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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING _____ B. WING _____	03/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/26/23 through 3/1/23. Aurora Brule Nursing Home Inc was found not in compliance with the following requirements: F610, F657, F812, and F880.	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a complete and accurately documented assessment and investigation had been conducted to determine the source of multiple bruises for one of one sampled resident (15). Findings include:	F 610	Director of Nursing or designee will review and revise policies and procedures on investigations as needed. All staff that is responsible for investigations will be re-educated on the policies and procedures. Director of Nursing or designee will audit investigation process on resident #15. Director of Nursing or designee will audit investigation process on all other residents from past 6 months. Director of Nursing or designee will audit investigation process on all incidents weekly times four weeks, then monthly for two months. Director of Nursing or designee will report these findings to monthly QAPI for review and consideration.	03/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen Styles	Administrator	03/17/2023

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 610	Continued From page 1 1. Observation and interview on 2/28/23 at 10:15 a.m., when certified nursing assistants (CNA) M and N were providing perineal care to resident 15, revealed four fading bruises light green in color on the resident's left leg. Three bruises were located on her inner thigh and the fourth bruise was below her left knee. CNA N indicated: *The bruises were old because they were fading. *Due to the resident's weight, when they provided perineal care, they moved the resident's skin to ensure good perineal care. *She was unaware if the bruises had been reported to the nurse or investigated as to how the resident obtained the bruises. Review of the "Skin Monitoring: Comprehensive CNA [certified nursing assistant] Shower Review" forms for resident 15 revealed: *On 2/16/23, the "Visual Assessment" section had "1. Bruising" circled and the thigh area on the body shape was circled. The form was not signed by the CNA or dated. The "Charge Nurse Signature" was present but the assessment written by the nurse did not address the bruises. The "Forwarded to the DON [director of nursing]" section was not documented. *On 2/23/23, bruising and the thigh area was again circled. There was no CNA signature. A nurse signed on the charge nurse line but did not write an assessment and the form was not forwarded to the DON. *On 2/27/23, bruising was circled. Notations were made on the body shape to show a bruise was noted under the left arm and "scattered yellow bruising" was noted in the thigh areas on both legs. The CNA line had a signature and date, but the charge nurse section was blank, and it was not noted if the form was forwarded to the DON.	F 610		

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F 610	Continued From page 2 Review of resident 15's electronic medical record revealed: *The quarterly Minimum Data Set (MDS) assessment dated 11/12/22 coded that she had no cognitive impairment; required weight-bearing assistance of one or two persons for bed mobility, transferring, toileting, and personal hygiene; and she was incontinent of bowel and bladder. *The care plan noted she was on anticoagulant (blood thinner) therapy related to a stroke on 6/23/22 and the interventions initiated on 7/13/22 included "monitor/document/report PRN [as needed] adverse reactions" including bruising. *Two progress notes dated 2/28/23 documented: -"Bruising noticed on resident's inner thighs. Bruising is old. Resident did not know how she received these bruises. Resident did note that no one did it to her. Thinking possibly from the sling for Hoyer." -"Resident also c/o [complained of] of tenderness on right shoulder to this nurse when I was asking her questions on the bruise. Under her sleeve is a newer bruise. She states she got it from when she was in the whirlpool. RN [name] was trying to help her adjust so she would not fall and her arm got bumped. Resident stated; 'I know it was for my safety, she did not mean to do it.' " Review of the provider's "Skin Care Policy," dated 8/20/21, revealed: *All reports of skin irritation, lacerations, bruises, skin tears, and abrasions will be reported by CNA to the Charge Nurse." *"Charge Nurse will then investigate alteration in skin by assessing the area of concern." *"Non-Pressure skin issues, skin tears, bruises, abrasions etc, will be assessed and documented weekly on Non-Pressure Skin Condition Report."	F 610		

