

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

ORIGINAL

PRINTED: 01/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUNQUEST HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1345 MICHIGAN AVENUE SW HURON, SD 57350</b>
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F 000	INITIAL COMMENTS  Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/16/13 through 12/18/13. SunQuest Healthcare Center was found not in compliance with the following requirements: F176, F241, F281, and F323.	F 000	Addendums noted with an asterisk per 01/21/14 telephone to facility DON. CS/SDDH/MF	
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, record review, interview, and policy review, the provider failed to follow their policy for resident self-administration of medications for: *Five of six residents (1,15, 25, 26, and 27) observed during two of two meal observations. *One of twenty-one sampled residents (7) who had medications at the bedside. Findings include:  1. Observation on 12/16/13 at 6:20 p.m. during the evening meal revealed registered nurse (RN) D: *Prepared medications and placed them in a medication cup. *Placed the cup in front of resident 1 while seated at the dining room table with other residents at	F 176	The facility policy for self administration of medications will be updated to specify that no resident will receive a self administration of medications order for medications they receive in the dining room.  All resident rooms were checked and medications were removed from all residents without self administration of drugs by bedside orders.  Resident #7 observed having a medication at her bedside during survey had that medication removed from her bedside the day of the survey. * 1, 15, 25, 26 and 27 CS/SDDH/MF  Those residents that had medication left at the meal table to self administer during survey did not have self administration orders and will not receive self administration orders for these areas. Nurses D, E, F & G will be audited weekly times 4 weeks and monthly times 2 months to ensure compliance. 5 random audits per month will be completed on all other nursing staff passing medications in the dining rooms for 3 months.	01-15-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Laurie L. Sloan</i>	TITLE <i>Administrata</i>	(X6) DATE <i>1/17/2014</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.

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F 176	Continued From page 1 that table. *Returned to the medication cart and charted the medications as administered. *Left the medications without observing the resident taking them.  2. Observation on 12/17/13 at 8:30 a.m. during the breakfast meal revealed RN E: *Prepared the medications and placed them in a medication cup. *Placed the cup in front of resident 25 while seated at the dining room table with other residents. *Returned to the medication cart and charted the medications as administered. *Left the medications without observing the resident taking them. *Repeated the same process for resident 26.  3. Observation on 12/17/13 at 8:45 a.m. of RN F revealed: *Prepared the medications and placed them in a medication cup. *Placed the cup in front of resident 15 while seated at the dining room table with other residents. *Returned to the medication cart and charted the medications as administered. *Left the medications without observing the resident taking them.  4. Observation on 12/17/13 at 9:00 a.m. of RN G revealed: *Prepared the medications and placed them in a medication cup. *Placed the cup in front of resident 27 while seated at the dining room table with other residents at that table. *Returned to the medication cart and charted the	F 176	Resident #7's room will be audited weekly times 4 weeks and monthly times 2 months to ensure there are no medications in her room.  5 random audits will be conducted in all other resident rooms monthly for 3 months.  The facility's updated Self Administration of Medications policy was reviewed on January 15, 2014 with all nursing staff.  The Director of Nursing and /or Designee will be responsible for compliance and will report audit findings at monthly Client Care and CQI meetings for 3 months.		

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F 176	<p>Continued From page 2</p> <p>medications as administered. *Left the medications without observing the resident taking them.</p> <p>5. Review of the medical records for residents 1, 15, 25, and 26 revealed: *There had been no self-administration of medications assessments completed. *There had been no physician's orders to self-administer medications. *There had been no documentation on the care plans revealing the residents' wishes to self-administer medications.</p> <p>6. Review of the medical record for resident 27 revealed: *There had been a self-administration assessment completed on 6/11/13 stating she "is not able to do due to cognitive deficits." *There had been no physician's orders to self-administer medications. *There had been no documentation on the care plan revealing the resident's wishes to self-administer medications.</p> <p>7. Interview on 12/17/13 at 3:00 p.m. with the director of nursing (DON) revealed she had understood that medications left in the dining room while the nurse continued to be in the dining room within line of sight was not considered self-administration of medications.</p> <p>Interview on 12/18/13 at 1:45 p.m. with the DON revealed: *This surveyor showed her the definition of self-administration from Center for Medicare and Medicaid Services (CMS) website [www.cms.gov/Regulation-and-Guidance/Transmittals/downloads/R91BP.pdf] defined administered</p>	F 176			

