

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

ORIGINAL

PRINTED: 04/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/02/2014
NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428		
(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 Surveyor: 32572 Arecertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/1/14 through 4/2/14. Bowdle Nursing Home was found not in compliance with the following requirements: F253, F281, F354, and F441.	F 000	<i>Addendums noted with an asterisk per 4/28/14 telephone to facility DON. LA/SDDOH/MF</i>		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and interview, the provider failed to ensure a clean and sanitary environment for the following: *Cleanable wood surfaces had not been maintained in random areas of the building: -Two of twenty resident's dressers (room 5 bed 2, and room 10 bed 2) on A wing. -One of eleven resident doorway casings on B wing (5) had gouges in the wood. -One of one B wing soiled utility room door. -One of one B wing soiled utility room cupboards. *Maintaining the cleanliness of four of eleven (3, 5, 6, and 7) resident's bathroom walls on B wing. *Maintaining the cleanliness of four of eleven (3, 4, 5, and 6) resident's bathroom floors on B wing. *One of one coffee maker in the resident dining room had a residue on the hot water spigot and on the backsplash. *One of two ice machines in the conference room	F 253			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sandra Schlecker* TITLE *CEO* (X6) DATE *04/23/14*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosed 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 disclosed 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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APR 28 2014
If continuation sheet Page 1 of 10
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F 253	<p>Continued From page 1 on B wing had a white residue on surfaces. Findings include:</p> <p>1. Random observations from 4/1/14 through 4/2/14 revealed random wood surfaces throughout the building had not been cleanable surfaces:</p> <ul style="list-style-type: none"> *The wood surface finish on two resident's dressers (5A2 and 10A2) had not been intact revealing bare wood or paper board making them uncleanable (photo 1). *The doorway casing for resident room 5 B had gouges in the wood revealing raw wood making it noncleanable (photo 2). *The door leading into the soiled utility room on B wing had rough surfaces revealing exposed raw wood (photo 3). *The cupboard in the soiled utility room on B wing revealed rough surfaces and exposed raw wood (photo 4). *The bathroom walls in resident's rooms 3, 5, 6, and 7 on B wing had a residue on the wall covering going down the wall under the sinks. This surveyor had been able to scratch the residue off with her fingernail (photo 5). *The bathroom floors for residents in rooms 3, 4, 5, and 6 on B wing had staining and residue on the floor; this surveyor had been able to scratch off with a sharp object (photo 6). *The coffee maker in the resident dining room had a white residue on the back splash and the hot water spigot. This surveyor had been able to wipe the residue off with a damp cloth and scratch off the residue with her fingernail (photo 7). *The ice machine in the conference room had a white residue and rust on the grates. A white residue had been on the front of the machine and the side panels (photo 8) 	F 253	<p>The surfaces on the resident's dressers have been filled in and are cleanable. This will be monitored monthly by the housekeeping supervisor. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p>The doorway casing for the resident room 5B has been ordered and will be installed on arrival. This will be monitored monthly by the housekeeping supervisor. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p>The door leading into the soiled utility room on B wing and cupboard in the soiled utility room on B wing will be resurfaced. This will be monitored monthly by the housekeeping supervisor. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p>The bathroom walls in noted rooms have been cleaned. * [redacted] be monitored monthly by the housekeeping supervisor. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p>All bathroom walls will [redacted]</p>	<p>[redacted]</p> <p>5-22-14</p> <p>[redacted]</p> <p>[redacted]</p>
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F 253	<p>Continued From page 1 on B wing had a white residue on surfaces. Findings include:</p> <p>1. Random observations from 4/1/14 through 4/2/14 revealed random wood surfaces throughout the building had not been cleanable surfaces:</p> <ul style="list-style-type: none"> *The wood surface finish on two resident's dressers (5A2 and 10A2) had not been intact revealing bare wood or paper board making them uncleanable (photo 1). *The doorway casing for resident room 5 B had gouges in the wood revealing raw wood making it noncleanable (photo 2). *The door leading into the soiled utility room on B wing had rough surfaces revealing exposed raw wood (photo 3). *The cupboard in the soiled utility room on B wing revealed rough surfaces and exposed raw wood (photo 4). *The bathroom walls in resident's rooms 3, 5, 6, and 7 on B wing had a residue on the wall covering going down the wall under the sinks. This surveyor had been able to scratch the residue off with her fingernail (photo 5). *The bathroom floors for residents in rooms 3, 4, 5, and 6 on B wing had staining and residue on the floor; this surveyor had been able to scratch off with a sharp object (photo 6). *The coffee maker in the resident dining room had a white residue on the back splash and the hot water spigot. This surveyor had been able to wipe the residue off with a damp cloth and scratch off the residue with her fingernail (photo 7). *The ice machine in the conference room had a white residue and rust on the grates. A white residue had been on the front of the machine and the side panels (photo 8) 	F 253	<p>The bathroom floors in noted rooms have been cleaned. This will be monitored monthly by the housekeeping supervisor. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p><i>*and all bathroom floors LAISSODH/MF</i></p> <p>The coffeemaker in the resident's dining room has been cleaned. Cleaning of the coffeemaker will be placed on a checklist. This will be monitored monthly by the housekeeping supervisor. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p>The ice machine in the conference room has been cleaned. This will be placed on a checklist. This will be monitored monthly by the housekeeping supervisor. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.</p>	<p><i>*LAISSODH/MF</i></p> <p><i>*LAISSODH/MF</i></p> <p><i>*LAISSODH/MF</i></p>
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F 253	Continued From page 2 Interview on 4/2/14 at 12:45 p.m. with the director of nursing (DON) confirmed the wood surfaces were uncleanable, the bathroom walls had not been cleaned, and the floors revealed stains that were able to be removed. She also confirmed the residue on the coffee maker could be removed and stated it should have been cleaned. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident (7) with a peripherally inserted central catheter (PICC) line (intravenous access) had appropriate documentation for its use and care. *One of one sampled resident (1) with a standing physician's order had been clarified. *The physician had been notified of one of one resident's (11) refusal to follow manufacturer's instructions for an inhalation medication. *A Lantus insulin pen had been stored appropriately in one of one medication room refrigerator. Findings include: 1. Review of resident 7's 3/13/14 physician's orders revealed: *No current order for a PICC line. *No current order for a weekly dressing change	F 253	*and any resident that has a PICC line LA/SDDO/HIME 1. This deficiency has the potential to affect resident 7, as there could be an increased risk of infection due to PICC line with weekly dressing changes. There was an order from admission, however there was no current order on the recertification orders. This has been corrected as the physician has discontinued the PICC line as of 4/7/14. The DON will monitor new residents with PICC lines to insure there is a current order for the PICC line and dressing change. The DON will monitor this monthly and report to the QA Committee quarterly until the committee recommends to discontinue.	4-17-14
F 281 SS=D		F 281		

