

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

**ORIGINAL**

PRINTED: 09/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435099</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/28/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ESTELLINE NURSING &amp; CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>205 FJERESTAD AVENUE EAST POST OFFICE BOX 130 ESTELLINE, SD 57234</b>
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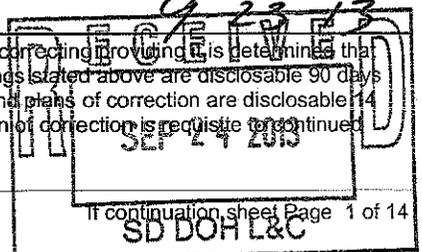
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/27/13 through 8/28/13. Estelline Nursing and Care Center was found not in compliance with the following requirements: F241, F280, F431, and F441.	F 000	Addendums noted with an asterisk per 10/3/13 telephone to facility DON.  KG/SDDOH/JJ	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to maintain dignity during two of two meals for one of four sampled residents (4) needing assistance to eat. Findings include:  1. Observation on 8/27/13 from 10:50 a.m. through 11:45 a.m. of resident 4 revealed: *At 10:50 a.m. he was placed at the table by a staff member. *There were a total of five residents at the table who needed to have assistance eating. *The activity Chow Time Chatter took place from 11:30 a.m. through 11:45 a.m. *At 11:45 a.m. four residents had received their meals. *Certified nursing assistant (CNA) B was sitting	F 241	Facility will ensure that residents' dining experience is provided with dignity. Resident Rights booklet is in admission packet. At mandatory all-staff meeting on 9/18/13, DON and Administrator reviewed new updated Serving Meals in the Dining Room policy. Dignity in the Dining Room will be monitored and [redacted] Each meal will be monitored at least one time per week. If no problems for one month for each meal, then the meal time will be monitored every two weeks for two months, and then monthly monitoring will be done for 9 months. Data will be reported to DON and presented at monthly and quarterly QA meetings. This will address Resident #4 and all other residents in the facility. At this time, DON and Staff Development are working on the development of a Dining Assistant (Continued..)	

*and reported to the DON by the charge nurses during the meal observations. The DON will report those findings to QA.  
KG/SDDOH/JJ*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael P. Ward</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-23-13</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 for continued program participation.



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F 241	<p>Continued From page 1</p> <p>next to him but was assisting the resident to his left.</p> <p>*CNA C was assisting two other residents at the same table.</p> <p>*A random staff member was feeding the fourth resident to his right.</p> <p>*He had not received his meal and staff had not spoken to him during that observation.</p> <p>Interview on 8/27/13 at 11:55 a.m. with CNA B and C regarding resident 4 revealed he had not gotten his meal, because they were waiting for another staff member to come assist him.</p> <p>Observation on 8/27/13 at 12:00 noon regarding resident 4 revealed:</p> <p>*He had gotten his meal, and staff had started to assist him.</p> <p>*He had been at the table for an hour and ten minutes before he had gotten his meal.</p> <p>*The other four residents at the table had received their meals fifteen minutes before he had gotten his.</p> <p>Observation on 8/27/13 from 5:15 p.m. through 6:00 p.m. of resident 4 revealed:</p> <p>*At 5:15 p.m. he had his meal and was being assisted by registered nurse (RN) D.</p> <p>*RN D got up three times during the observation and left him while he was still eating.</p> <p>Interview on 8/28/13 at 6:00 p.m. with resident 4 revealed he:</p> <p>*Had made eye contact when spoken to.</p> <p>*Replied "yeah" when asked if he was done with his meal.</p> <p>*Had not said any other words other than "yeah."</p> <p>Review of resident 4's 7/1/13 Minimum Data Set</p>	F 241	<p>Program. The book, "Assisted Dining: The Role and Skills of Feeding Assistant" has been received.</p>	9/23/13

*MW 9-23-13*

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F 241	<p>Continued From page 2 assessment revealed: *He needed extensive assistance of one staff member to eat. *He was sometimes able to make himself understood. *He was sometimes able to understand others. *His attention, orientation, and ability to recall things were severally impaired.</p> <p>Review of resident 4's 7/5/13 care plan revealed: *Staff were to "set up and assist with eating as needed; usually extensive assist of one." *To have met his activities of daily living he was to have an "extensive to total assist of one with eating."</p> <p>Interview on 8/28/13 at 2:00 p.m. with assistant director of nursing (ADON) and the director of nursing (DON) revealed: *Lunch was served starting at 11:15 a.m. *They had known resident 4 needed staff to assist him with his meals. *They had not known resident 4 had waited an hour and ten minutes at lunchtime before he had gotten his meal. *They had not been able to state what their expectation was regarding how long residents should have to wait to get their meals. *CNA B was allergic to hand sanitizer which was why she had only been assisting one resident at lunchtime. *They were not sure why the other staff at the table who had only been assisting one other resident had not helped resident 4.</p> <p>Review of the provider's May 2012 Serving Meals in Dining Room policy revealed meals were to have been served rapidly to keep the hot foods hot and the cold foods cold.</p>	F 241		