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F 176	<p>Continued From page 3</p> <p>as "the physical process by which the drug enters the patient's body."</p> <p>*She was in agreement that leaving medications in front of the resident and the nurse not observing the process of consuming the medication was in fact self-administration.</p> <p>Surveyor: 26180</p> <p>8. Observation on 12/17/13 from 9:45 a.m. until 11:20 a.m. revealed in resident 7's room on her bedside table was a bottle of Sarna cream (an anti-itch cream) with a prescription label on it.</p> <p>Review of resident 7's physician's orders revealed:</p> <p>*An order that originated on 11/1/12 that read "May self administer all po (oral) medication after set-up by nurse." This order had been renewed by the physician on 12/1/13.</p> <p>*A 12/10/13 physician's order that read "Apply Sarna BID [twice a day] to arms and chest."</p> <p>*There was not an order to self-administer the topical (lotion) cream.</p> <p>Review of resident 7's 11/23/13 Assessment for Self-Administration of Medications revealed when asked "Can the resident apply topical ointments, creams, or transdermal patches (placed on skin) according to proper procedure?" The answer was "Not applicable."</p> <p>Interview on 12/17/13 at 11:20 a.m. with RN G revealed the bottle of Sarna cream should not have been left in resident 7's room. It should have been on the nurses medication cart.</p> <p>Surveyor: 32572</p> <p>9. Review of the provider's undated Administering</p>	F 176		

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F 176	Continued From page 4 Medications policy revealed "Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely."  Review of the provider's undated Self-Administration of Medications policy revealed: **"As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications." **"In addition to the general evaluation of decision-making capacity, the staff or practitioner will perform a more specific skill assessment, including the resident's:" -"Ability to read and understand medication labels." -"Comprehension of the purpose and proper dosage and administration time for his or her medications." -"Ability to remove medications from a container and to ingest and swallow them." -"Ability to recognize risks and major adverse consequences of medications." **"The staff and practitioner will periodically (for example, during quarterly minimum data set [MDS] reviews) reevaluate a resident's ability to continue to self-administer medications."	F 176			
F 241 SS=E	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	F 241			

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F 241	<p>Continued From page 5 full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and Resident Rights Handbook review, the provider failed to ensure two of four sampled residents (6 and 8) and four of four randomly observed residents (28, 29, 30, and 31) who needed assistance with eating were assisted in a timely and dignified manner during meals in two of four dining rooms (Nixon and Independence). Findings include:</p> <p>1a. Observation on 12/16/13 at 6:00 p.m. of resident 8 in the Independence dining room revealed: *She had been served her food. *At 6:10 p.m. nurse aide (NA) J sat down to assist her with her meal. *At 6:13 NA J had gotten up and had not returned to help resident 8 until 6:19 p.m. *NA N had assisted resident 8 one time while NA J was gone from the table. *At 6:23 p.m. NA J had gotten up and walked away from the table.</p> <p>b. Observation on 12/17/13 at 7:50 a.m. of resident 8 in the Independence dining room revealed: *She had been brought to the table for breakfast. *Chocolate milk and orange juice were on the table in front of her. *Staff walked away after pushing her up to the table. *She had been tilted back in her chair and had been reaching for the drinks.</p>	F 241	<p>All facility staff was educated on 1-15-2014 to ensure that residents 6, 8, 29, 30 &amp; 31 (resident #28 expired 12-21-2013) receive dignified assistance with their meals at all times. All other facility residents who need assistance with meals were reviewed to ensure dignified and timely assistance at all times as well.</p> <p><i>*The DON or designee will complete</i> CS/SDDH/JMF Audits on residents 6, 8, 29, 30 &amp; 31 will be conducted weekly for 4 weeks and then monthly for 2 months to ensure dignified dining.</p> <p>5 random audits on all other residents receiving meal assistance will be conducted weekly for 4 weeks and monthly for 2 months to ensure dignified dining.</p> <p>The Director of Nursing and/or Designee will be responsible for compliance and will report audit findings at monthly Client Care and CQI meetings for 3 months.</p>	01-15-14

