

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

ORIGINAL

PRINTED: 05/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNITED RETIREMENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 FIRST AVE BROOKINGS, SD 57006</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 000	INITIAL COMMENTS  Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/22/14 through 4/23/14. United Retirement Center was found not in compliance with the following requirements: F281, F323, and F441. <b>F 281</b> 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  SS=E  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, and policy review, the provider failed to follow professional standards for: *Following physicians' orders for 5 of 13 sampled residents (1, 2, 4, 10, and 12). *Administration of nebulizer medication for 1 of 2 observed resident's (16) nebulizer treatments. *Documenting an accurate birth date for 1 of 13 sampled residents (3). Findings include:  1a. Review of resident 1's medical record revealed a 3/6/14 physician's order for Skin Prep (a skin protectant) to the left heel twice daily.  Review of resident 1's March and April 2014 treatment administration records (TAR) revealed the Skin Prep had not been documented as given 14 out of 104 times.	F 000	<i>Addendums noted with an asterisk per utility telephone to facility administrator. SJD/DOH/ME</i>  The physicians' orders on residents 1,2,4,10, and 12 was reviewed by proper staff and corrective action was taken to ensure, treatment (s) and documentation of treatment is proper. The facility is assured that A nurse or UAP shall document all medications administered on each resident's medication administration record (MAR) and all treatments rendered on the resident's treatment administration record (TAR) Administration of medication or treatment must be documented immediately after (never prior) it is given Documentation must include, as a minimum (on MAR) a. Name and Strength of medication b. Dosage c. Method or route of administration d. Date and time of administration e. Medication diagnosis f. Reason(s) why medication was withheld, not administer, or refused. May use an (R) for refusal or may circle initials and write reason for refusal on the back of the MAR g. Signature and title of person administering medication and/or initials h. Resident's follow up response to the medication, if applicable (e.g. PRN) i. When giving the PRN medication the Nurse or UAP must pull the blue tab on the MAR and complete follow up documentation. Either follow up	6/12/2014

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

*Sally Lamm*

TITLE

*Administrator*

(X6) DATE

5/19/2014

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.

DEFENSE  
MAY 22 2014  
SD DOH L&C  
If continuation sheet Page 1 of 11

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F 281	<p>Continued From page 1</p> <p>Review of resident 1's medical record revealed no documentation of why the treatment had not been documented.</p> <p>Interview on 4/23/14 at 11:30 a.m. with the Sunshine registered nurse (RN) case manager revealed if the nurse had not documented on the TAR or in the interdisciplinary notes that it was done, then it had not been done.</p> <p>b. Review of resident 10's medical record revealed: *A 2/11/14 physician's order for EPC (a skin protectant cream) to the coccyx (tailbone) twice daily. *A 2/28/14 physician's order for oxygen at 5 liters during the night. *A 4/11/14 physician's order for Lotrisone cream (for fungal skin infections and itching), apply to spots on face twice daily for two weeks.</p> <p>Review of resident 10's April 2014 TAR revealed: *The EPC cream had not been documented as given eight of forty-five times. *The oxygen had not been documented as given for seven of twenty-two nights. *The Lotrisone cream had not been documented as given for six of twenty-three times.</p> <p>Interview on 4/23/14 at 2:20 p.m. with the Robin's View RN case manager revealed if the nurse had not documented treatments on the TAR or in the interdisciplinary notes, then it had not been done.</p> <p>Surveyor: 32335 c. Review of resident 2's medical record revealed he had been admitted on 12/4/13.</p> <p>Review of resident 2's 12/18/13 and 2/12/14</p>	F 281	<p>on PRN documentation on the back of the MAR or pain assessment Flow-sheet as appropriate. If Nurse or UAP giving PRN medication is switching shifts or leaving post this must be communicated to oncoming Nurse or UAP for follow up documentation.</p> <ol style="list-style-type: none"> <li>1. Documentation must include, as a minimum (on TAR)             <ol style="list-style-type: none"> <li>a. Type of the treatment</li> <li>b. Treatment directions including site of application and dose of any medications used</li> <li>c. Method of route of administration</li> <li>d. Date and time of administration</li> <li>e. Treatment diagnosis</li> <li>f. Reason(s) why medication was withheld, not administered or refused (as applicable)</li> <li>g. Signature and title of person administering the treatment and/or initials</li> <li>h. Resident's follow up response to the treatment, if applicable (e.g. PRN)</li> </ol> </li> </ol> <p>When giving the PRN treatment the nurse must pull the red tab on the TAR and complete follow up documentation. Either follow up on the PRN documentation o the back of TAR or Pain assessment flow sheet, as appropriate. If nurse is giving PRN treatment is switching shifts or leaving post this must be communicated to oncoming nurse for follow up documentation</p>	

