

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

ORIGINAL

PRINTED: 03/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2015
NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104	
(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	<p><i>Addendums noted with an asterisk per 4/11/15 telephone to facility administrator RN. CS/SDDO/HMF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/16/15 through 3/18/15. Dow Rummel Village was found not in compliance with the following requirement(s): F159, F248, F281, F309, F431 and F441.</p>	F 000	<p>Preparation, submission and implementation of the Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
F 159 SS=E	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p>	F 159	<p>F159 Facility Management of Personal Funds</p> <p>The Resident Trust Funds are deposited into an interest bearing account separate from any Dow Rummel Funds. The lowest balance for an interest bearing account available to Dow Rummel at our bank was \$25,000. Therefore, we will only receive interest if the balance is over \$25,000. Should we receive any interest on this account it will be distributed to the residents on a monthly basis through our trust fund accounting program. Due to the small participation we have in our Resident Trust Fund the balance has not reached the \$25,000 minimum required by the bank. The highest balance in an individual Resident Trust Fund is \$1,800 (not \$200 as stated).</p> <p><i>*including residents 5 and 16 CS/SDDO/HMF</i></p>	4/11/15

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

Rebecca Tarish, Administrator

TITLE

(X6) DATE

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.

4-6-15
APR 07 2015
SD DOH L&C

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F 159	<p>Continued From page 1</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265</p> <p>Surveyor: 35121 Based on observation, interview, account review, and policy review, the provider failed to ensure two of two sampled residents (15 and 16) with money deposited in a trust account: *Had it in an interest bearing account. *Had continuous access to their funds. Findings include:</p> <p>1. Observation, interview, and account review including accounts for resident's 15 and 16 on 3/18/15 at 8:50 a.m. with the office manager revealed: *Current statements showed no interest earned. *There was a ten dollar limit on funds residents could request on the weekends.</p>	F 159	<p>Procedures have been clarified so that a resident or financial POA has access to 100% of the money in their account any time the business office is open. The hours that a resident or POA can access their funds have been expanded to Sunday through Saturday 8:00 a.m. to 8:30 p.m. which is when Dow Rummel's business office is open. The Resident Handbook has been revised to provide this information stating: "We offer through our Business Office, the ability to deposit personal funds in to a Resident Trust Account. Residents and their POA's have access to these funds during our Business Hours: Sunday through Saturday 8:00 a.m. to 8:30 p.m."</p> <p>By Monday, April 6, 2015 all current evening and weekend staff have been trained on the procedures for handling resident trust funds.</p> <p>The CFO or designee will audit the Resident Trust Fund accounts monthly and report their findings to the CQI Committee on a monthly basis for 3 months and they quarterly for 3 quarters. The CQI Committee will then evaluate the plan for continued compliance and effectiveness. Based on findings, the CQI Committee will make recommendations to continue or discontinue audits.</p>		

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F 159	Continued From page 2 *The office manager would ask social services or family members for permission for funds requested by residents that were fifty dollars or more. *The highest amount of individual funds in the account was two-hundred dollars. Interview on 3/18/15 at 9:10 a.m. with the chief financial officer revealed the residents fund account did not bear interest until it reached the amount of twenty-five thousand dollars. Review of the provider's revised 10/ 9/14 Admission Handbook Valuables Policy revealed: *"Residents have the right to manage their financial affairs." *"We do offer, through our Business Office and upon request, the ability to deposit personal funds into a Resident Trust Account." *Amount of withdrawal limits were not addressed.	F 159			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, and job description review, the provider failed to ensure two of two sampled residents (8 and 14) received individual activity programming based on their assessed interests and needs. Findings	F 248	F248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT All nursing home residents have the potential to be affected. Resident #14 discharged from the facility on 3/31/14. Resident #8's charting within AOD was updated to include an automatic reminder (Activity Icon will be shaded yellow meaning there is 1:1 charting to be done) to provide a daily 1:1 visit, with the options to chart: Resident Refused, Resident Sick/Not Available, Resident on Hold, Resident Out of Facility. An activity assessment was created to be completed for initial care plan and updated at quarterly care plans. Activity Manager (AM) will work with the care plan team to determine residents who need 1:1	4/11/15	