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F 241	<p>Continued From page 6</p> <p>*She could not reach them from the tilted position.</p> <p>*At 7:55 a.m. she continued to reach for the drinks.</p> <p>*No staff had noticed her reaching.</p> <p>*At 7:56 a.m. she had raised her arm to get staff attention, and no one had noticed.</p> <p>*At 7:58 a.m. she raised her arm again.</p> <p>*At 7:59 a.m. she raised her arm and stated "How can you get service?"</p> <p>*At 8:00 a.m. she had been served breakfast.</p> <p>*Restorative aide L sat down to assist her with her meal.</p> <p>*At 8:02 a.m. restorative aide L had gotten up from assisting her and walked away.</p> <p>*She returned at 8:05 a.m. At 8:07 a.m. she had gotten up again.</p> <p>*At 8:09 certified nursing assistant (CNA) K sat down to assist resident 8 with her meal.</p> <p>*At 8:11 a.m. restorative aide L had returned to assist her.</p> <p>c. Review of resident 8's 10/15/13 Minimum Data Set (MDS) assessment revealed she had needed total assistance from one staff person to eat.</p> <p>2. Observation on 12/16/13 at 6:10 p.m. of resident 31 in the Independence dining room revealed:</p> <p>*She had been served her dessert.</p> <p>*She reached for it and started to eat it with her fingers.</p> <p>*Her silverware were out of reach.</p> <p>*No staff person stopped to assist her until they delivered her meal at 6:21 p.m.</p> <p>Review of resident 31's 10/29/13 MDS assessment revealed she had needed extensive assistance from one staff person to eat.</p>	F 241		

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F 241	<p>Continued From page 7</p> <p>3. Observation on 12/16/13 at 6:20 p.m. of resident 28 in the Independence dining room revealed: *He had been served his food with no one around to assist him. *At 6:30 p.m. CNA I sat down to assist him with eating. *She had to feed him as he was not able to do so.</p> <p>Review of resident 28's 10/8/13 MDS assessment revealed he had needed extensive assistance from one staff person to eat.</p> <p>4. Interview on 12/18/13 at 1:45 p.m. with the director of nursing (DON) regarding the dining experience in the Independence dining room revealed: *Staff should not have placed resident 8 at the table for breakfast until staff were able to assist her. *The staff should have assisted her with reaching the drinks in front of her. *The food should not have been served until staff were available to assist the residents. *She thought it was okay for staff to get up while assisting residents with their meals if the resident needed something. *Staff should not have left the residents for other reasons or as frequently as stated above.</p> <p>Surveyor: 26180</p> <p>5. Observation on 12/16/13 at the supper meal in the Nixon dining room revealed: *CNA C assisted resident 29 with eating from 6:00 p.m. until 6:15 p.m. at which time she left the</p>	F 241			

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F 241	Continued From page 8 table and the dining room *At 6:28 p.m. an unidentified CNA sat with resident 29 and asked him if he wanted to keep eating. That CNA began feeding the resident his soup, and he proceeded to finish feeding him most of his soup.  Interview on 12/16/13 at 6:40 p.m. with CNA C revealed: *She had been told by a supervising nurse that if a particular resident needed help she had to stop what she had been doing to go help the other resident. *That was why she had stopped feeding resident 29.  6. Observation on 12/17/13 at the noon meal in the Nixon dining room revealed: *Residents 6, 29, and 30 were seated at the same table. *Resident 30 was quite sleepy. *CNA C was attempting to assist and feed all three residents. *Throughout the meal she stood up multiple times and walked from one corner of the table to the other corner. She tried to assist/feed each of the three residents seated there.  7. Review of the provider's Resident Rights Handbook given at admission revealed "Quality of Life Dignity: 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."	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 9</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure physician's orders were followed for one of two sampled residents (16) on dialysis. Findings include:</p> <p>1. Review of resident 16's 12/4/13 admission physician's orders revealed he: *Had an order for a renal diet. *Was on a 1500 cubic centimeter (cc) fluid restriction.</p> <p>Observation on 12/18/13 at 7:45 a.m. of resident 16's room revealed he had a full water pitcher on his bedside table.</p> <p>Interview on 12/18/13 at 9:00 a.m. with registered nurse (RN) M regarding resident 16 revealed: *The nurses had not documented fluids offered during his medication passes. *The resident had not documented the fluids he drank.</p> <p>Review of resident 16's fluid intake records revealed: *Fluids had not been recorded on 12/7/13, 12/8/13, and 12/9/13. *On 12/14/13 his fluid intake had been recorded three times including: -At 4:17 a.m. he had 220. -At 1:50 p.m. he had 600. -At 10:34 p.m. he had 1500. *None of those recordings reflected what unit of</p>	F 281	<p>The revised facility Fluid Restriction Policy was reviewed with all nursing staff 12-30-2013.</p> <p>There are currently no residents in the facility on fluid restrictions. <i>*The nurse managers will notify the DON if there is a resident on fluid restrictions. cc/sno/htme</i> Audits will be conducted on residents receiving fluid restrictions weekly for 4 weeks and monthly for 2 months for the next 3 months.</p> <p>The Director of Nursing and/or Designee will be responsible for compliance and will report audit findings at monthly Client Care and CQI meetings for 3 months.</p>	12-30-13