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F 281	<p>Continued From page 3 for the PICC line.</p> <p>Review of resident 7's care plan most recently updated on 3/28/14 revealed she had a weekly dressing change at the hospital for her PICC line.</p> <p>Interview on 4/2/14 at 1:00 p.m. with the director of nursing revealed: *The resident had been admitted from the hospital on 1/30/14 with the PICC line. *She was unsure of why the resident still had the PICC line. *The resident was taken to the hospital weekly for her PICC line dressing changes. *There had been no other documentation in the resident's medical record regarding the reason for the PICC line. *They had no documentation for outpatient services provided to the nursing home residents from the hospital other than verbally.</p> <p>Review of the provider's January 2014 PICC Line Catheter Care policy revealed "Follow the doctor's orders."</p> <p>2. Review of resident 1's 3/21/14 physician's orders revealed: *An order for Dulcolax suppository as needed (PRN). *There had been no clarification of how many or how often the resident could receive that medication.</p> <p>Review of the 1/16/14 Standing Orders for Bowdle Nursing Home revealed: *Dulcolax suppository one per rectum PRN constipation or hard stools. *There had been no clarification of how often the medication could be given.</p>	F 281	<p>*The DON has reviewed all the current resident's orders for accuracy. LAISDDOH/MF</p> <p>2. This deficiency has the potential to affect all residents. The physician has reviewed all standing orders to insure that dosages and frequency of use are included. The RN's have been instructed to transcribe standing orders exactly as written and clarify any questions with the physician. The DON will monitor this monthly. The DON will report results to the QA Committee quarterly until the committee recommends to discontinue. LAISDDOH/MF</p> <p>*all resident charts LAISDDOH/MF</p>	