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F 248	<p>Continued From page 3 include:</p> <p>1. Review of resident 8's 1/20/15 care plan revealed: *Problem: "I am not able to attend activities independently; spends some time in room napping, spends time in dayroom or somewhere near nurse's desk or dining area. I enjoy music and singing, At times I enjoy 1:1 [one-on-one] visits. *Approach: "Offer 1:1 visits and sensory therapy (such as taste, smell, touch). -Invite and encourage to go on w/c [wheelchair] rides outside of facility when weather permits. -Visit 1:1 with ____ [name of resident] when not interested in attending group activities. -Staff to bring to Devotions when it is offered."</p> <p>Review of resident 8's 1/14/15 Minimum Data Set (MDS) assessment revealed her interests included getting fresh air when the weather permitted, religious programs, music, and being with people.</p> <p>Observation of resident 8 from 3/16/15 through 3/17/15 revealed: *She had advanced dementia (memory loss) and made repeat vocalizations throughout the day. *Had the radio on softly in her room playing Christian music. *Spent most of the day in her room alone.</p> <p>Interview and review of resident 8's 2015 activity attendance records 3/17/15 at 9:25 a.m. with the activity manager regarding resident 8 revealed: *Resident 8 was very difficult to bring to activities because of her repetitive (repeat sounds) vocalizations. -She was supposed to receive 1:1s. several times</p>	F 248	<p>activities daily. All other residents currently receiving daily 1:1 activities were identified, care plans updated, and AOD software reminder put into place. An Activity Programming Policy was developed to reflect care planned 1:1 and group activities. AM and Administrator provided a directed in-service to Activity Associates on 4/3/15.</p> <p>Residents needing daily 1:1 activity programming will be identified through the care plan team and Activity Manager (AM), who will then maintain a resident daily 1:1 list. The AM will then update the AOD software system for each resident so that the software will provide a daily reminder. Upon admission and at quarterly care conferences, a resident activity assessment of likes and dislikes will be done by the AM or designee and this information will be used in developing the activity care plan.</p> <p>*two times weekly for one month & one time weekly To monitor for compliance, the Activity Manager will review daily Activity ADL charting [redacted] for 3 months and bring the findings to the CQI committee for recommendations on continuing the monitoring. Activity Manager will maintain a list of residents needing daily 1:1 visits and [redacted] that the AOD software is generating that daily reminder. * will monitor weekly (S/S/D/O/H/M/F)</p>	

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F 248	<p>Continued From page 4 per week.</p> <ul style="list-style-type: none"> -On days when she was more calm, staff were supposed to bring her out to activities. -Her January, February, and March 2015 activity records revealed she: <ul style="list-style-type: none"> -Had received 1:1s four times. -Had attended faith based programs ten times. -Participated in pet visits twice. -The care plan had not specified how often this resident was to have received 1:1s. <p>2. Review of resident 14's 2/14/15 Minimum Data Set (MDS) assessment revealed his interests included getting fresh air when the weather permitted, religious programs, music and doing his favorite activities. He was currently on Hospice.</p> <p>Observation of resident 14 from 3/16/15 through 3/18/15 revealed he was usually in his room and in bed.</p> <p>Review of resident 14's 2/10/15 care plan revealed:</p> <ul style="list-style-type: none"> *He was to receive massage, aromatherapy, music, read the Bible, and spiritual sayings. *Listen to music in his room. *Have pet therapy. *It had not addressed what favorite activities he was to have received. <p>Review of resident 14's February and March 2015 activity participation record revealed he:</p> <ul style="list-style-type: none"> *Had not attended an out of room activity. *Had no attended any religious program, pet programs, or music programs. <p>Interview on 3/18/15 at 9:45 a.m. with the activity manager revealed:</p>	F 248		

