed beef stew and one non-pureed biscuit.</p> <p>Observation on 3/24/15 at 5:20 p.m. with dietary assistant G in the dining room revealed resident 1 received one-cup of finely chopped lettuce salad with a dressing on top and one piece of a non-pureed chocolate-chip bar.</p> <p>Observation on 3/24/15 at 5:40 p.m. in the dining room of resident 1 revealed he was feeding himself the biscuit with butter on top of it. He had a significant lean to the right side while seated in his wheelchair.</p> <p>Interview on 3/24/15 at 5:50 p.m. with registered nurse A regarding resident 1's revealed he sometimes coughed during his meals. She thought that was due to his significant lean to his right side during meals.</p> <p>Observation on 3/25/15 at 7:45 a.m. in the dining room revealed resident 1 had received non-pureed scrambled eggs and finely chopped strawberries, and regular oatmeal.</p> <p>Observation on the same date and location as the above at 8:10 a.m. revealed resident 1 had consumed greater than seventy-five percent of his meal except the strawberries.</p> <p>Record review of resident 1 menu card used by staff for serving their meals revealed he was on a Low Cholesterol All Pureed consistency diet.</p>	F 363	<p>3. Audits on all residents with pureed diet orders for appropriate preparation and serving by Dietary Manager/Designee, (reviewed by Registered Dietician consultant monthly), daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	4-18-15	

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F 363	<p>Continued From page 20</p> <p>Review of resident 1's physician ordered diet revealed: *His diet on 7/16/14 "Regular diet Pureed texture, Regular consistency, With chopped or ground meat, for choking precautions until swallow study done." -That diet had been reviewed and continued on 1/28/15.</p> <p>Review of resident 1's revised 3/9/15 care plan revealed he: *Had a goal to not have injury related to aspiration (the intake of a foreign substance into the respiratory tract during inhalation (drawing air into the lungs), choking, and swallowing with each meal. *He was to have received no bread, however, if he requested he was to have been monitored. *He was a choking risk.</p> <p>2. Observation and interview with the dietary manager on 3/24/15 at 11:10 a.m. in the kitchen revealed : *Pureed chicken was the only pureed food item prepared in the steam table. *She stated resident 9 was on a pureed consistency diet. *She stated resident 9 had preferred her bread not pureed.</p> <p>Observation on 3/24/15 from 11:10 a.m. through 11:15 a.m. in the kitchen revealed resident 9 received one-third cup of pureed chicken, one-half cup non-pureed cornbread stuffing, one-half cup non-pureed creamed corn, and one full piece of a bread bun.</p> <p>Observation on 3/24/15 from 11:30 a.m. through 12:25 p.m. in the dining room revealed resident 9</p>	F 363		
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F 363	<p>Continued From page 21</p> <p>had consumed greater than seventy-five % (percent) of her solid foods, and she had not consumed her bread.</p> <p>Observation and interview on 3/24/15 at 5:10 p.m. with cook F at the evening meal in the kitchen revealed:</p> <ul style="list-style-type: none"> *Beef stew was the only pureed food item prepared in the steam table. *She stated resident 9 was on a pureed consistency diet. *She stated resident 9 had preferred her bread not pureed. <p>Observation on 3/24/15 from 5:12 p.m. through 5:20 p.m. in the kitchen revealed resident 9 received two-third cup of pureed beef stew and one non-pureed biscuit.</p> <p>Observation on 3/24/15 at 5:20 p.m. with dietary assistant G in the dining room revealed resident 9 received one-cup of finely chopped lettuce salad with a dressing on top and one piece of a non-pureed chocolate-chip bar.</p> <p>Observation on 3/25/15 at 7:45 a.m. in the dining room revealed resident 9 had received non-pureed scrambled eggs and finely chopped strawberries, and regular oatmeal.</p> <p>Observation on the same date and location as the above at 8:10 a.m. revealed resident 9 had consumed all of her meal.</p> <p>Record review of resident 9's menu card used by staff for serving her meals revealed she was on a Low Lactose-Free (no milk sugar) Diet Puree consistency diet.</p>	F 363		
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F 363	<p>Continued From page 22</p> <p>Review of resident 9's physician ordered diet revealed: *Her diet on 9/13/13 "Lactose Free diet Pureed texture, Regular consistency Regular diet Mechanical Soft Texture, Regular consistency, depending on food may be pureed." -That diet had been reviewed and continued on 3/16/15.</p> <p>Review of resident 9's revised 1/21/15 care plan revealed she: *Had a lactose-free diet that was to have been pureed to accommodate her chewing. *She did not have bottom teeth. *A speech study had been done, and she was able to have bread and butter with her meals. *She had a diagnosis that had included dysphagia (poor swallowing).</p> <p>Review of the written menu (cycle II 2014-2015 Tuesday and Wednesday Day 24 and 25) for the pureed diets revealed: *On 3/24/15 at the noon meal the pureed diets were to have received -One-half cup pureed cornbread dressing. -One three-eighth cup pureed cream-style corn. -One three and one-third tablespoon pureed wheat roll/bread. *At the evening meal the pureed diets were to have received: -One three-eighth cup pureed vegetable of the day. -One three and one-third tablespoon pureed biscuit. -One one-third cup pureed chocolate-chip bar. *On 3/25/15 at the breakfast meal the pureed diets were to have received: -Three-fourth cup pureed oatmeal. -One three-eighth cup pureed strawberries</p>	F 363		
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F 363	<p>Continued From page 23</p> <p>-One fourth-cup pureed scrambled egg.</p> <p>Interview on 3/25/15 from 2:10 p.m. through 3:00 p.m. with the dietary manager and at 3:00 p.m. with the director of nursing regarding the pureed diets for residents 1 and 9 revealed:</p> <p>*The physician's diet order needed to have been followed.</p> <p>*The written menu for the pureed diets was not being consistently followed as per the physician's order.</p> <p>Review of the provider's 2003 diet manual revealed the pureed diet:</p> <p>*Was for residents with severe chewing difficulties.</p> <p>*Was designed to permit easy swallowing and required minimal or no chewing.</p> <p>*Was to have been modified in consistency by pureeing or modifying food to a smooth consistency.</p> <p>Review of the provider's November 2002 Resident Services Puree Foods policy revealed pureed food would have had a smooth uniform texture no thinner than pudding.</p>	F 363		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371		

