

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

PRINTED: 11/30/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2022
NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN ROSLYN, SD 57261	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/15/22 through 11/17/22. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F609, F656, and F657.	F 000		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609	Resident 19 and 22 incidents will be reported to state by DON/representative by 12-16-2022. DON/Representative will audit injuries/ incidens and report all reportable incidents to the SD DOH. DON/Representative will update policy to include reportable incidents and provide education to all staff about reporting incidences to SDDOH. Education will be provided by 12/16/2022, staff unable to attend education will be given written education at the start of thier next shift. DON/Representative will audit new injuries/ incidents once per week for four weeks, thenmonthly for four more months to ensure reports are filled out and submitted in a timley manner. DON/Representative will present findings to monthly QAPI meeting.	1-2-2023

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

TITLE

(X6) DATE

Rachel Lee Holler, Administrator, 12-5-2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 609	<p>Continued From page 1</p> <p>appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified of incidents that caused physical harm for two of two sampled residents (19 and 22). Findings include:</p> <p>1. Review of resident 19's medical record revealed: *On 8/2/22 by an unknown author: *A physician from (name of facility) called and gave report to the nurse on resident 19. He: -Was able to return to the facility. -Had steri-strips over his right eye. -Had two staples on his head. -Had a fractured nose.</p> <p>Interview on 11/16/22 at 9:30 a.m. with director of nursing (DON) B revealed: *Resident 19 had a fall on 8/2/22. *He did seek outside medical attention. *It was her responsibility to notify the SD DOH for reportable incidents. *She had overlooked that incident.</p> <p>Interview on 11/16/22 at 3:32 p.m. with administrator A revealed: *The DON was responsible for notifying the SD DOH for reportable incidents. *It was her expectation it would have been reported. *Their accidents and incidents policy had not given direction for them to notify the SD DOH. *She confirmed their policy had not included guidance to notify the SD DOH.</p>	F 609			

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F 609	<p>Continued From page 2</p> <p>2. Review of resident 22's electronic and paper medical record revealed:</p> <p>*There was a "change in skin" notification sent to resident 22's primary care provider on 11/5/22 regarding blisters on his fingers.</p> <p>*The note read, "Resident has large blister on [left] pinky finger and small popped blister on [left] ring finger. Blisters cleaned [with] soap [and] water. Triple [antibiotic ointment] placed on popped blister [and] covered [with] bandaid. Pinky blister covered loosely. Resident stated blister came from hot pizza."</p> <p>Review of resident 22's care plan revealed:</p> <p>*A new focus area of "Risk for Injury/burns as I have decreased sensation to my fingers and toes. I drink coffee and my potential for spilling it" was added on 11/7/22.</p> <p>*The goal read as follows: "I will not receive any burns/blisters from hot liquids/foods through next review. 11-12-22- not met as I received a burn to my left index [finger] and to my left thumb. New goal- my areas to my left and right hand will heal without any infections, I will state that my pain is well controlled to my hands, and I will not have any further burns to my hands through next review."</p> <p>Interview on 11/15/22 at 3:11 p.m. and 11/16/22 at 4:46 p.m. with DON B about resident 22 revealed:</p> <p>*He was blind and had decreased sensation in his fingers and toes due to complications with diabetes.</p> <p>*They noticed he had blisters on his fingers on 11/7/22, which worsened, and he developed more blisters on 11/12/22.</p> <p>*He went to the clinic to see his primary care provider for wound management</p>	F 609			

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F 609	Continued From page 3 recommendations on 11/8/22 and 11/16/22. *Staff think he may have burned his fingers on a hot pizza box or by spilling hot liquids. *She was not aware that an incident like that was supposed to be reported to the SD DOH. Review of the provider's March 2017 Accidents and Incidents-Investigating and Reporting policy revealed: *"The nurse supervisor/charge nurse and/or the department director or supervisor would complete a report of incident/accident form and submit the original to the director of nursing (DON) services within 24 hours of the incident or accident. *The DON would ensure that the administrator received a copy of the report of incident/accident form for each occurrence." *The policy had not identified reportable incidents or accidents should have been reported to the SD DOH.	F 609			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656	DON updated resident 16 care plan prior to 11-28-2022. DON/Representative will audit all care plans to ensure comprehensive care plans were created by 12-31-2022. DON/Representative will provide education to all staff involved with creating initial care plans for new admits by 12-12-2022. Any Care Plan team staff not able to attend will be given written education at the start of thier next shift. DON/Representative will audit new residents care plans once per week for four weeks then monthly for four more months after admission to ensure a Comprehensive care plan was created. DON/Representative will report audit findings to monthly QAPI meeting.	1-2-2023	

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F 656	<p>Continued From page 4</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview record review, and policy review, the provider failed to develop a comprehensive person-centered care plan regarding respiratory care for 1 of 13 sampled residents' (16) care plans reviewed. Findings include:</p> <p>1. Interview on 11/15/22 at 9:39 a.m. with resident</p>	F 656			