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F 248	Continued From page 5 *One of her staff was not assigned to do a 1:1 with residents. They just knew they were supposed to. *She agreed the documentation would not have supported that 1:1s were being done. *She had not done any progress notes for activities. *Their new electronic documentation system did not show when a resident refused an activity or was unable to attend for some other reason. -She thought that was something that should have been documented. Because all you could tell by the documentation now was the resident had not attended. Review of the provider's activities manager job description revealed the essential duties and responsibilities included: *Provide a plan of activities appropriate to the needs of the residents that included but was not limited to: -Group social activities. -One-to-one attention. -Encourage resident participation in activities and document outcomes. -Review goals and progress notes. -Develop an appropriate plan with measurable goals for each resident consistent with plan of care and orders of physician based on assessment. -Regularly update assessments and plans of care."	F 248	F281 SERVICES PROVIDED MEET PROFESSIONAL SERVICES Resident #12 interdisciplinary notes were reviewed. On 11/27/2014 the nurse notified the on-call primary care physician (PCP) regarding change of status at 0255 and received orders for Morphine, Ativan and Atropine for comfort. Resident #12 assessed and had no pulse or respirations for > 5 minutes. PCP was notified by nurse. The Policy and Procedure, Death of a Resident, was reviewed and revised. A Directed In-service Training for healthcare center nurses was completed on 4/7 and 4/8/2015 with review of example cited and of the Policy and Procedure Death of a Resident. The Director of Nursing (DON) or designee will audit all closed charts when residents die in facility monthly X 3. Results of the findings will be reported by the DON or designee at the monthly Continuous Quality Improvement (CQI) Committee meeting for the next 3 months. The CQI Committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the CQI Committee will make recommendations to continue or discontinue audits.	4/11/15
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 6 This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on record review, interview, and policy review, the provider failed to follow nursing professional standards by not ensuring: *Nurses had not declared death for one of one sampled residents (12). ed. *A physician's order had been obtained for one of two sampled residents (10) on hospice. Findings include: 1. Review of resident 12's closed (no longer in facility) medical record revealed: *She was admitted on 8/11/14. *She had died on 11/27/14. *The nurse's note on 11/27/14 at 4:54 a.m. regarding her death revealed: -The nurse stated the resident died at 3:55 a.m. -There was an order from the doctor to "release the earthly remains." Interview on 3/18/15 at 10:35 a.m. with the director of nursing (DON) revealed she agreed the nurses call the time of death. Review of the provider's 8/23/02 Resident Death Policy revealed: *In the case of imminent death of a resident the physician would have been kept informed of the resident's progressing condition. *Physician responses were to have been documented in the nursing notes or physician orders. **"When respirations and heart beat cease, the physician will be notified." Review of the South Dakota Board of Nursing	F 281	Resident #10 was transferred on 2/17/15 from assisted living to long term care. Hospice faxed A Change in Location of Care Order to resident's primary care physician (PCP) that was signed by PCP on 2/17/15 with order reading "Pt transferring from ALF to SNF 2/17/15" and "ok to transfer with current medications and treatments". The Director of Nursing did not agree with the surveyors and showed the order obtained - Change in Level or Location of Care Order - Pt transferring from ALF to SNF 2/17/15. Dow Rummel obtained a second order for hospice services from PCP on 3/19/15. Dow Rummel had a new written and signed order for hospice, medications, and treatments on resident #10. The Physician Orders Policy and Procedure was reviewed and revised. A Directed In-service Training for healthcare center nurses was completed on 4/7 and 4/8/2015 with review of example cited and of the Policy and Procedure Physician Orders. The Director of Nursing (DON) or designee will audit all long term care residents that are admitted on hospice services monthly X 3. Results of the findings will be reported by the DON or designee at the monthly Continuous Quality Improvement (CQI) Committee meeting for the next 3 months.	

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F 281	<p>Continued From page 7</p> <p>8/4/14 letter clarifying the intent of SDCL 34-25-18 and 34-25-18.1 pronouncement of death revealed: "The Board of Nursing has been advised by legal counsel that in order for pronouncement of death to be effective it must be accompanied by a certificate, which the law recognizes, stating the party died with the cause of death and since a nurse cannot sign a death certificate, a nurse cannot pronounce death."</p> <p>Surveyor: 33265</p> <p>2. Review of resident 10's complete medical record revealed:</p> <ul style="list-style-type: none"> *He had been on hospice since 1/27/15. *He had transferred from assisted living to long term care on 2/17/15. *There had been no order written for hospice care to continue at the time of transfer or since that date. <p>Interview on 3/18/15 at 9:50 a.m. with the DON revealed she:</p> <ul style="list-style-type: none"> *Agreed there should have been an order written for continuation of hospice care. *Believed the sending facility should have gotten the order for continuation of hospice when the resident had been transferred. <p>Review of the provider's revised 1/19/15 Physician Orders Policy and Procedure revealed:</p> <ul style="list-style-type: none"> *All orders for treatment shall be written and signed by the physician, advanced nurse practitioner and or/physician assistant. *All residents transferred within the provider's complex must have new orders written and/or approved by the admitting physician or designee, which shall include medications, treatments, diet, lab requests, activities of daily living and condition of patient code (if the resident's heart stopped 	F 281	<p>The CQI Committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the CQI Committee will make recommendations to continue or discontinue audits.</p>	