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F 281	<p>Continued From page 4</p> <p>*There had been several medications listed on the standing orders that had no frequency of use indicated including Pepto Bismol and Mylanta.</p> <p>Interview on 4/2/14 at 1:00 p.m. with the director of nursing revealed: *All physician's orders should have had the dosage and frequency of use. *She would have expected the nurses to have clarified the dosage and frequency of use when transcribing physician's standing orders.</p> <p>Surveyor: 28057 3. Observation and interview on 4/2/14 at 8:00 a.m. revealed licensed practical nurse (LPN) D administered an Advair Diskus 250/50 milligram inhaler medication to resident 11. After the resident had inhaled the medication she had taken a drink of water. She had not rinsed and spit after the inhalation. LPN D confirmed the resident chose not to rinse and spit. The nurse showed this surveyor where it had been documented on the resident's medication administration record that she had chosen not to rinse and spit.</p> <p>Review of resident 11's medical record revealed no documentation had been found that the resident's physician had been notified of the resident's non-compliance when she had used the inhaler.</p> <p>Review of the provider's 3/18/10 Administration and Documentation of Medications policy revealed all medications were to have been administered as prescribed.</p>	F 281	<p><i>* and all residents who do not follow physician's orders or manufacturer directions. LA/SDDH/MF</i></p> <p>3. This deficiency has the potential to affect resident 11. An order was received from the physician on 4-3-14 for the resident to swish and swallow per resident request. At the staff meeting on 4-21-14 the nurses were instructed that a physician's order must be obtained for any resident that does not wish to follow the manufacturer's instructions. The DON will monitor all residents who are on inhalers to insure that the manufacturer's instructions are followed. The DON will report the results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p><i>* for all medications. LA/SDDH/MF</i></p> <p><i>* LA/SDDH/MF</i></p>	
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F 281	<p>Continued From page 5</p> <p>Review of the January 2011 GlaxoSmithKline manufacturer's package insert for the use of the Advair Diskus inhaler revealed: *After each dose the resident was to have rinsed the mouth with water and spit it out. *The resident was not to have swallowed the water.</p> <p>Interview on 4/2/14 at 1:15 p.m. with registered nurse E confirmed she had not been able to find any documentation that: *Resident 11's physician had been notified of her refusing to take the medication appropriately. *It had not been as directed by the manufacturer of the medication.</p> <p>4. Observation and interview on 4/2/14 at 2:00 p.m. revealed a SoloStar Lantus insulin pen in the medication refrigerator. It had been opened. Interview with LPN D confirmed it had been opened and was in use. She further confirmed she had not known once it had been opened it was not to have been refrigerated.</p> <p>Review of the SoloStar Lantus pen package insert included with that pen revealed once it was in use it was to be stored at room temperature only and not to be refrigerated.</p>	F 281	<p>4. This deficiency has the potential to affect all residents that receive insulin. All insulin once opened will be kept at temperature per manufacturer's instructions. This was corrected on 4-2-14. This was reviewed with nurses on 4-21-14 at the staff meeting. The DON will monitor [redacted] daily x 1 week and then weekly. The DON will report the results to the QA Committee quarterly until the committee recommends to discontinue. [redacted]</p>	
F 354 SS=E	<p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a</p>	F 354		*LAKS... [redacted]

* insulin storage LA-8300H/MF

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F 354	<p>Continued From page 6</p> <p>registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and guideline review, the provider failed to ensure registered nurse (RN) coverage for eight consecutive hours, seven days a week. Findings include:</p> <p>1. Review of the January, February, and March 2014 nursing schedules revealed: *January 2014 there had been six days without RN coverage. *February 2014 there had been five days without RN coverage. *March 2014 there had been four days without RN coverage.</p> <p>Interview on 4/1/14 at 3:15 p.m. with the director of nursing (DON) confirmed she had not had eight hours of continuous RN coverage, seven days a week. She stated she was aware of the coverage requirement with RN staff. She stated she had RNs from the hospital that covered if needed during that time. The DON reviewed the paid hours during that time frame and did not reveal RN coverage for the days that were missing. Reviewed the nursing advertisements that had been posted in the papers revealed the provider had not posted nursing advertisements for January, February, and March 2014.</p>	F 354	<p>1. This deficiency has the potential to affect all residents. The DON has placed an ad in the paper and on the facility website advertising for an RN. The DON has arranged to utilize other facility RNs to cover open days at the nursing home to achieve 8 hours RN coverage daily. The DON will monitor this daily x 1 month, then monthly. The DON will report results to the QA Committee quarterly until the committee recommends to discontinue.</p> <p><i>* until someone has been hired. LHS/DON/IME</i></p>	5-22-14