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F 281	<p>Continued From page 10 measure was used (ccs or milliliters).</p> <p>Interview on 12/18/13 at 9:30 a.m. with RN/Care coordinator B and review of the fluid documentation revealed: *She acknowledged they had not consistently kept track of his fluid intake. *They should have had an accurate documentation of fluid intake when there was a physician's order. -The physician would have expected that. *The dialysis unit monitored his weight. *The resident had not recorded his fluid intake. *She thought there had been an error in documentation on 12/14/13 when they had recorded 1500, because then he would have had more than the 1500.</p> <p>Interview on 12/18/13 at 1:05 p.m. with the director of nursing revealed they should have been documenting fluids for a resident on fluid restriction.</p> <p>Review of the provider's 10/20/12 Restricting Fluids policy revealed: *"The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health." *General Guidelines included: -"Be accurate when recording fluid intake." -"Be sure an intake record is maintained." *"Record the amount of fluid consumed each shift. Record fluid intake in mls [milliliters]."</p> <p>Review of the provider's undated Care of Resident Receiving Dialysis Services policy revealed "Nursing staff shall work to maintain fluid an dietary restrictions as ordered by the physician."</p>	F 281			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/18/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUNQUEST HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1345 MICHIGAN AVENUE SW HURON, SD 57350</b>		
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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to provide an environment free from potential accident hazards for one of one stove located in a resident area (Rushmore dining room). Findings include:</p> <p>1. Observation on 12/16/13 at 5:45 p.m. in the Rushmore dining room revealed: *A stove's shut off switch had not been turned off. *The indicator light on the stove's front panel had become red when this surveyor turned the dials to the "HI" setting and each burner had become hot to the touch. *There were fourteen residents and one staff person in the dining room at that time.</p> <p>Interview on 12/16/13 at the above time with registered nurse (RN) B and RN H regarding the stove revealed: *The Rushmore dining room was available to residents at all times. *It was not a locked area. *The stove's shut off switch was to have been turned off when not in use and not attended by staff.</p>	F 323	<p>The facility Electrical Safety for Residents Policy was reviewed with all facility staff on 01-15-2014.</p> <p>The Dietary Department will check and log the breaker which is located in dietary department every day to ensure the breaker remains off at all times unless the stove located in Rushmore dining room is being used under the direction of facility staff.</p> <p>The Dietary Manager will be responsible for compliance and will report log results at monthly Safety and CQI meetings for 3 months.</p>	01-15-14	