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F 281	Continued From page 8	F 281		
F 309 SS=D	<p>beating or they quit breathing would they want emergency steps to revive them) status.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 A. Based on record review, interview, and program review, the provider failed to ensure bowel management interventions were in place for two of two sampled residents' (4 and 6) bowel programs. Findings include:</p> <p>1. Review of resident 4's 5/14/14 admission and 1/28/15 quarterly Minimum Data Set assessments revealed constipation had been present.</p> <p>Review of resident 4's 2/3/15 care plan revealed "Please help nurse/MA [medication assistant] administer analgesics [pain medication] and monitor BM [bowel movement] to help keep me comfortable."</p> <p>Review of resident 4's daily charting review forms revealed no documentation of a BM: *From 1/25/15 to 2/3/15 - eight days. *From 2/17/15 to 2/23/15 - four days.</p>	F 309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Resident #4 and Resident #6 medical records were reviewed. Bowel function assessed and review of medications done. Both these residents are able to toilet themselves and are forgetful with poor memory that would impair their ability to report bowel movements to any associate.</p> <p>All associates will be responsible to document bowel movements in the electronic medical record, Answers on Demand (AOD).</p> <p>All residents have the potential to be affected by this practice.</p> <p>The Policy and Procedure, Bowel Management Program, was reviewed and revised.</p> <p>A Directed In-service Training for all healthcare associates was completed on 4/7 and 4/8/2015 with review of example cited and of the Policy and Procedure Bowel Management Program.</p> <p>The Night Charge is printing the AOD Report – No BM for 9 Shifts. The Charge Nurse is reviewing the report, verifying with UAPs that the bowel movements have been</p>	4/11/15

Handwritten notes:
*see page 109
*see page 110

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F 309	<p>Continued From page 9</p> <p>*From 2/24/15 to 2/28/15 - five days. *From 3/2/15 to 3/9/15 - seven days.</p> <p>Review of resident 4's Medication Administration Records for January 2015, February 2015, and March 2015 revealed no as needed medications had been given to promote BMs.</p> <p>Interview on 3/18/15 at 11:00 a.m. with the director of nursing (DON) revealed: *The night nurses would have reviewed residents' BM records. *If a resident had not had a BM for nine shifts medications should have been administered to promote a BM. *Their bowel maintenance program should have been followed for resident 4.</p> <p>Review of the provider's 2/6/14 Bowel Management Program revealed: *The night shift nurses reviewed charting for residents that had not had a BM for nine (day, evening, and night) shifts. *A laxative and/or stool softener would be administered if there had been no BM for nine shifts. *The day shift nurses would check if the laxative and/or stool softener had been effective. *Results would be noted on the resident's daily report sheet. *If no results had been noted the night shift would administer an enema the following morning. *Licensed nursing and CNAs were responsible for documentation in the computer and on the daily report sheets.</p> <p>Surveyor: 35121 2. Review of resident 6's bowel function reports and daily report sheets for December 2014,</p>	F 309	<p>documented electronically, and then offering to resident to administer a laxative and/or stool softener.</p> <p>Director of Nursing (DON) or designee will review the AOD reports bi-weekly X 4 weeks, then weekly X 8 weeks, then monthly to ensure the BMs are being documented in AOD and the laxatives and/or stool softeners are being administered as ordered. Results of the findings will be reported by the DON or designee at the monthly Continuous Quality Improvement (CQI) Committee meeting for the next 6 months. The CQI Committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the CQI Committee will make recommendations to continue or discontinue audits.</p> <p><i>* (continued from page 9). The bowel management policy will be followed if no bowel movement has been recorded for residents 4 and 6. as per DPHM</i></p>	