*MW*  
*9-23-13*

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F 241	Continued From page 3	F 241		
F 280 SS=D	<p>A policy on dignity was requested from the DON and she referred to the admission packet for that information. Review of the admission packet revealed no dignity policy in the contents.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, record review, interview, and policy review, the provider failed to ensure care plans had been revised for 2 of 12 sampled residents (5 and 6) to reflect the current resident's status. Findings include:</p>	<p>F 280</p> <p>The ADON and DON KG(S000H)J</p> <p>by the DON. KG(S000H)J</p>	<p>Short term care plans were immediately updated for Resident #5 and Resident #6. DON and A-DON met on 8/25/13 with care team members and reviewed the RAI process. At the RN/LPN meeting on 9/18/13, the new updated short term care plan policy was discussed and reviewed. At the 9/16/13 interdisciplinary care team meeting, the DON and A-DON reviewed new policy with Social Worker, Certified Dietary, and Activity Director Certified. * will monitor 10% of the residents' charts weekly x 4 weeks; if no problems, then every 2 weeks x 2 months; then monthly for 9 months for compliance with the policy. Data will be reported to DON and presented at the monthly and quarterly QA meetings. This will address Residents #5 and #6 and all other residents in the facility.</p>	9/23/13

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*9-25-13*

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F 280	Continued From page 4  1. Resident 5 had been admitted on 10/2/12. *He had a diagnosis of depression. *He had been started on an antidepressant medication on 7/2/13. *The care plan dated 6/27/13 did not reflect any issues of depression.  2. Resident 6 had been admitted on 4/19/05 The 7/2/13 care plan had stated: **"His dad is now a resident of this facility. His parents assist with health care decisions." *The charting within the medical record indicated his father had passed away on 7/17/13. *The care plan dated 7/2/13 did not reflect: -His father had passed away. -To monitor or assess the grieving process.  3. Interview on 8/28/13 at 10:27 a.m. with the director of nursing (DON) confirmed she would have expected the care plans to have been updated within fourteen days of the status change using the resident assessment index (RAI) process.  The provider did not produce a care plan or care plan revision policy prior to exiting.	F 280		
F 431 SS=E	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	F 431	Immediately on 8/28/13, upon learning of the failure to ensure the security and accountability of Schedule III medications, the Consultant Pharmacist, [REDACTED] was notified and a controlled counting	

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F 431	Continued From page 5 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 controls, and permit only authorized personnel to have access to the keys.  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.  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to ensure security and accountability was maintained for government controlled and highly diverted (stolen) medications (schedule III) for 8 of 14 sampled and random residents (2, 3, 13, 14, 15, 16, 17, and 18) reviewed who received as needed (PRN) schedule III medications. Findings include:	F 431	procedure was initiated. The SD Department of Health and local law enforcement were also notified. On 8/28/13, all charge nurses were verbally informed of new procedure for medication count. At the RN/LPN meeting on 9/18/13, the DON and A-DON reviewed the importance of security and accountability of Schedule II, III, and IV medications. The policies regarding medication administration, storage of medications, and shift verification (narcotic control record) of controlled substances were reviewed also at this time. The security and accountability of Schedule medications will be monitored <del>through</del> QA through QA by the DON/A-DON. The shift verification narcotic count record will be reviewed 5x/week for 3 months, looking for discrepancies. If no problems, noted after three months, monitoring will be done weekly for 9 months. The findings will be presented at monthly and quarterly QA meetings for recommendations. Data from weekly audit will be reported by DON/A-DON	
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F 431	Continued From page 6 1. Review on 8/28/13 at 10:30 a.m. of schedule III medications from two of two medication carts revealed the following information:  a. Resident 2 had a blister pack (pre-formed plastic packaging) for PRN alprazolam (for anxiety) 0.5 milligrams (mg). *The blister pack containing thirty tablets had been issued on 1/21/13. *Five of the tablets had been removed from the blister seals. *Review of resident 2's January 2013 through August 2013 medication administration records (MARs) revealed three tablets had been documented as given. *Two tablets had not been accounted for.  b. Resident 3 had a blister pack for PRN Lorazepam (for anxiety) 1 mg. *The blister pack containing thirty tablets had been issued on 4/30/13. *Twenty-one of the tablets had been removed from the blister seals. *Review of resident 3's April 2013 through August 2013 MARs revealed thirteen tablets had been documented as given. *Eight tablets had not been accounted for.  c. Resident 13 had a blister pack for PRN Lorazepam 0.5 mg. *The blister pack containing thirty tablets had been issued on 5/21/13. *Five tablets had been removed from the blister seals. *Review of resident 14's May 2013 through August 2013 MARs revealed three tablets had been documented as given. *Two tablets had not been accounted for.	F 431	to Administrator. Any discrepancies will be reported immediately to the Administrator. This will address Residents #2, 3, 13, 14, 15, 16, 17, 18, and all other residents in the facility.	9/23/13