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F 610	Continued From page 3 Interview on 3/1/23 at 9:23 a.m. with DON B revealed: *They had "trialed various processes to ensure skin concerns are identified and assessed, and we continue to monitor and revise the process as needed." *The "Skin Monitoring: Comprehensive CNA Shower Review" forms were developed during the trial process, but the written "Skin Care Policy" policy had not been revised. *She confirmed the forms that noted bruises on resident 15's thighs had not been forwarded to her. *She agreed there should have been an investigation regarding the origin of those bruises.	F 610		
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 657	Director of Nursing or designee will review and revise as necessary policy and procedure for Care Planning and Revision. All Staff responsible for Care planning will be re-educated on the updated policy for Care Planning and revision. Director of Nursing or designee will review and revise care plan for resident 15 along with reviewing and revising all resident's care plans. Director of Nursing or designee will complete audits for care planning and revision once per week for four weeks and monthly for 2 months to secure that all care plans are completed and revised in timely manner. Director of Nursing will present audit findings at monthly QAPI meetings for review and consideration.	03/21/2023

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F 657	Continued From page 4	F 657		

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to review and revise the care plan for restorative nursing services for one of two sampled residents (15). Findings include:

1. Observation and interview on 2/26/23 at 2:10 p.m. with resident 15 in her room revealed:
*She was leaning to the far right in her wheelchair.
*Her left hand was closed, resting on her leg, and appeared swollen.
*She opened her left hand to show her contracted fingers, and she confirmed it had fluid build-up.
*She lifted her right hand slightly above the overbed table in front of her to demonstrate the limitation in the shoulder of her right arm.
*She was not able to shift her body posture to a more upright position.

Observation and interview on 2/27/23 at 10:27 a.m. with resident 15 in her room revealed:
*She was sitting more upright in her wheelchair.
*A wedge-shaped cushion was positioned in the wheelchair on her right side.
*She said the pillow was not always positioned well because some staff "don't take the time to listen" to her instructions.

Observation and interview on 2/28/23 at 9:21

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F 657	Continued From page 5 a.m. with resident 15 revealed: *When asked about wearing a pair of white mesh sleeves and a tan glove that were on the bedside stand next to her, she said: -The sleeves were on her hands "yesterday," but the certified nursing assistants (CNAs) "have not put them on yet" today. -She had not worn them on Sunday because they "were in the wash." -She had not worn the tan glove anymore because it was "ripped." *When asked about an exercise device, also setting on the bedside stand, she said, "the rubber bands are broken." Review of resident 15's care plan revealed: *No interventions related to the use of the white mesh gloves, the tan glove, or the wedge positioning cushion *A focus initiated 5/3/19, revised 7/13/22, "ADL [activities of daily living] self-care performance deficit r/t [related to] Impaired balance, Limited Mobility, left sided weakness (CVA [stroke] on 6/23/22)." *A focus initiated 5/20/19, revised 4/4/22, "limited physical mobility r/t Weakness, Balance deficits, is non-ambulatory, low motivation, ROM [range of motion] limitations in upper and lower extremities. Refuses to participate often." *Interventions initiated 5/20/19: -"Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of immobility: contractures forming." -"PT [physical therapy], OT [occupational therapy] referrals as ordered, PRN." -"NURSING REHAB/RESTORATIVE: [name] may participate in RC [restorative care] ROM program, including A-AAROM [active-active assisted] to all four extremities and hand helpers. She does not	F 657		

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tolerate much RC as her limitations prevent her from participating and she will not do more. She has been participating as she desires." Revised 8/30/22.
*A focus initiated 7/13/22, "Right sided cerebral vascular accident [CVA/stroke] on 6/23/22 resulting in left sided weakness."
*Interventions initiated 7/13/22:
-"Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical therapy and Occupational therapy to evaluate and treat."
-"Monitor/document residents [sic] abilities for ADLs and assist resident as needed. Encourage resident to do what he/she is capable of doing for self."

Review of the task documentation for the nursing rehab/restorative care plan revealed:
*Ten minutes of ROM was completed each day only on the following days: 11/7/22 and 11/8/22.
*No minutes of ROM were documented as completed in December 2022 or January and February 2023.