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F 309	<p>Continued From page 10</p> <p>January 2015, and March 2015, revealed he had no BM from:</p> <ul style="list-style-type: none"> *12/2/14 to 12/6/14 - five days. *1/2/15 to 1/6/15 - five days. *1/9/15 to 1/12/15 - four days. *1/14/15 to 1/21/15 - eight days. *1/29/15 to 1/31/15 - three days. *2/13/15 to 2/18/15 - six days. *2/22/15 to 2/24/15 - three days. *3/11/15 to 3/15/15 - five days. <p>Review of resident 6's Medication Administration Records for December 2014, January 2015, and March 2015 revealed no as needed medications to promote a BM had been given.</p> <p>Review of resident 6's care plan revealed the nurse was to monitor BMs.</p> <p>Interview on 3/17/15 at 10:10 a.m. with licensed practical nurse B revealed the certified nurse aides (CNA) were responsible for charting BMs in the computer and on the daily report sheets.</p> <p>Interview on 3/18/15 at 10:25 a.m. with the DON revealed she:</p> <ul style="list-style-type: none"> *Expected the CNAs to document BMs in the computer at the time it occurred. *Agreed that as needed medications were not being administered after nine shifts of no reported BMs. <p>Surveyor: 26180 B. Based on record review, interview, and agreement review, the provider failed to ensure</p>	F 309	<p>Resident #10's facility and hospice interdisciplinary plan of cares and facility activities of daily living list were reviewed and revised to define specific services provided by each caregiver.</p> <p>Resident #14 was discharged from facility on 3/31/15.</p> <p>All hospice residents' plan of cares and activities of daily living lists was reviewed and revised to define frequency of visits and specific services provided by hospice and facility defined.</p> <p>The Assessment and Care Planning Policy and Procedure was reviewed. An Integrated Plan of Care with Hospice Policy and Procedure was written along with a Dow Rummel & Hospice Communication Tool developed.</p> <p>Collaborative meetings with hospice have been scheduled: Aseracare Hospice – 4/22/15, Compassionate Care Hospice – 4/29/15, and Sanford Hospice – 5/06/15. These collaborative meetings will be held at a minimum every quarter.</p>		

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F 309	<p>Continued From page 11</p> <p>two of two sampled residents (10 and 14) had care plans that were integrated with Hospice care plans. Findings include:</p> <p>1. Review of resident 14's physician's orders revealed an order for Hospice effective 1/31/14.</p> <p>Review of resident 14's 2/19/15 care plan revealed: *Problem: I am approaching end of life. On 1/31/14 I was admitted to ___[name of Hospice agency] with paralysis agitans (Parkinson's Disease)." -Approach: "I am on hospice. Please see hospice care plan for additional options." *Problem: "I have difficulty completing fine motor ADLs [activities of daily living for or including dressing, grooming, eating). -Approach: "Hospice will partner with me to provide cares." *Problem: "I am incontinent of urine." -Approach: "Please involve Hospice in help me stay dry and clean." *Problem: "I feel that I've been more quiet and tired but don't feel I'm depressed." -Approach: "Confer with hospice SS [social services] as needed r/t (related to) emotional comfort needs." *The care plan had not clarified specific approaches that hospice was responsible for and those the nursing staff were responsible for.</p> <p>Interview on 3/18/15 with the Minimum Data Set assessment coordinator regarding resident 14's care plan revealed she agreed the care plan had not specified the specific responsibilities Hospice caregivers had with the resident.</p> <p>Review of the provider's 6/4/14 annual agreement</p>	F 309	<p>Currently, the Minimum Data Set assessment coordinator develops the electronic plan of care. Healthcare nurses will be receiving training on electronic care planning in May, 2015 with Answers on Demand Consultant.</p> <p>A Directed In-service Training for all healthcare associates was completed on 4/7 & 4/8/15 with review of example cited and of the Policy and Procedure Care Plans - Comprehensive.</p> <p>The Director of Nursing (DON) or designee will audit all long term care residents that are admitted on hospice services monthly X 3. Results of the findings will be reported by the DON or designee at the monthly Continuous Quality Improvement (CQI) Committee meeting for the next 3 months. The CQI Committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the CQI Committee will make recommendations to continue or discontinue audits.</p>	