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F 431	<p>Continued From page 7</p> <p>d. Resident 14 had a blister pack for PRN Lorazepam 0.5 mg. *The blister pack containing thirty tablets had been issued on 11/30/2012. *Twenty-three tablets had been removed from the blister seals. *Review of resident 15's November 2012 through August 2013 MARs revealed eighteen tablets had been documented as given. *Five tablets had not been accounted for.</p> <p>e. Resident 15 had a blister pack for PRN hydrocodone-APAP (for pain) 5-325 mg. *The blister pack containing thirty tablets had been issued on 7/11/13. *Fourteen tablets had been removed from the blister seals. *Review of resident 15's July 2013 and August 2013 MARs revealed thirteen tablets had been documented as given. *One tablet had not been accounted for.</p> <p>f. Resident 16 had a blister pack for PRN hydrocodone-APAP 5-325 mg. *The blister pack containing thirty tablets had been issued on 2/20/13. *Five tablets had been removed from the blister seals. *Review of resident 17's February 2013 through August 2013 MARs revealed three tablets had been documented as given. *Two tablets had not been accounted for.</p> <p>g. Resident 17 had a blister pack for PRN Alprazolam 0.25 mg. *The blister pack containing thirty tablets had been issued on 6/27/2013. *Eleven tablets had been removed from the blister seals.</p>	F 431			

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F 431	<p>Continued From page 8</p> <p>*Review of resident 17's June 2013 through August 2013 MARs revealed four tablets had been documented as given. *Seven tablets had not been accounted for.</p> <p>h. Resident 18 had a blister pack for PRN hydrocodone-APAP 5-325 mg. *The blister pack containing twenty tablets had been issued on 4/16/13. *Seven tablets had been removed from their blister seals. *Review of resident 18's April 2013 through August 2013 MARs revealed one tablet had been documented as given. *Six tablets had not been accounted for.</p> <p>i. Interview on 8/28/13 at 11:00 a.m. with the assistant director of nursing (ADON) revealed the previous DON used a book in her office to account for schedule III medications on a monthly basis. The ADON had been unsure how the tracking system had worked.</p> <p>Interview on 8/28/13 at 1:05 p.m. with the director of nursing, ADON, and administrator revealed: *They had been unable to locate documentation for the missing schedule III medications. *The previous DON had developed a system for accountability of the schedule III medication, but they had been unable to understand the system. *They had contacted their consultant pharmacist and would institute a policy to count all PRN schedule III medications every shift beginning 8/28/13. *They had already contacted the local law enforcement, and the law enforcement had been in contact with the division of criminal investigation. *They had contacted the Department of Health to</p>	F 431			

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F 431	Continued From page 9 report the missing medication.  Review of Patricia A. Potter and Ann Griffin Perry, Fundamentals of Nursing, 6 th edition, Mosby, St. Louis, Mo, 2005, revealed: *Page 907: -"All controlled substances are handled according to strict procedures that account for each medication." -"Medications should be charted immediately after administration." *Page 828: -"Discrepancies in narcotic counts are reported immediately." -"A special inventory record is used each time a narcotic is dispensed and provides an accurate ongoing count of narcotics used and remaining."	F 431		
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.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	On 8/28/13, the DON visited with the bath aides on proper procedure for cleaning and disinfecting the whirlpool tub and multiple use resident care items. Policy on cleaning of equipment for personal cares in bath area and cleaning of century tub updated. This policy was placed in the Facility Policy Manual and in the bath area. DON reviewed policies with all CNA's as all CNA's may work in the bath area. Cleaning and disinfecting of tub and multiple use personal care equipment will be monitored through QA.	