Review of the quarterly reviews of the restorative program, signed by social services designee (SSD) C and director of nursing (DON) B, revealed the restorative program note included:
*On 11/11/22, a repeat of the same text was used for the above NURSING REHAB/RESTORATIVE intervention.
*On 2/12/23, a repeat of the same text for the first phrase in the above intervention with the following insertions:
-Neck and trunk were added as areas for ROM.
-"She refused to do anything more as it causes pain for her too much pain. [sic] She has very limited ROM in her arms and legs. She has not

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been participating in RC per her decision."

Review of therapy notes for resident 15 revealed:
*Between 12/7/22 and 1/5/23, a physical therapy long-term goal noted, "Staff will demonstrate ability to position [resident] hips in neutral while seated in w/c [wheelchair] and adequately place support devices as educated by therapy 100% [percent] of the time without cues."
*Between 12/20/22 and 1/17/23, an occupational therapy short-term goal noted, "Patient will exhibit a decrease in edema in the left hand to Slight (no lasting impression) in order to facilitate follow-through with techniques and strategies."
*The OT discharge instructions noted, "Pt [patient] assist for BADLs [basic activities of daily living] with setup for self feeding with items positioned within reach. Edema glove for LUE [left upper extremity] to wear during the day and off at night."
*The OT discharge recommendations included a restorative program for passive ROM to her LUE and active assisted ROM to her right upper extremity (RUE) for "increased joint mobility," and active ROM to her RUE for strength.

Interview on 2/28/23 at 9:26 a.m. with CNA I and licensed practical nurse (LPN) K revealed:
*CNA I had let DON B know that the tan glove had a hole in it.
*LPN K reported resident 15 had the white mesh sleeves on "yesterday."
*CNA I said the white mesh sleeves were supposed to be on resident 15 every day.
*Both confirmed the CNAs do not do ROM exercises, the restorative care CNA does the ROM,
*They both agreed that resident 15 was "not very cooperative" with ROM exercises, so "she will

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F 657	Continued From page 8 have skilled therapy at times until she plateaus (little or no change)." Interview on 2/28/23 at 9:37 a.m. with DON B and SSD C revealed: *They do the quarterly restorative care review together. *Restorative CNA G completed the restorative care tasks, not the CNAs, and completed documentation when the tasks were done. *They both agreed resident 15 did not want to complete the exercises most of the time and did not like the mesh sleeves nor the tan glove. *Resident 15 did not participate during the PT and OT service windows. *SSD C confirmed that CNA G had not completed the task documentation to note when resident 15 refused to participate in ROM. *They admitted the wedge positioning cushion was not added to the care plan and might not have because they thought "therapy was trying to figure out what type of wedge would work best." *Communication with therapy "was improving, but we need to figure out a better way" to get updates. *They clarified the "hand helpers" noted on the care plan were "rubber bands to stretch her fingers." *They could not state what the exercise device was on resident 15's bedside stand, but CNA G "would know about that." Interview on 2/28/23 at 10:07 a.m. with physical therapy assistant (PTA) L revealed: *She had been working with resident 15 on leg and arm strengthening so she could continue to use the sit-to stand-lift, but strength was not recovered so she practiced with and trained the staff on using the total lift with resident 15.	F 657		

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F 657	Continued From page 9 *OT "probably worked on ROM, positioning, edema sleeves, and hand helpers." *A customized wheelchair had been ordered for her to help support resident 15's positioning. Interview on 2/28/23 at 10:14 a.m. with CNA G revealed: *She was not currently doing any RC exercises with resident 15. *No RC was offered to resident 15 during the PT and OT therapy windows. *It had been "a while, approximately 2 months," since she had done any RC with resident 15. *CNA G had not been documenting RC for resident 15 because she was "sleeping or not willing." *When a resident did not want to perform the RC tasks, she would "usually tell" SSD C but she had not communicated about resident 15 to her. Review of the provider's "Care Plan Policy and Procedure," updated 1/2/20, revealed: *"Aurora Brule Nursing Home recognizes the resident's right to participate in choosing care and treatment options and decisions in about any changes in the plan of care and treatment." *"The care plan allows every department to gain a clear understanding of the resident's condition and/or need by setting simple attainable goals." *"Evaluation of the care plan will be done quarterly to assess goals that are attained, the need to continue or change the current plan of care." *"Care plans will be updated as needed and with quarterly care conferences."	F 657		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	Dietary Manager will review and revise as necessary the Food safety policies for dating/ storing of food and food temperatures.	03/21/2023