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F 309	Continued From page 12 with resident 14's Hospice provider revealed: *"Hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care." Surveyor: 33265 2. Interview and record review on 3/18/15 at 9:50 a.m. with the DON regarding the care plan for resident 10 revealed: *The resident had been on hospice since 1/17/15. *There were two separate care plans for resident 10, the provider's care plan and the hospice agency's care plan. *There was no integrated (combined) care plan.	F 309		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F 431	F431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The Hydrocodone –APAP medication card was removed from the medication room and placed in the locked drawer on the locked medication cart. The Omnicare Long Term Care (LTC) Pharmacy Policy & Procedure Manual was available to surveyors. Effective 4/1/15, the facility changed pharmacy vendors to Avera LTC Pharmacy. A Directed In-Service Training for healthcare nurses was completed on 4/7 and 4/8/2015 with review of example cited and The Medication Storage in the Facility - Controlled Substance Storage Policy and Procedure. The Director of Nursing (DON) or designee will randomly audit the medication room for controlled substances weekly X 4. Results of the findings will be reported by the DON or designee at the monthly Continuous Quality Improvement (CQI) Committee meeting. The CQI Committee	4/11/15

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F 431	<p>Continued From page 13</p> <p>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: Surveyor: 33265 Based on observation, interview, and record review, the provider failed to assure the accountability for one of one randomly observed scheduled (drug with high potential for misuse) medication punch card since the medication was delivered from the pharmacy on 3/1/15. Findings include:</p> <p>1. Observation on 3/17/15 from 4:30 p.m. through 4:52 p.m. with licensed practical nurse (LPN) B in the medication storage room revealed: *One full medication punch card (thirty tablets) of Hydrocodone-APAP 5-325 mg (scheduled medication [pain medication]), was located in a locked cupboard in the medication storage room. *All other scheduled medications were secured in the north/west medication cart in a locked box within the locked cart.</p> <p>Interview on 3/17/15 at 4:45 p.m. with LPN B regarding the above medication revealed:</p>	F 431	<p>will evaluate the plan for continued compliance and effectiveness. Based on findings, the COI Committee will make recommendations to continue or discontinue audits.</p>		

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F 431	Continued From page 14 *The medication should have been placed with the other scheduled medications in the locked box within the north /west medication cart. -The Hydrocodone -APAP medication was in the cupboard for "convenience." *There had been no documentation of counting the amount of tablets or tracking the location of that medication since the medication had been delivered from the pharmacy on 3/1/15. -The medication should have been counted routinely as were the other scheduled medications. Interview on 3/18/15 at 9:50 a.m. with the director of nursing (DON) regarding the medication above revealed she agreed the medication should: *Not have been in the locked cupboard in the medication storage room. *Have been locked in the north/west medication cart when it arrived on 3/1/15. *Have been counted and tracked. Review of the schedule II controlled drug record for the above medication revealed it had been delivered to the provider on 2/1/15. The policy on the scheduled drug storage was requested of the DON, but it was not received before the end of the survey.	F 431	F441 INFECTION CONTROL, PREVENT SPREAD, LINENS Hand washing: Nursing Assistant A has been re-educated on hand washing/hygiene policy and procedure. Education completed on 3/18/15. Nursing Assistant A will be randomly monitored during personal cares by Resident Care Supervisor or designee every week X 4 to ensure compliance. All associates will be completing the mandatory training on Relias Learning – Hand Washing Training by April 10, 2015*to ensure proper handwashing for all residents including resident B. CSISODDIME Disinfection of one of one whirlpool tubs: Nursing Assistant C has been retrained on cleaning and disinfecting the whirlpool tub. Education was completed on 3/18/15.	4/11/15	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	All associates assigned to the bath aide position will be completing the mandatory training on Relias Learning - a u-tube video by Penner Patient Care on cleaning and disinfecting the whirlpool by April 10, 2015.		

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F 441	<p>Continued From page 15</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and policy review, the provider failed to ensure proper infection control practices were followed for: *Handwashing during one of four sampled residents (8) who received personal care.</p>	F 441	<p>A competency on whirlpool bath cleaning/disinfection will be completed by all bath aides by April 10, 2015.</p> <p>Cleaning of glucometers:</p> <p>Licensed practical Nurse B has been re-educated on cleaning/disinfecting meter. Education done on 3/18/15. Blood glucose competencies will be checked with all associates doing testing upon hire, randomly and as part of their annual performance review. The Director of Nursing, Resident Care Supervisor, Infection Control Nurse, or designee will monitor.</p> <p>Residents #3, #17 and #18</p> <p>A Directed In-service Training for all healthcare associates was completed on 4/7 and 4/8/2015 with review of example cited and of the Policy and Procedures: Hand washing/Hygiene, Whirlpool Bath Cleaning/Disinfectant, and Blood Glucose Meter Cleaning & Disinfecting.</p> <p>A competency Checklist on hand washing/hygiene will be completed by all associates at the directed in-service. A competency checklist on blood glucose monitoring system will be completed by all nurses and medication aides at the directed in-service.</p> <p><i>* to ensure proper glucometer disinfecting for all residents including residents 3, 17 and 18. (SIEDD0HMF</i></p>		