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F 371	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, testing, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for the following: *Nine of nine dining room tables in the main dining room and three of three dining room tables in the secured unit. *One of one hood above the stove in the kitchen. Findings include:</p> <p>1. Observation and testing on 3/24/15 with dietary assistant E in the dining room from 12:20 p.m. through 12:30 p.m. revealed: *The nine dining room tables were being cleared of dishes. *Those tables were being wiped down with the a cloth from a green-colored bucket that contained suds. *That above bucket was located on a three-tiered cart that also contained: -Three empty gray buckets. -One empty white container. -One trash container attached to the side of the cart. *This surveyor tested the above green-colored bucket with a Hydrion QT-40 quaternary (quat) test strip (a type of special testing paper), and it tested zero parts per million (ppm). -That test strip needed to have measured at least 150 ppm for proper sanitizing strength.</p> <p>Interview on 3/24/15 at 12:30 p.m. with dietary assistant E revealed: *That was how the tables were cleaned after</p>	F 371	<p>1. The facility will store, prepare, distribute and serve food under sanitary conditions by:</p> <ol style="list-style-type: none"> a. Sanitizing dining tables with hot soap and water, rinsing and Sani-Tyze spray per revised facility policy b. Range hood will be clean quarterly by contracted company and by maintenance staff. 	