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F 812	Continued From page 10 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure their policies had been followed for: *The process of dating and storing food items according to their opened or use by dates in one of one walk-in refrigerator. *Documenting food temperatures during meal preperation to ensure food safety for 38 of 38 residents since December 2022. Findings include: 1. Observation on 2/26/23 at 11:55 a.m. of the kitchen revealed: *A walk-in refrigerator/freezer in the back of the kitchen. *The refrigerator had outdated containers of the following: -Horseradish had a best when used by date of 15	F 812	All staff responsible for handling food and food storage will be re-educated on the updated policies for Food safety. Dietary manager or designee will complete audits for food storage and dating in refrigerator/freezer and food temperatures are taken and recorded every meal once per week for 4 weeks and monthly for 2 months to secure that all food storage and temperature procedures are completed. Dietary manger will present audit findings at monthly QAPI meetings for review and consideration	

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F 812	Continued From page 11 February 2023. -French onion dip had a sell by date of 23 February 2023. -Cream cheese spread had a best if used by date of 12 February 2023. -None of the above items had been dated when opened. *There was an undated stainless steel bowl of green gelatin covered with plastic wrap. *There was a clear plastic container of browned meat that was not dated. Interview on 2/27/23 at 8:34 a.m. with dietary manager D on the above findings confirmed: *Dietary cooks should have monitored food/product use-by dates on a daily basis. *Product containers should have been dated when opened. *He knew they had a policy to date food items when opened. *He expected staff to monitor and date products as they were put in the walk-in refrigerator.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	1. For the identification of lack of: *Appropriate hand hygiene and glove use as well as procedural technique during personal care. *Appropriate care and maintenance of multi-resident use mechanical lift. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 03/20/2023 by Administrator or Director of Nursing. On 03/15/2023, DON spoke individually to staff F, N, and O about the importance of infection control and discussed the 5 Whys. Return demonstration was performed with hand hygiene, glove use, and lift cleaning.	03/21/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING _____ B. WING _____	03/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	2. Identification of Others: ALL residents and staff have the potential to be affected by lack of: *Appropriate processes and follow through for the above identified items. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 03/20/2023 by Director of Nursing or designee. System Changes: 3. Root cause analysis conducted answered the 5 Whys: We have determined that our staff lack the confidence to fully implement infection control procedures and do not see the value of their role in the infection control process. They require more education to fully understand infection control and the risk factors that contribute to possible consequences such as facility wide illnesses, hospitalizations and death. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator and Director of Nursing contacted the South Dakota Quality Improvement Organization (QIN). On 03/15/2023 spoke with Lori Hintz reviewed infection control plans. Resources sent. All questions answered. We verbalized understanding of quality improvement methodology and using the 5 Why's in root cause analysis. The examples cited related to lapses in proper hand hygiene, gloving and disinfection of shared equipment (mechanical lifts) between residents are all actions that require auditing with high attention.	

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F 880	Continued From page 13 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure three of four certified nursing assistants (F, N, and O) had provided personal care in a sanitary manner for one of one sampled resident (15). Findings include: 1. Observation on 2/27/23 at 11:40 a.m. while transferring resident 15 with a mechanical total lift revealed: *Certified nursing assistants (CNA) F and O had not washed or sanitized their hands upon entering the resident's room or when leaving the room after the transfer had been completed. *CNA F put on a pair of gloves before assisting with the transfer and then removed them before leaving the room. *CNA O pushed the mechanical lift equipment out of the resident's room without cleaning it and before entering another resident's room with the same mechanical lift. *CNA F transported resident 15 to the dining room, and upon returning to the same hallway, entered another resident's room without sanitizing her hands.	F 880	In addition to the auditing, we discussed implementing a positive reinforcement campaign among peers such as publicly recognizing those that were caught doing hand hygiene, gloving and disinfection of lift right. Additionally, our campaign could include peers having a "code" word that they use if they notice their coworker not following correct hand hygiene, glove use, etc. This strategy would play off a "I got your back" type of mentality. Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