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F 441	<p>Continued From page 16</p> <p>*Disinfection of one of one whirlpool tubs.</p> <p>*Cleaning of glucometers (device used to test blood sugars) by one of one licensed practical nurse (LPN) B during three of three residents (3, 17, and 18) randomly observed residents who had their blood sugar checked.</p> <p>Findings include:</p> <p>1. Observation on 3/16/15 at 3:55 p.m. of certified nursing assistants A and D with resident 8 revealed:</p> <p>*They entered her room, washed their hands, and put on a pair of gloves as they prepared to get the resident out of bed for supper.</p> <p>*The resident had a bowel movement (BM), and CNA A:</p> <ul style="list-style-type: none"> -Obtained several disposable wash cloths to use for cleaning the resident's buttocks. -Removed the resident's soiled disposable brief, threw it in the waste basket, and washed the resident's buttocks. -Opened her bedside stand drawer and obtained an unidentified item. -Resumed cleaning her buttocks. -Put a clean disposable brief on her and assisted CNA D with pulling her pants up. -Positioned the Hoyer (lift used for transferring) sling under the resident. -Pushed the Hoyer lift over to the resident's bed and attached the sling to the Hoyer lift. -Assisted CNA D with lifting the resident and positioning the chair. -Obtained a comb from her bedside stand and combed her resident's hair. -Had not washed his hands or changed his gloves from the time he had entered the room. <p>*After the CNAs had completed getting the resident up in her chair CNA D tied up the bag of garbage and left the room.</p>	F 441	<p>The Director of Nursing, Resident Care Supervisor, Infection Control Nurse, or designee will report results of these competencies at the next monthly Continuous Quality Improvement (CQI) Committee meeting. The CQI Committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the CQI Committee will make recommendations to continue or discontinue audits.</p>		