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9-25-13

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

PRINTED: 09/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435099</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/28/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>ESTELLINE NURSING &amp; CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>205 FJERESTAD AVENUE EAST POST OFFICE BOX 130 ESTELLINE, SD 57234</b>	
(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 10 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, policy review, and manufacture recommendations, the provider failed to ensure appropriate sanitary practices were followed for: *The cleaning and disinfecting of the whirlpool tub between residents use in one of one whirlpool room (200 Hall). *Multiple use resident care equipment (nail clippers, scissors, tweezers, nail files, hair brush, manicure stick, and razor) in one of one whirlpool room (200 Hall). Findings include:  1. Observation on 8/27/13 at 1:40 p.m. in the whirlpool room on the 200 hall (room 209) with CNA A revealed the Century whirlpool tub disinfectant was Penner Classic Whirlpool	F 441	This will be monitored <sup>by the DON</sup> weekly x 4 weeks. If no <sup>problems noted,</sup> then monitoring will occur every 2 weeks for 2 months, then monthly for 9 months. Results will be reported to DON and presented at the monthly and <sup>quarterly QA meetings</sup> This will address all the residents in the facility.  by the ← DON. KG (SPOOH) DJ	9/23/13

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F 441	<p>Continued From page 11 Disinfectant Cleaner.</p> <p>Interview at the above time with certified nursing assistant (CNA) A revealed the Penner Classic Whirlpool Disinfectant Cleaner disinfectant time used on the whirlpool tub between residents was two to five minutes.</p> <p>2. Observation at the same time and at the same location as above revealed: *In a plastic cart with four pull-out shelves there were: -Three nail clippers, three scissors, two tweezers, and two nail files in a cream-colored plastic container. -There were visible nail clippings, hair, and multiple tan and brown specks on the bottom of the container. -Two nail files and a manicure stick next to an antiperspirant container, several hair shampoo bottles, a mouthwash bottle, a small white hair brush, one package mouth sponge swabs, and several cotton tipped sticks in a gray-colored plastic container. -There was visible gray and white hair on the hair brush, nail clippings, hair, and multiple tan and brown specks on the bottom of the container. *A Remington razor was opened and multiple, short, gray and white hairs were present.</p> <p>Interview at the above time with CNA A revealed: *The nail clippers, scissors, tweezers, nail files, brush, and the razor were to have been disinfected with the same disinfectant cleaner used to clean the whirlpool tub after each use. *Visible nail clippings, hair, and multiple tan and brown specks were on the bottom of both plastic containers containing the above listed items. *Visible gray and white hair was on the hair brush.</p>	F 441			

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F 441	<p>Continued From page 12</p> <p>*The razor was opened and multiple, short, gray and white hairs were present.</p> <p>*She was unsure why the mouth sponge swabs and cotton tipped sticks were in the cart.</p> <p>Interview on 8/28/13 at 10:15 a.m. with the director of nursing confirmed:</p> <p>*The whirlpool tub should have been properly cleaned and disinfected after each resident's use.</p> <p>*Resident care items including nail clippers, scissors, tweezers, nail files, the brush, and the razor should have been cleaned after each use.</p> <p>Review of the provider's February 1995 Cleaning of the Century Bathing System policy revealed:</p> <p>*Cleaner disinfectant was diluted according to directions and used between residents use.</p> <p>*Allow sufficient time for thorough chemical action.</p> <p>Review of the provider's June 2011 Cleaning of Equipment for Personal Cares in Bath Area revealed:</p> <p>*To provide personal care in bath area with disinfected equipment.</p> <p>*"Personal items (i.e... combs, nail clippers) will be soaked in diluted disinfectant after use."</p> <p>Review of the provider's manufacture instructions label for the Penner Classic Whirlpool Disinfectant Cleaner to be used as a disinfectant was to allow it to remain wet for ten minutes.</p> <p>Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), APIC Text of Infection Control and Epidemiology, 3rd Ed., APIC, Washington, DC, 2009, p.100-2, revealed:</p> <p>*The key to cleaning and disinfecting environmental surfaces was physically removing</p>	F 441			

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F 441	Continued From page 13 visible dirt, organic material, and debris thereby removing microorganisms. *The cleaning of environmental surfaces needed frequent cleaning because of the high degree of handling and the risk of cross-contamination of infection. *Frequently touched items needed to be cleaned after each resident use.	F 441			

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

**ORIGINAL**

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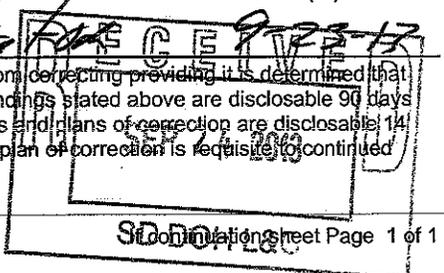
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/28/13. Estelline Nursing and Care Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael W. Wacht</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-23-13</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.



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10617</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/28/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>ESTELLINE NURSING &amp; CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>205 FJERESTAD PO BOX 130 ESTELLINE, SD 57234</b>
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S 000	<p>Initial Comments</p> <p>Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/26/13 through 8/28/13. Estelline Nursing and Care Center was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Signature]* Administrator **9-28-13**