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

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F 323	<p>Continued From page 12</p> <ul style="list-style-type: none"> <li>*The activity department used the stove for activities.</li> <li>*The therapy department used the stove with residents to train on stove safety prior to discharge.</li> <li>*They were unsure of the location of the shut off switch.</li> <li>*The maintenance director or the administrator would need to have been contacted regarding the location of the shut off switch.</li> </ul> <p>Interview on 12/17/13 at 7:40 a.m. with the maintenance director in the Rushmore dining room regarding the stove revealed:</p> <ul style="list-style-type: none"> <li>*It was the only stove located in a resident area in the facility.</li> <li>*The shut off switch was located in the kitchen's dish area inside a gray electrical panel box attached to the wall with a handwritten label "Stove Breaker" located next to the switch.</li> <li>*The shut off switch was to have been put in the off position when it was unattended by staff.</li> <li>*It was only used by the activity and therapy departments.</li> <li>*Access to the shut off switch was only through the kitchen.</li> <li>*The kitchen doors were locked at 8 p.m. and opened at 4 a.m. each day.</li> <li>*He usually checked the stove each morning when he was on duty.</li> <li>*He agreed the shut off switch needed to have been turned off.</li> <li>*He agreed it could have been a hazard to residents and/or visitors if the burners had been turned on and had not been monitored by staff.</li> </ul> <p>Interview on 12/17/13 at 11:45 a.m. with the activity director regarding the stove in the Rushmore dining room revealed:</p>	F 323		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 323	<p>Continued From page 13</p> <p>*The activity department used the stove one to two times per month for the cooking club with residents.</p> <p>*The therapy department used the stove with residents for teaching safe stove usage prior to home visits or discharge.</p> <p>*She agreed the stove's shut off switch needed to have been turned off when not in use.</p> <p>Interview on 12/17/13 at 4:07 p.m. with the occupational therapist regarding the stove in the Rushmore dining room revealed:</p> <p>*The therapy department had used the stove with residents as part of a safety assessment.</p> <p>*It had been at least one year since she or her two occupational therapy assistants had used the stove with residents.</p> <p>*She agreed the stove's shut off switch needed to have been turned off when not in use.</p> <p>Review of the provider's 10/12/12 Electrical Safety for Residents policy regarding the electric stove in the Rushmore dining room revealed:</p> <p>*It was permitted to be used to teach safety and promote meaningful activities to the residents.</p> <p>*It was permitted to be used under the direction of occupational therapy staff for resident training/teaching purposes.</p> <p>*It was permitted to be used under the direction of facility staff for special events with approval of the administrator, director of nursing, or designee.</p> <p>*The electrical panel and breaker for the stove was located in the dish area of the dietary department.</p> <p>*It was to have remained in the off position when not in use by appropriate staff.</p> <p>Review of the provider's 10/11/12 Safety and Supervision of Residents policy revealed resident</p>	F 323			

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

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F 323	Continued From page 14 safety, supervision, and assistance to prevent accidents were facility-wide priorities.	F 323		

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>SUNQUEST HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1345 MICHIGAN AVENUE SW HURON, SD 57350</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/17/13. SunQuest Healthcare Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 12/19/13 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K046, K062, and K064 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 01/17/14 telephone to facility administrator. LF/SDDH/MF</p>	
K 033 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and document review, the</p>	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Quirio B. Soler</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/17/2014</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.

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If continuation sheet Page 1 of 4  
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OMB NO. 0938-0391

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K 033	Continued From page 1 provider failed to maintain a one hour fire resistive protected path of egress from the basement to the exterior of the building. One randomly observed basement stair enclosure (east) discharged onto the main level corridor system. Findings include:  1. Observation at 10:30 a.m. on 12/17/13 revealed the east basement stair enclosure discharged onto the main level corridor near the Rushmore dining room. A continuous one hour enclosure was not provided to the exterior of the building. Review of previous survey reports confirmed that condition.  The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiency identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD	K 033		
K 046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to provide emergency lighting of at least one hour duration. There was not an emergency light with battery backup at the transfer switch for the generator. Findings include:  1. Observation at 11:35 a.m. on 12/17/13 revealed there was an emergency light installed at the emergency power transfer switch for the generator. Testing of that emergency light revealed it was not working. Review of the	K 046	The emergency light located at the emergency power transfer switch was repaired on 12-17-2013. The emergency light was added to the monthly preventative maintenance check list to ensure that is working properly each month.  The Plant Operations Supervisor and/or Designee will report monthly findings at monthly Safety and CQI meetings for 6 months.	12-17-13

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

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K 046	Continued From page 2 preventative maintenance checklist revealed that light was not being checked. Interview with the plant operations superintendent at the time of the observation confirmed that finding.	K 046		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had the required quarterly flow testing performed and documented during the previous twelve months. Findings include:  1. Record review at 11:00 a.m. on 12/17/13 of the provider's automatic sprinkler system inspection reports revealed quarterly flow testing documentation was not available. Interview with the maintenance director at the time of the record review indicated he was unaware of the quarterly flow testing requirements. Review of previous survey report also indicated that had been an issue last survey and had not been corrected.	K 062	<i>* LF/SDDOH/MF</i>   The Plant Operations Supervisor and/or Designee will be responsible for compliance and will report findings from quarterly checks at monthly Safety and CQI meetings for 6 months.	01-31-14
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064	<i>* The quarterly flow tests for the sprinkler system will continue to be done quarterly by maintenance personnel. The date and time it takes to activate the sprinkler riser flow sensor will be documented on the flow sheet which was created on 01/15/2014. LF/SDDOH/MF</i>	