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F 371	<p>Continued From page 25</p> <p>each meal.</p> <p>*The above bucket contained water and soap.</p> <p>*She had not been using a sanitizer on the tables after she had cleaned them.</p> <p>*She stated housekeeping cleaned the dining room after she cleared the dishes from the resident tables and wiped them down with the soapy water.</p> <p>Interview on 3/24/15 at 2:00 p.m. with the housekeeping and laundry supervisor regarding cleaning the dining room after each meal revealed:</p> <p>*Housekeeping was responsible for cleaning the floors, blinds, and fans.</p> <p>*Housekeeping was not responsible for cleaning the resident tables.</p> <p>*Housekeeping had not been sanitizing the tables after each meal.</p> <p>Interview on 3/24/15 at 3:00 p.m. with p.m. cook F revealed the resident tables in the dining room were to have been cleaned and sanitized after each meal by dietary.</p> <p>Observation and testing on 3/24/15 at 5:50 p.m. with dietary assistant G in the kitchen revealed:</p> <p>*He had prepared a green-colored bucket that contained a liquid with suds and one cloth.</p> <p>*That above bucket was located on a three-tiered cart that also contained:</p> <ul style="list-style-type: none"> -Three empty gray buckets. -One empty white container. -One trash container attached to the side of the cart. <p>*The above green-colored bucket of solution was tested with a Hydrion QT-40 quat test strip, and it tested zero ppm.</p>	F 371	<p>All staff, including dietary and maintenance staff, were in serviced on</p> <ol style="list-style-type: none"> a. Procedure to sanitize dining tables b. Quarterly cleaning schedule of range hood 	
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F 371	<p>Continued From page 26</p> <p>Interview on 3/24/15 during the above observation with dietary assistant G revealed: *He stated the bucket had been prepared for cleaning the tables after the residents were finished eating their evening meal. *The bucket located on the above three-tiered cart in the kitchen contained soap, water, and a cloth. *It was used to wipe down the tables in the residents' dining room after he cleared each table. *He stated he used no other product on the tables after he had used the soapy water. *He stated he had not been using a sanitizer after he wiped down each table.</p> <p>Observation and interview on 3/25/15 at 8:00 a.m. with certified nursing assistant H in the secured unit revealed: *There were three dining room tables where the residents ate their meals. *She stated the tables were wiped down after the residents were finished eating with a wet cloth that had contained water. *She stated she used no other products on the tables after she had wiped them down with the wet cloth.</p> <p>Interview on 3/25/15 at 8:05 a.m. with housekeeping assistant I regarding the tables in the secured unit revealed housekeeping was not responsible for cleaning the tables in the secured unit.</p> <p>Interview on 3/25/15 from 2:10 p.m. through 3:00 p.m. with the dietary manager regarding all the dining room tables in the main dining room and in the secured unit revealed: *Those areas were to have been sanitized after</p>	F 371	<p>a. Sanitation of dining tables audits will be completed by Dietary Manager/Designee for proper procedure daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p> <p>b. Range hood audits will be completed for required cleaning schedule or as needed by maintenance/designee and report to the administrator daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	4-18-15

* [Redacted Signature] JASDHME

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F 371	<p>Continued From page 27</p> <p>cleaning with a detergent and water.</p> <p>*She stated there should have been EcoLab Oasis 146 Multi-Quat Sanitizer used as the sanitizer.</p> <p>*She confirmed those areas were not being properly sanitized.</p> <p>Review of the provider's undated Product Specification Document of the Oasis 146 Multi-Quat Sanitizer revealed it:</p> <p>*Could be used to sanitize hard, non-porous food contact surfaces such as tables, counters, and food processing equipment.</p> <p>*Was an effective sanitizer on food contact surfaces when used at 150 to 400 ppm active quat.</p> <p>*Was to have been exposed to surfaces as a sanitizing solution for a period of not less than one minute.</p> <p>Review of the provider's revised November 2002 Sanitation and Infection Control cleaning procedure for tables revealed:</p> <p>*The surface was to have been cleaned and sanitized after each meal.</p> <p>*The bases of the tables were to have been cleaned and sanitized weekly.</p> <p>Review of the provider's revised November 2002 Sanitation and Infection Control food safety policy revealed:</p> <p>*A clearly labeled sanitizer of the proper concentration must have been available and used to sanitize all food-contact surfaces including tables.</p> <p>*Sanitizer test strips must have been used to ensure proper concentration.</p> <p>2. Observation on 3/24/15 in the kitchen from</p>	F 371		
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F 371	<p>Continued From page 28</p> <p>7:50 a.m. through 8:20 a.m. revealed the hood filters above the stove had a moderate accumulation of grease with multiple brown and black spots.</p> <p>Interview on 3/25/15 at 2:00 p.m. with the maintenance supervisor regarding the kitchen hood cleaning revealed: *Maintenance had not been responsible for cleaning the hood. *The provider contracted with a company to clean the hood twice per year. -He stated the above company had last cleaned the hood on 11/8/14.</p> <p>Interview on 3/25/15 at 2:10 p.m. with the dietary manager regarding the kitchen hood cleaning revealed: *It was to have been professional cleaned by a contracted company in April and October of each year. *It had been last cleaned by the above company in November 2014. *It had been scheduled to have been cleaned by the dietary department in January 2015. *November 2014 was the last time the hood had been cleaned. *She agreed the hood was dirty, and it had needed to have been cleaned more frequently.</p> <p>Review of the provider's undated, unlabeled procedure for cleaning the hood above the stove revealed: *It was to have been cleaned quarterly. *It was to have been cleaned professionally in April and October of each year. *It was to have been cleaned "in house" in January and July of each year. *The cleaning procedure was as follows:</p>	F 371		