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F 880	Continued From page 14 Interview on 2/27/23 at 12:12 p.m. with CNA F revealed: *She had not washed or sanitized her hands before or after transferring resident 15, nor before entering another resident's room. *She always used gloves, but she agreed gloves were primarily used when there was a potential for contact with bodily fluids. *The mechanical lift should have been wiped down using the disinfectant wipes that were hanging on the lift after use and before removal from the resident's room. Interview on 2/28/23 at 11:56 a.m. with CNA O revealed: *He sanitized his hands before and after assisting a resident using the hand sanitizer dispensers in the hallway, but he could not recall if he had done that yesterday before helping with resident 15. *He confirmed that he had not wiped down the mechanical lift yesterday with the disinfectant wipes. 2. Observation on 2/28/23 at 10:15 a.m. with CNA N during perineal care for resident 15 revealed she: *Pulled on a pair of gloves on her hands. *Provided perineal care. *Placed a clean incontinent product underneath the resident's left buttocks. *Became aware that the resident started to have a bowel movement and then cleansed the perineum area of that bowel movement. *Without removing the soiled gloves. she continued to position the clean incontinent product and adjusted the resident's clothing. *Then removed the soiled gloves. Interview on 2/28/23 at 10:40 a.m. with CNA N	F 880		

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	435132	A. BUILDING _____ B. WING _____	03/01/2023

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F 880	Continued From page 15 confirmed she had not removed the soiled gloves and sanitized her hands prior to the placement of the clean incontinent product and adjusting the resident's clothing.	F 880		

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

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	435132	A. BUILDING _____ B. WING _____	03/01/2023

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

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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 2/26/23 through 3/1/23. Aurora Brule Nursing Home Inc was found in compliance.	E 000		

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

Kathleen Styles

TITLE: Administrator

(X6) DATE: 03/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2023**

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

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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 2/27/23. Aurora Brule Nursing Home Inc 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 upon correction of deficiency identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to	
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (pulling the alarm, announcing the fire and closing doors). Findings include: 1. Observation on 2/27/23 at 1:55 p.m. revealed	K 712	Environmental services manager or designee will review and revise the fire drill policy as necessary. All staff will be re-educated on the updated fire drill policies. Environmental services manager or designee will complete audits for the fire drill once per week for 4 weeks and monthly for 2 months to secure that fire drill are being completed. Environmental services manager will present audit findings at monthly QAPI meetings for review and consideration	03/21/2023

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

Kathleen Styles

TITLE

Administrator

(X6) DATE

03/17/2023

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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	435132	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2023**

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AURORA BRULE NURSING HOME INC	**408 SOUTH JOHNSTON STREET** **WHITE LAKE, SD 57383**

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K 712	Continued From page 1 the fire simulation was set up for a drill at the kitchen grill. Two staff persons saw the simulated fire location. A third staff member working in the dining area was asked to sound the alarm. When that person was asked to find the pull station, she was taken across the line of fire to a pull station, although there was a pull station in the dining area. The door was not closed between the kitchen and the dining area. Two other storage room doors were not closed. The staff allowed the kitchen automated system to work (indicated by speech), but did not get the K extinguisher in case it was needed. A fourth staff person chose to stay in the dishwashing area. No announcement of the fire location was heard within the kitchen, although the director of maintenance said it was made and he will be checking the speaker in the kitchen. An interview with the director of maintenance after the drill was completed confirmed the drill was not satisfactory. The deficiency had the potential to affect all occupants within the smoke compartment.	K 712		

South Dakota Department of Health

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	10709	A. BUILDING: _____ B. WING _____	03/01/2023

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AURORA BRULE NURSING HOME INC	408 S JOHNSTON ST WHITE LAKE, SD 57383

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/26/23 through 3/1/23. Aurora Brule Nursing Home Inc was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/26/23 through 3/1/23. Aurora Brule Nursing Home Inc was found in compliance.	S 000		

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

Kathleen Styles

TITLE

Administrator

(X6) DATE

03/17/2023