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

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K 064	Continued From page 3  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to perform monthly checks of one randomly observed fire extinguisher (in the staff lounge) in accordance with NFPA 10. Findings include:  1. Random observation at 2:35 p.m. on 12/17/13 revealed one fire extinguisher did not have a monthly maintenance check written on the fire extinguisher tag for November 2013 in accordance with NFPA 10. Interview with the plant operations superintendent at the time of the observation confirmed that finding.	K 064	All fire extinguishers have been listed by location and put on a monthly checklist. Maintenance personnel will continue to do the monthly checks.  The Plant Operation Supervisor and/or Designee will be responsible for compliance and will report on monthly checks at monthly Safety and CQI meetings for 6 months.	01-31-14

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NAME OF PROVIDER OR SUPPLIER <b>SUNQUEST HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1345 MICHIGAN AVE SW HURON, SD 57350</b>
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S 000	Initial Comments  Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 12/16/13 through 12/18/13. SunQuest Healthcare Center was found not in compliance with the following requirement: S206.	S 000	Addendums noted with an asterisk per 01/11/14 telephone to facility DON. CS/SDDOH/MF	
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.	S 206	The facility policy Attendance at In-Service Training Meetings was reviewed with all facility staff on 1-15-2014.  Facility staff members will either attend the 10 required in-services or within 2 weeks from the date of the in-service will be expected to do the make-up requirements for those in-services. *The DON or designee CS/SDDOH/MF will maintain documentation of employees who received the in-service information if they were unable to attend. *by the DON or designee CS/SDDOH/MF  Audits will be conducted on documentation of staff attendance of required in-services monthly for 3 months to ensure compliance. The Director of Nursing and Staff Development Coordinator will be responsible for compliance and will report on audit findings at monthly Client Care and CQI meetings for 3 months.	01-15-14

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

*[Signature]*

TITLE (X5) DATE

*[Signature]*  
Administrative

RECEIVED	(X5) DATE
JAN 21 2014	
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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 206	<p>Continued From Page 1</p> <p>This Rule is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure all employees attended ten of ten annual topics for staff education inservices. Findings include:</p> <p>1. Record review of the staff education inservice attendance records for infection control revealed: *It had been held on 1/09/13. *The make-up inservice for staff that had not been in attendance needed to have been completed by 2/15/13. *Fifty-one percent (%) of the required staff had attended that staff education inservice.</p> <p>Interview on 12/18/13 at 1:20 p.m. with the director of nursing regarding the staff education inservice attendance records for the infection control inservice revealed: *There should have been a better turnout for the required inservice meeting. *There needed to have been documentation of employees receiving the inservice information that were unable to attend. *There needed to be an improvement in attendance at all required inservice meetings.</p> <p>Surveyor: 26180 2. Interview on 12/18/13 at 8:00 a.m. with the staff development coordinator and review of the provider's required annual inservice training revealed: *All required training had been offered during the last year. *Approximately 50% of staff had not attended the required training. -She confirmed that a lot of staff had not come to the inservices. *When staff missed an inservice they sent a copy of the information covered to the employee.</p>	S 206		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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NAME OF PROVIDER OR SUPPLIER  <b>SUNQUEST HEALTHCARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1345 MICHIGAN AVE SW HURON, SD 57350</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) COMPLETE DATE
S 206	Continued From Page 2  *There was no follow-up with the staff to verify they reviewed the information. *There was no tracking of who never came to inservices. *They had not reviewed when care issues arose if that staff person had attended the pertinent inservice. *She was unaware if there were any consequences for missing an inservice.  Review of the provider's 12/12/12 Attendance at Inservice Training Meetings policy revealed: *All personnel were required to attend their scheduled training classes. *If an employee was to be absent from a scheduled training class approval was to have been obtained from the employee's supervisor. *Records were to have been maintained of absences, so that make-up classes could be scheduled. *Failure of an employee to attend a scheduled training class would be grounds for disciplinary action.	S 206		