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F 371	<p>Continued From page 29</p> <p>-1. Remove filters and run through dishmachine when delimiting dishwasher. -2. Stand on drain board and let air dry. -3. Put filters back in hood. -4. Clean the outside of the hood."</p> <p>Review of the provider's revised November 2002 Sanitation and Infection Control policy revealed: *Chemical cleaning companies were used to clean areas of the kitchen that had included the hood with a signed contract that had explained the scope of their service. *Hood cleaning was to have been conducted at a minimum of twice per year.</p> <p>Review of the provider's revised November 2002 Cleaning Schedule for the kitchen revealed: *Cleaning schedules were to have provided an overview of how often equipment was to have been cleaned. *The purpose was to have achieved a clean, sanitary environment. *The hood/vent filters were to have been cleaned monthly. -Weekly if there were heavy dust and grease build up.</p> <p>Review of the provider's November 2002 Sanitation and Infection Control Cleanliness and Sanitation policy revealed: *Hoods should have been free of grease, dust, and dirt. *Corners, edges, and lips should have been free of grease, dust, and dirt build-up. *Filter frames should have been free of dust, dirt, and grease. *Filters should not have been clogged with grease and dust.</p>	F 371			

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<p>F 431 F 431 SS=E</p>	<p>Continued From page 30</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	<p>F 431 F 431</p>		
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F 431	<p>Continued From page 31 Surveyor: 29354</p> <p>Surveyor: 35237 Based on observation, interview, and policy review, the provider failed to appropriately dispose of Duragesic patches (controlled narcotic pain medicine delivered through the skin) in sharp's containers (type of puncture proof plastic used for hazardous waste materials) located in one of two soiled utility rooms (West unit) that were accessible to all staff. Findings include:</p> <p>1. Interview on 3/24/15 at 4:08 p.m. with registered nurse (RN) A revealed: *Duragesic patches were put into the sharp's containers after they were removed from a resident. *The sharp's containers were put into a locked soiled utility room when full. *Certified nursing assistants had access to the soiled utility room.</p> <p>Observation on 3/24/15 at 4:20 p.m. revealed a soiled utility room on the West unit hallway. Inside the room was a large box that contained several used sharp's containers.</p> <p>2. Medication cart observation and interview on 3/24/15 at 4:35 p.m. with the director of nursing (DON) revealed: *Duragesic patches had been discarded in the sharp's containers attached to the side of the medication cart. *When the containers were full they had been removed from the cart and were placed in the West unit soiled utility room. *That room was accessible to all staff.</p> <p>3. Interview with the director of nursing (DON) on</p>	F 431	<p>1. The facility will follow the licensed pharmacist recommendation for a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation in regard to disposal of duragesic patches per facility policy of "all narcotic patches will be destroyed by flushing with 2 nurses present, and documented accordingly. No narcotic patches shall be placed in the sharps containers at any times."</p>	