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F 656	<p>Continued From page 5</p> <p>16 in her room revealed she: *Was admitted to the facility on 9/16/22 and was there for rehabilitation and therapy services. *Had an oxygen concentrator machine. *Only used the oxygen concentrator at night.</p> <p>Review of resident 16's care plan dated 9/16/22 revealed there was no focus area or interventions regarding her use of an oxygen concentrator machine.</p> <p>Interview on 11/16/22 at 4:30 p.m. with director of nursing B about care plans revealed: *She was also the Minimum Data Set coordinator and developed resident care plans. *Oxygen therapy was normally something they would have put on the care plans. *She was unaware that resident 16's care plan had not included her use of oxygen at night.</p> <p>Review of the provider's 10/12/17 "Baseline Care Plan" policy revealed: *The policy stated: "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care." *Under the "Policy Explanation and Compliance Guidelines" section: --"1. The baseline care plan will..." --"b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to..." ---"i. Initial goals based on admission orders." ---"ii. Physician orders." ---"iii. Dietary orders." ---"iv. Therapy services." ---"v. Social services."</p>	F 656		

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F 656	Continued From page 6 ---"vi. [Preadmission screening and resident review] recommendation, if applicable." -"2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable." --"b. Interventions shall be initiated that address the resident's current needs including..." ---"iii. Any special needs such as for [intravenous] therapy or wound care."	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657	Resident 2 Care plan was updated by DON prior to 11-28-2022. DON/Representative will audit current care plans by 12-31-2022 to ensure care plans are current. Care Plan Policy will be updated by DON/ Representative to include when/how often care plans should be reviewed/revised. DON/Representative will provide education to care plan team by 12-12-2022, any team members not able to attend will be provided written education at the start of their next shift. DON/Representative will audit all MDS changes once a week for four weeks then monthly for four more months to ensure updates are transferred to the resident care plan. DON/Representative will report findings at monthly QAPI meeting.	1-2-2023	

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F 657	<p>Continued From page 7</p> <p>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and policy review, the provider failed to revise 1 of 13 sampled residents' (2) care plans reviewed after a significant change assessment had been completed to accurately reflect the current status of the resident. Findings include:</p> <p>1. Review of resident 2's annual Minimum Data Set (MDS) assessment from 7/12/22 revealed he:</p> <ul style="list-style-type: none"> *Had a Brief Interview for Mental Status (BIMS) score of 15, indicating he was cognitively intact. *Was independent with no setup assistance or help from staff with activities like bed mobility, transferring from surface to surface, walking, locomotion off the unit, dressing, toilet use, and personal hygiene. *Was independent with eating after setup assistance from staff. <p>Review of resident 2's significant change MDS assessment dated 9/21/22 revealed he:</p> <ul style="list-style-type: none"> *Had a BIMS score of 3, indicating severe cognitive impairment. *Required extensive assistance with the help of two or more people for activities like bed mobility, transferring from surface to surface, dressing, and toilet use. *Required extensive assistance with the help of one person for locomotion on and off the unit. *Required limited assistance with the help of one person for activities like eating and personal hygiene. 	F 657		

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F 657	<p>Continued From page 8</p> <p>Review of resident 2's care plan revealed: *There was a focus area of "The resident has an [activities of daily living] (ADL) self-care performance deficit [related to] delayed mental status," which was last revised on 2/17/21. *The interventions included: -"AM ROUTINE: The resident preferred dressing/grooming routine is to take his time getting dressed and ready for the day. Offer assistance, but usually independent with ADL's." Last revised on 6/23/21. -"BATHING/SHOWERING: The resident is able to wash himself once he is assisted into the tub/shower. Limited assist of one." Last revised on 7/8/21. -"BED MOBILITY: The resident is independent. May use side rails per [doctor's] order for bed mobility, body positioning, and transferring in/out of bed." Last revised on 9/15/22. -"DRESSING: Allow sufficient time for dressing and undressing. Independent with dressing." Last revised on 6/23/21. -"ORAL CARE ROUTINE... Resident is independent with oral cares." Last revised on 6/23/21. -"PERSONAL HYGIENE ROUTINE: The resident is independent with hygiene." Last revised on 6/23/21. -"TOILET USE: The resident is independent with toileting. Continent of bowel and usually continent of bladder. Wears pull up for stress incontinence at times." Last revised 6/23/21. -"TRANSFER: The resident is independent. Self propels in a wheelchair about the facility." Last revised on 10/17/22.</p> <p>Interview on 11/15/22 at 3:03 p.m. with director of nursing B revealed: *Resident 2 had a significant decline in</p>	F 657		