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F 354	Continued From page 7 Interview on 4/2/14 at 9:10 a.m. with the chief executive officer (CEO) confirmed she was aware of the RN coverage requirement. She was aware that nurses from the hospital were not to be counted as RN coverage. Review of the provider's updated October 2011 Nursing Staff Guidelines revealed: **"Nursing personnel are scheduled according to the needs of the specified nursing area." **"DON has final say on ALL scheduled with the goal to maintain proper number of staff to care for pts[patients]/residents."	F 354		
F 441 SS=D	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 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	F 441		

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F 441 Continued From page 8
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: 32572
Based on observation, interview, and policy review, the provider failed to ensure a sanitary environment had been maintained for:
*Twenty-one of twenty-one resident's bathroom ceiling vents that had debris hanging from the vents.
*One of one oxygen concentrator stored in the clean utility room that had a dirty filter.
*Random resident's bathrooms had unlabeled resident care supplies sitting on the back of the toilets.
*One of one supply room on B wing had an opened dressing package that was not labeled or dated.
Findings include:
1. Random observations on 4/1/14 and 4/2/14 revealed:
*Resident's bathroom ceiling vents had gray to white debris doen hanging approximately 1/4 inch from the vents.

F 441

**All of the WARDENHIMF*

1.  ceiling vents will be cleaned. This will be put on a checklist to be done with room washes. This will be monitored by the housekeeping supervisor monthly. The housekeeping supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.

5-22-14

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

PRINTED: 04/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435107	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2014
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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428
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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 441 Continued From page 9

*There had been an oxygen concentrator stored in the clean storage room on A wing. The oxygen concentrator filter had gray to white debris present (photo 9).

*Random resident's bathrooms had unlabeled resident care supplies sitting on the back of the toilets (photo 10).

*In the supply room on B wing there had been an opened dressing package with a dressing that had been cut laying on the shelf. That dressing had not been labeled as to who it belonged to nor had it been dated when opened (photo 11).

Interview on 4/2/14 at 12:45 p.m. with the director of nursing (DON) confirmed the resident's bathroom vents had not been cleaned recently. She had been unaware of the soiled oxygen concentrator filter. She confirmed resident care supplies were stored on the backs of toilets.

Interview on 4/2/14 at 1:00 p.m. with the housekeeping supervisor confirmed the resident's bathroom ceiling vents had not been cleaned recently. He stated he had recently been hired and "expected adults to clean everything when cleaning a room." He confirmed there was no cleaning schedule for the vents.

Review of Journal of Microbiology, 2005; 99(2); 339-47, revealed "Many individuals may be unaware of the risk of air-borne dissemination (spread) of microbes (germs) when flushing the toilet and the consequent surface contamination that may spread infections ... via direct surface-to-hand contact."

*clean equipment in the clean storage room
LAKSDOHMF*

*all supplies are labeled
LAKSDOHMF*

*the dressing stored in the medication room
LAKSDOHMF*

F 441

2. This deficiency has the potential to affect all residents. All equipment when not in use will be cleaned, including filters, before placing in clean storage. This was reviewed at the staff meeting on 4-21-14. The DON will monitor [redacted] * weekly x 1 month and then monthly. The DON will report the results to the QA Committee quarterly until the committee recommends to discontinue [redacted] * LAKSDOHMF

3. This deficiency has the potential to affect all residents. All resident care supplies are labeled with the resident's name and the date opened. This was reviewed at the staff meeting on 4-21-14. A CNA was appointed to monitor this [redacted] * and report findings to the DON. LAKSDOHMF
All supplies will be stored in a three drawer plastic wheeled container. The DON will monitor [redacted] * weekly x 1 month and then quarterly. The DON will report the results to the QA Committee quarterly until the committee recommends to discontinue [redacted] * LAKSDOHMF

4. This deficiency has the potential to affect all residents. Dressing packages that have been opened and not fully used will be discarded to prevent a possible infection from occurring. This was reviewed at the staff meeting on 4-21-14. The DON will monitor [redacted] * weekly x 1 month and then quarterly. The DON will report the results to the QA Committee quarterly until the committee recommends to discontinue [redacted] * LAKSDOHMF