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F 431	<p>Continued From page 32</p> <p>3/25/15 at 1:40 p.m. regarding the storage of discarded Duragisc patches revealed: *All staff had access to the sharp's containers placed in the West unit soiled utility room. *The Fentanyl patches would have been accessible to all staff.</p> <p>Review of the provider's revised 5/1/10 General Dose Preparation and Medication Administration policy and procedure revealed to dispose of unused medication portions in accordance with facility policy.</p> <p>Review of the provider's revised 5/1/10 Disposal/Destruction of Expired or Discontinued Medication policy and procedure revealed: **"Wasted controlled medications should be destroyed by two licensed nurses employed by the Facility, and the disposal should be documented..." -"This procedure should apply to the disposal of unused doses (whole tablets, partial tablets, unused portions of single dose ampoules and doses of controlled substances) wasted for any reason." **"Wasted single doses of medications for disposal may be placed in the trash, or Sharp's container, if permitted by Facility policy and Applicable law." *It had not addressed where the sharp's container should have been placed to limit access to staff.</p> <p>Review of the provider's undated Sharps/Biohazard policy and procedure revealed the sharp's containers would be placed in the soiled utility room when full, then the Biohazard company would pick up when designated.</p>	F 431	<p>2. All staff ,including professional nurses, were in serviced on 04/16/15 on facility policy for disposal of duragesic patches</p> <p>3. Proper disposal of duragesic patches audits will be completed by DON/Designee daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	4-18-15
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=E	<p>Continued From page 33 SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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 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>	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 This REQUIREMENT is not met as evidenced by: Surveyor: 32355 3. Observation on 3/24/15 from 11:40 a.m. through 11:55 a.m. of resident 11 during lunch time revealed: *When she had completed eating her meal she: -Picked up soiled clothing protectors from three unidentified residents without gloves. -Held the soiled clothing protectors against her sweater and walked over to the soiled linen container in the dining room. -Laid the soiled clothing protectors on top of a over-the-bed table by the soiled linen container. *On the over-the-bed table was a plastic laundry basket containing several clean housekeeping cloths. The basket had several large holes that allowed for air and bacterial (infectious particles) particles to pass through it. -Opened the soiled linen bin that contained several soiled linens. *Without gloves she touched and rolled up all of those soiled linens. *After she completed rolling up those soiled linens she requested assistance from a staff member with retrieving a protective jacket. *She put on the protective jacket and a pair of gloves. *With those gloved hands she: -Retrieved a soiled clothing protector from the over-the-bed table, held it up against her pant legs beneath her protective jacket, and folded it in half. -Rolled up the clothing protector and placed it inside of the soiled linen container. -Repeated the above process for several clothing protectors she gathered from the residents who had completed their meals.	F 441	1. The facility will maintain on Infection Control Program to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection by staff washing their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. All staff was in serviced on 04/16/15 on infection control policies for handling and storage of linens, clean linen delivery, dirty utility room, hand washing, whirlpool cleaning, and therapy room equipment.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015	
NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221		
(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 35</p> <p>Observation on 3/24/15 from 5:30 p.m. through 5:50 p.m. of resident 11 after the evening meal revealed she had repeated the same process with the soiled clothing protectors as documented above.</p> <p>Surveyor: 35121 Observation on 3/24/15 at 12:08 p.m. of resident 11 revealed after she was done handling the soiled clothing protectors, with the soiled gloves on her hands, she: *Left the dining room. *Touched the handrail in the hallway. *Returned to her room. *Entered her bathroom.</p> <p>Observation on 3/24/15 at 5:00 p.m. of resident 11 revealed she was taking items out of the soiled linen bin without gloves on.</p> <p>Interview on 3/25/15 at 8:20 a.m. with the laundry and housekeeping supervisor revealed: *She had been aware resident 11 was handling soiled linens in the dining room. *She had not been a part of her training or supervision for that task. *The nursing department had been responsible for the resident's training and supervision. *The housekeeping cloths in the laundry basket would have been placed on the housekeeper carts after they were folded and used by them to clean all the residents' rooms. *She had not been aware that basket had not been considered a closed and protective container for clean linens. *She agreed that had created an environment for cross-contamination for all the residents.</p>	F 441	<p>A. When handling, storing, processing and transporting linens to prevent the spread of infection.</p> <ol style="list-style-type: none"> 1. Resident #11 will no longer assist with collecting clothing protectors after meals. 2. All linen will be covered when distributing clean linen to resident rooms. <p>A. Audits for delivering and handling linens will be performed by Laundry supervisor/designee, daily x5, weekly x 2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	4-18-15