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F 441	<p>Continued From page 17</p> <p>*CNA A removed his gloves and washed his hands for six seconds.</p> <p>Interview with CNA A when he had finished the above procedure with resident 8 revealed: *He should have washed his hands after he had completed washing the resident's buttocks with the bowel movement on them. *They were to wash their hands for twenty to thirty seconds using water that was a comfortable temperature for them. *He could not recall if he had washed his hands during the care of the resident, but thought he had washed his hands for an appropriate amount of time.</p> <p>Interview on 3/18/15 at 8:25 a.m. with the director of nurses (DON) revealed: *They should wash their hands upon entering a room and preparing to care for a resident. *They should wash their hands whenever they were soiled with bodily fluids. *CNA A should have washed his hands after he washed the resident's buttocks of the BM. He should have washed them for longer than six seconds.</p> <p>Review of the provider's 2/26/15 Handwashing policy revealed: **Indications for Handwashing or antiseptis include, but are not limited to: -1. When hands are visibly dirty or contaminated, hands are to be washed with soap and water. -8. After contact with blood, body fluids or excretions or mucous membranes, such as blowing a residents nose. -14. After using the bathroom or assisting a resident with toileting, wash hands with soap and water.</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>*Handwashing Technique: -1. When washing hands with soap and water, wet hands first with water, apply an amount of the product recommended by the manufacturer to hands and rub hands together vigorously for at least 15 seconds covering all surfaces of the hands and fingers."</p> <p>Surveyor: 25107</p> <p>2. Observation, record review, and interview with certified nurse assistant (CNA) C on 3/16/15 at 3:00 p.m. in regards to disinfecting the whirlpool tub revealed:</p> <p>*She added an unknown amount of water (approximately ten gallons) to the bottom of the tub and added two cap fulls of disinfectant (approximately two ounces).</p> <p>*She was not sure how many gallons of water were in the tub or how many ounces of chemical she had added.</p> <p>*She used the solution to disinfect the inside of the tub and the tub chair.</p> <p>*She stated that was the way she had been trained to disinfect the tub.</p> <p>*The provider's Whirlpool Bath Cleaning/Disinfection policy was taped to the side of the whirlpool tub.</p> <p>*The Whirlpool Bath Cleaning/Disinfection policy dated 12/18/13 stated:</p> <p>-The tub and chair were to be disinfected between each use following the manufacturer's directions using two ounces of disinfectant to one gallon of water.</p> <p>-Staff were to remove an visible residue by rinsing the tub with hot water using the shower wand.</p> <p>-They were to allow the tub to drain.</p> <p>-They would then press and hold the disinfect jets button that would dispense the properly mixed dilution of disinfectant through the air jet system.</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>-They were to hold the disinfect jets button until about a gallon of disinfectant solution was in the foot well of the tub.</p> <p>-They were to use that solution to disinfect the tub and chair.</p> <p>*She agreed she was not following the provider's procedure for disinfecting the whirlpool tub.</p> <p>Interview on 3/17/15 at 4:40 p.m. with the director of nurses revealed:</p> <p>*All bath aides had been trained on the provider's policy and procedure.</p> <p>*She had made sure the policy and procedure was posted on the whirlpool tub for the staff to reference.</p> <p>*She was not aware CNA C was not following the policy and procedure.</p> <p>Review of the January 22, 2014 in-service on the proper cleaning and disinfection of the whirlpool tub revealed CNA C had attended the training.</p> <p>Surveyor: 33265</p> <p>3. Observation on 3/16/15 from 4:30 p.m. through 4:55 p.m. with licensed practical nurse (LPN) B, doing blood glucose level testing (measure the level of sugar in the blood) on residents 3, 17, and 18 revealed:</p> <p>*A new Super Sani-Cloth germicidal (kills germs) disposable wipe was used to clean the glucometer (device used to measure the level of sugar in the blood) and the tray the glucometer was carried in following the testing of each of the three residents.</p> <p>-The instructions on this germicidal wipe stated to keep the surface being disinfected (cleaned) wet with the solution for a full two minutes.</p> <p>*Resident 17 had her own glucometer; a</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2015
NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104		
(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 20</p> <p>glucometer was shared between residents 3 and 18. Both were cleaned and disinfected with the same process.</p> <p>*The glucometer was wiped down with the germicidal wipe for seven to eight seconds following use.</p> <p>*The inside of the tray the glucomter was carried in was wiped down with the same germicidal wipe for four to five seconds immediately after the glucomter was wiped down.</p> <p>*The glucometer was then placed in the wet tray.</p> <p>*Both the glucometer and the tray were allowed to air dry at that point.</p> <p>*The bottom and outside rims of the tray were not cleaned.</p> <p>Interview on 3/16/15 at 4:55 p.m. with LPN B revealed the above was the standard practice she followed with all glucometers.</p> <p>Interview on 3/18/15 at 9:50 a.m. with the DON regarding disinfecting of glucometers revealed she agreed the glucometers were not kept wet with the disinfectant solution for the full two minutes as indicated in the manufacturer's instructions.</p> <p>Review of the undated glucometer manufacturer's instructions revealed the provider should have followed the germicidal wipe instructions for disinfection.</p> <p>Review of the provider's revised 2/1/12 Blood Glucose Meter (glucometer) Cleaning and Disinfecting policy and procedure revealed:</p> <p>*If a glucometer was used or shared between residents the device must be cleaned and disinfected inbetween each resident use.</p> <p>*Cleaning and disinfecting were to have been</p>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2015
NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104		
(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 21 completed by using a commercially available EPA (environmental protection agency) registered disinfectant detergent or germicide wipe. *They were to follow product label instructions to disinfect the meter. *They were to follow the disinfectant product label instructions to ensure proper drying time.	F 441			

ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALLEN WING B. WING _____	(X3) DATE SURVEY COMPLETED 03/18/2015
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NAME OF PROVIDER OR SUPPLIER DOW RUMMEL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104
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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 3/18/15. Dow Rummel Village 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>Rebecca Varish</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-6-15</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 07 2015
If continuation sheet Page 1 of 1
SD DOH L&C

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10678	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/18/2015
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NAME OF PROVIDER OR SUPPLIER DOW-RUMMEL VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104
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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) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/16/15 through 3/18/15. Dow Rummel Village was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Rebecca Varish *Administrator*

STATE FORM 6899 0J5Q11

(X6) DATE

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If continuation sheet 1 of 1

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