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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/2/14. Bowdle Nursing Home 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 upon correction of deficiencies identified at K029 and K056 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 029 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas in one randomly observed storage room (clean linen storage room). Findings include:</p>	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>David Schlechter</i>	TITLE CEO	(X6) DATE 04/23/14
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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 30 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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K 029	Continued From page 1 1. Observation at 11:10 p.m. on 4/2/14 revealed a storage room in the B wing next to the tub room. That room was over fifty square feet and was being used to store combustible material. The door to that room was not provided with a door closer. Interview with the maintenance supervisor at the time of observation confirmed that finding. This deficiency affected 1 of 4 smoke compartments.	K 029	A door closer has been ordered and will be installed by the maintenance supervisor. This will be monitored monthly by the maintenance supervisor. The maintenance supervisor will report results to the QA Committee quarterly until the committee recommends to discontinue.	5-22-14
K 056 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the automatic sprinkler system in two randomly observed locations (boiler room and communications room). Findings include:</p> <p>1. Observation at 11:15 a.m. on 4/2/14 revealed a boiler room. That boiler room was protected by a</p>	K 056	<p>The maintenance supervisor has contacted Western States to remove the old sprinkler systems in the boiler room and the communications room in the A wing next to the public restroom. This will be monitored by the maintenance supervisor. The maintenance supervisor will report to the QA Committee quarterly until the committee recommends to discontinue.</p>	5-22-14

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K 056	<p>Continued From page 2</p> <p>new automatic sprinkler system connected to a fully supervised sprinkler system riser. That system meets NFPA 13 standards. That room was also protected by an old supervised sprinkler system connected to the potable water system. The old system will no longer meet NFPA 13 standards and should be removed.</p> <p>2. Observation at 12:15 p.m. on 4/2/14 revealed a communications room in the A wing next to the public restroom. That room was protected by a new automatic sprinkler system connected to a fully supervised sprinkler riser. That system meets NFPA 13 standards. That room was also protected by an old sprinkler system unknown if supervised and connected to the potable water system. The old system will no longer meet NFPA 13 standards and should be removed.</p> <p>3. Interview with the maintenance supervisor at the time of those observations confirmed those findings. This deficiency affected 2 of 4 smoke compartments.</p>	K 056		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10596	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2014
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NAME OF PROVIDER OR SUPPLIER BOWDLE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 8001 W 5TH STREET, PO BOX 308 BOWDLE, SD 57428
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S 000	Initial Comments Surveyor: 32572 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/1/14 through 4/2/14. Bowdle Nursing Home was found not in compliance with the following requirement: S206.	S 000	<i>Addendums noted with an asterisk per 4/8/14 telephone to facility DON. LA/SDDOH/MF</i>	
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		

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

Sandra Schlechter

STATE FORM

021199

JPMN11

TITLE: _____

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If continuation sheet 1 of 2

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10596	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2014
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S 206	<p>Continued From Page 1</p> <p>This Rule is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the provider failed to ensure all mandatory education for three of five sampled staff members (A, B, and C) had been completed and documented. Findings include:</p> <p>1. Record review on 4/2/14 of employee files of those hired between April 2013 and February 2014 revealed employees A, B, and C had not received mandatory training on the following topics: *Proper use of restraints: A and B. *Dining assistance, nutritional risks, and hydration needs of residents: A and B. *Care of cognitively impaired and residents with unique needs: A and B. *Mandatory reporting of incidents and diseases: A, B, and C. *Infection control: C.</p> <p>Interview on 4/2/14 at 4:30 p.m. with the director of nursing confirmed employees A, B, and C had not received all of the mandatory trainings. She had not expected employees other than licensed nurses and certified nursing assistants to receive all of the mandatory training.</p>	S 206	<p>Employee A is no longer employed. Employee B has viewed the mandatory training DVD on proper use of restraints, dining assistance, nutritional risks, and hydration needs of residents, care of cognitively impaired and residents with unique needs and mandatory reporting of incidents and diseases. Employee C has viewed the mandatory training DVD on mandatory reporting of incidents and diseases and infection control. All new hires will watch the mandatory training DVD within 2 weeks of their hire date. Department supervisors will monitor their new hires to insure that the training is completed. Department supervisors will monitor this monthly. Department supervisors will report results to QA Committee quarterly until the committee recommends to discontinue.</p> <p><i>* within two weeks of hire date. LA/SDDO/HMF</i></p>	5-22-14