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NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221		
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F 441	<p>Continued From page 36</p> <p>Interview on 3/25/15 at 2:05 p.m. with the administrator and director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *They confirmed the nursing department had been responsible for the training and supervision of resident 11 while performing the above task. *The staff in the dining room at those times should have supervised her with that task. *They had no audits to provide that indicated resident 11 was able to perform the above task in a sanitary manner. *They agreed that had created an environment for cross-contamination for all the residents. <p>Review of the provider's January 2013 Laundry and Bedding, Soiled policy revealed:</p> <ul style="list-style-type: none"> **"Soiled laundry/bedding shall be handled in a manner that prevents gross microbial [bacteria in the air]contamination of the air and persons handling the linen." **"Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use." **"Place and transport contaminated laundry in bags or containers in accordance with established policies governing handling and disposal of contaminated items." <p>4. Random observations on 3/24/15 from 10:20 a.m. through 11:00 a.m. of a clean linen cart on the 200 wing revealed:</p> <ul style="list-style-type: none"> *There was clean clothing inside of the cart. *Those clean linens were in the process of being delivered to the residents' rooms. *The protective covering for those clean linens had been left open during the entire delivery process. *Several unidentified residents and staff had been observed walking by those clean linens. 	F 441	<p>B. Utility Room</p> <p>The 2 soiled utility rooms on west wing and Freedoms Path clean items have been removed and relocated.</p> <p>Facility policy for storage in dirty utility room has been implemented.</p> <p><i>Audit on</i></p> <p>B. Soiled Utility Room for any clean items will be performed by DON/designee, daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	<p>* [REDACTED]</p> <p><i>JKSDHME</i></p>

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NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221		
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F 441	<p>Continued From page 37</p> <p>Interview on 3/25/15 at 8:00 a.m. with the laundry supervisor revealed she: *Had been trained to deliver linens as observed above. *Had trained all of her staff to deliver clean linens using that process. *Agreed that process created the potential of cross-contamination for the residents.</p> <p>The provider had no policy and procedure in place for the safe delivery of clean linens.</p> <p>5. Observation on 3/24/15 from 1:40 p.m. through 1:55 p.m. of two soiled utility rooms located on the 200 wing and Freedom Pathway (secured unit) revealed: *A tall plastic cupboard with five shelves in each room. *There had been soiled linen containers sitting in front of those cupboards. *The cupboards contained multiple clean resident-use items including: -Emesis basins. -Plastic tubs for bed baths and resident use. -Rolls of toilet paper. -Packages of isolation gowns. -Boxes of denture cleaning tablets. -Toilet risers. -Containers of powder. -Toothbrushes. -Tubes of skin protectant. -Containers of cleansing wet wipes. -Bottles of mouth wash. *The soiled linen containers from the cupboards had to be moved to view all the clean items listed above.</p> <p>Interview on 3/25/15 at 2:20 p.m. with the</p>	F 441	<p>C. Hand Washing Staff will follow facility policy for hand hygiene (hand washing and glove usage) per facility policy with direct resident contact.</p> <p>C. Hand washing audits will be performed by DON/Designee, daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	<p>X [REDACTED] JKSD00H/MF</p>

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F 441	<p>Continued From page 38</p> <p>administrator and DON revealed: *They were aware of the clean resident-use items stored in the soiled utility rooms. *They could not guarantee any of the resident-use items above would have been clean due to being stored in the soiled utility rooms and where they were located in those rooms.</p> <p>The provider had no policy and procedure in place for the proper storage of clean resident-use items.</p> <p>6. Observation on 3/24/15 at 10:05 a.m. of certified nursing assistants (CNA) C and L during personal care for resident 5 revealed: *They entered the resident's room without washing or sanitizing their hands and put on clean pairs of gloves. *With those gloved hands they: -Assisted her to roll to her right side. -Removed a soiled pad and urine soaked incontinent brief from underneath the resident. *CNA L: -Removed her soiled gloves, opened the resident's door, and left the room to retrieve a clean pad. -When she returned to the resident's room she had put on a clean pair of gloves without washing or sanitizing her hands. -Turned the handle on the faucet, wet a clean washcloth, and cleaned resident 5's perineal area (private area). -Removed her soiled gloves, opened the resident's door, and left the room to get the DON. -When she returned to the resident's room she had put on a clean pair of gloves without washing or sanitizing her hands. -Assisted CNA C with positioning the resident in bed.</p>	F 441	<p>D. Whirlpool Policy was edited and revised for proper cleaning of whirlpool according to manufacturer's recommendations. Policy was posted in Whirlpool Room.</p> <p>D. Audits of proper cleaning of whirlpool tub will be performed by DON/designee, daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>	<p>X [REDACTED] JL/SDD/HMF</p>