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F 657	<p>Continued From page 9</p> <p>independence and behavior after he returned from a therapeutic family leave this past summer. *He had been taken to the emergency room on several occasions due to his significant behavior changes.</p> <p>*Several different medical tests were completed to determine a cause of the behavior change and physical decline, but they were not able to pinpoint the root cause.</p> <p>*He was now dependent on staff for dressing, toileting, transferring, and he no longer was walking on his own.</p> <p>Continued interview on 11/16/22 at 4:30 p.m. with director of nursing B about resident 2's care plan revealed:</p> <p>*She thought she had revised his care plan to reflect that he was no longer independent with ADL's.</p> <p>*It was their normal process to review care plans with each quarterly MDS assessment and make revisions as needed.</p> <p>A request was submitted on 11/16/22 at 10:50 a.m. for a care plan policy. The provider delivered a policy titled "Care Planning - Interdisciplinary Team." The policy explained which individuals should have been involved in the care planning process. The policy did not indicate when or how often care plans should have been reviewed and revised.</p>	F 657			

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/15/22. Strand-Kjorsvig Community Rest Home (building 01) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) 11/16/22. Please mark an F in the completion date column for K223 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K222 and K522 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on	K 222	Maintenance Director will audit all Delayed Egress doors to ensure others have correct signage. New sign stating Delayed Egress message of 30 seconds will be posted on front door Durign tests of fire doors Maintenance Director/ Representative conducting drill, will also ensure appropriate signage is still posted monthly for three months. Maintenance Director/Representative will report findings to Monthly QAPI report.	11-28-2022

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(X6) DATE

Rachel Lee Holler, Administrator, 12-5-2022

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.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2022
NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN ROSLYN, SD 57261	
(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
K 222	Continued From page 1 each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K 222		

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K 222	<p>Continued From page 2</p> <p>ARRANGEMENTS</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, testing, and interview, the provider failed to provide egress doors as required at one randomly observed exit door location (main entrance). Findings include:</p> <p>1. Observation beginning on 11/15/22 at 11:02 a.m. revealed the main entrance exit door was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked door was functioning as a delayed egress locked door. There was not the required signage mounted on the door indicating it was delayed egress and how to exit.</p> <p>Interview at the time of the observation with the maintenance director confirmed that condition. He stated they had recently had a new door installed but had forgotten to provide the required signage.</p> <p>Failure to provide egress doors as required increases the risk of death or injury due to fire.</p> <p>The deficiency affected 100% of the building occupants.</p>	K 222		

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K 222	Continued From page 3	K 222		
K 223 SS=C	<p>Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)</p> <p>Doors with Self-Closing Devices CFR(s): NFPA 101</p> <p>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <ul style="list-style-type: none"> * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. <p>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches in the cross-corridor smoke barriers in two of two locations (east and west corridors). Findings include:</p> <p>1. Observation on 11/15/22 at 11:52 a.m. revealed the cross-corridor doors in the east and west wing corridors were only 32 inches wide and did not provide a clear opening width of 32 inches. Record review of the previous survey report revealed those doors were the original doors.</p> <p>This deficiency may affect the egress of all</p>	K 223		F

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K 223	Continued From page 4 residents and staff present during a fire emergency.	K 223		
K 522 SS=D	<p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.</p> <p>HVAC - Any Heating Device CFR(s): NFPA 101</p> <p>HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on testing and interview, the provider failed to maintain combustion (fresh) air in one randomly observed area (laundry). Findings include:</p> <p>1. Observation of the commercial gas-fired dryer and water heater in the laundry room on 11/15/22 at 11:27 a.m. revealed the following: a. There was dedicated combustion (fresh) air ductwork provided for the operation of the natural gas-fired commercial clothes dryer and water heater. b. The ductwork provided for combustion air had been blocked off by a piece of wood.</p>	K 522	<p>Maintenance Director will audit existing devices for appropriate air flow.</p> <p>Wood has been removed from air ductwork on 11-15-2022. Since then air automatic closure has been ordered for install to ensure both fresh air availability and climate control.</p> <p>Maintenance Director/Representative will Monitor fresh air availability to heating devices weekly for four weeks and report findings to monthly QAPI meeting.</p>	11-15-2022

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K 522	Continued From page 5 c. The window to the laundry room was open about one inch to provide cool air. d. Windows may not be used as a source of combustion air for the dryer and water heater since they do not open automaticaly and can be left closed. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency affected one of several requirements for fuel fired devices.	K 522		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 11/15/22 through 11/17/22. Strand-Kjorsvig Community Rest Home was found in compliance.	E 000		12-5-2022

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

TITLE

(X6) DATE

Rachel Lee Holler, Administrator, 12-5-2022

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10673	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/17/2022
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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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S 000	<p>Compliance/Noncompliance Statement</p> <p>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/15/22 through 11/17/22. Strand-Kjorsvig Community Rest Home was found in compliance.</p>	S 000		12-5-2022

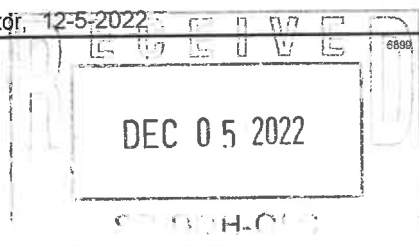
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Rachel Lee Holler, Administrator, 12-5-2022

STATE FORM



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If continuation sheet 1 of 1