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F 441	<p>Continued From page 39</p> <p>-Retrieved a hairbrush from a basket containing personal care products and brushed the resident's hair. *At that time they both removed their soiled gloves and left the room. *Neither CNA C or L had sanitized or washed their hands prior to leaving the room.</p> <p>Interview on 3/25/15 at 11:10 a.m. with the administrator and the DON revealed: *Personal care and handwashing had been a random audit they did all year long. *They would have provided education at the time of the observations. *They would have expected the CNAs to remove their gloves and wash their hands when going from a dirty to a clean technique. *The CNAs should have washed their hands upon entering and exiting the resident's room. *They confirmed the technique used to provide personal care for resident 5 had not been sanitary.</p> <p>Review of the provider's January 2013 Handwashing/Hand Hygiene policy revealed: *"This facility considers hand hygiene the primary means to prevent the spread of infections." *"Employees must wash their hands for at least twenty seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: -Before and after direct resident contact. -Before and after assisting a resident with personal care."</p> <p>Surveyor: 35121 Based on observation, interview, and policy review, the provider failed to ensure sanitary</p>	F 441	<p>E. Therapy Room Equipment Policy was revised to state that equipment will be sanitized after each resident contact.</p> <p>E. Therapy room equipment audits for cleaning after use by a resident will be performed by DON/designee, daily x5, weekly x2, monthly X 2, with results reported to Administrator who will report to the quarterly QAA x 4 until advised to discontinue by QAA committee.</p>		

* [Redacted] JK/SDDH/ME

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

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221		
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F 441	<p>Continued From page 40</p> <p>conditions were maintained for:</p> <ul style="list-style-type: none"> *One of one observed whirlpool tub cleaning. *One of one observed therapy room that contained therapy equipment for residents' use. *One of one observed resident (11) handling soiled linens. *Two of two observed soiled utility rooms that contained clean residents' use items. *One of one sampled resident (5) who received personal care by two of two certified nurse aides (CNA) C and L. <p>Findings include:</p> <p>1. Observation and interview on 3/25/15 at 9:55 a.m. with CNA C regarding cleaning of the whirlpool tub revealed she:</p> <ul style="list-style-type: none"> *Did not press and hold the disinfect button located on the side of the whirlpool tub. *Added two short streams of unknown amount of disinfectant to the whirlpool water. *Did not know how much disinfectant she: <ul style="list-style-type: none"> -Had added. -Should have added. *Stated "We should probably have a measuring cup in here." <p>Interview on 3/25/15 at 10:20 a.m. with the director of nursing (DON) revealed she "thought the disinfectant was set at what the manufacturer required and that we didn't add any extra."</p> <p>Interview on 3/25/15 at 2:40 p.m. with the DON revealed she:</p> <ul style="list-style-type: none"> *Confirmed the disinfectant was pre-set to be mixed per manufacturer's instructions. *Agreed they should not have added any additional disinfectant to the water. <p>Review of the provider's undated whirlpool</p>	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2015
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F 441	<p>Continued From page 41</p> <p>cleaning instructions revealed "add disinfectant marked on side of the tub."</p> <p>Review of the undated manufacturer's Penner Spas Aqua-Aire Sit-Bath System cleaning instructions revealed: "Press and hold the disinfect button located on the left side of the tub. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub."</p> <p>2. Observation on 3/24/15 at 3:15 p.m. of the therapy room revealed multiple therapy equipment items including: large therapy balls, hand cones, therapy putty, and hand weights.</p> <p>Interview on 3/25/15 at 4:00 p.m. with physical therapist D revealed she did not clean the therapy equipment between each resident use.</p> <p>Surveyor: 32332</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221
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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	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/25/15. Bryant Parkview Care Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>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.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lynelle Rust</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-16-15</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.

APR 20 2015
SD DOH L&C

ORIGINAL

PRINTED: 04/07/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10602	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER BRYANT PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 303 W 6TH AVE BRYANT, SD 57221
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S 000	<p>Initial Comments</p> <p>Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04; Medical Facilities, requirements for nursing facilities, was conducted from 3/24/15 through 3/25/15. Bryant Parkview Care Center was found in compliance.</p>	S 000		

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

Lynall Rust

Admin's Note

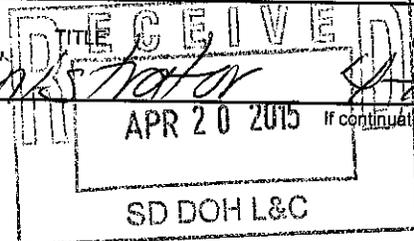
(X6) DATE

4/16/15

STATE FORM

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If continuation sheet 1 of 1