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F 281	<p>Continued From page 2</p> <p>physician's orders revealed he was to have "Sween 24 cream" applied to his bottom two times per day and as needed.</p> <p>Review of resident 2's 1/1/14 through 4/21/14 TARs revealed the cream had not been applied 83 times out of 222 times.</p> <p>d. Review of resident 12's 2/12/14 physician's orders revealed he was to have "CeraVe moisturizing" cream applied to his foreskin two times per day.</p> <p>Review of resident 12's 4/1/14 through 4/22/14 TARs revealed it had not been applied eleven times out of forty-four times.</p> <p>e. Interview and policy review on 4/23/14 at 11:40 a.m. with the director of nursing revealed: *The nurses should have put their initials on the TAR after completing the treatment. *"If the nurse had not initialed the TAR the treatment had not been done." *If the treatment had not been done they had not followed the physician's orders. *The provider's July 2012 Treatment Administration Documentation policy had not been followed.</p> <p>Surveyor: 18560</p> <p>2. Review of resident 4's physician's orders revealed: *An order dated 8/26/13 to check the placement of the Fentanyl patch (pain medication) two times daily. *An order dated 1/10/14 for polyethylene glycol 3350 powder 17 grams every day for</p>	F 281	<p>Failure to follow policy will be a medication error and the <u>Medication Error Pathway</u> will be followed. The Director of Nursing or designee (Casemanagers) is responsible for reviewing medical records information [redacted] on a weekly basis for four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for four (4) weeks, then quarterly for one year.</p> <p>There was direct and immediate response to resident #16 nebulizer treatment by appropriate personnel. The facility is assured provide guidelines in administrating nebulizer treatments.</p> <ol style="list-style-type: none"> <li>1. Wash hands.</li> <li>2. Obtain equipment (nebulizer kit, nebulizer machine, medication)</li> <li>3. Explain procedure to resident.</li> <li>4. Open nebulizer kit and instill solution into cup, attach top and tubing then attach to machine.</li> <li>5. Administer treatment.</li> <li>6. After treatment, disconnect tubing from machine.</li> <li>7. To clean nebulizer equipment, rinse equipment out with sterile water (excluding tubing) and air dried after every use.</li> <li>8. Discard nebulize</li> </ol> <p>The Director of Nursing or designee (Casemanagers) is responsible for observing nebulizer treatments [redacted] on a weekly basis</p>	

*10% plus resident 16 observation*

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F 281	<p>Continued From page 3 constipation.</p> <p>Review of resident 4's following Medication Administration Records revealed: *In February 2014: -Her Fentanyl patch had not been checked thirteen out of fifty-six times. -She had been given the polyethylene every other day. *In March 2014: -Her Fentanyl patch had not been checked eight out of sixty-three times. -She had been given the polyethylene every other day. *From 4/1/14 through 4/21/14: -Her Fentanyl patch had not been checked six out of forty-two times. -She had been given the polyethylene every other day.</p> <p>Interview on 4/23/14 at 11:00 a.m. with the Southridge RN care manager confirmed resident 4's Fentanyl patch should have been checked twice a day. She further confirmed resident 4 should have received her polyethylene every day not every other day.</p> <p>Review of the provider's Medication Administration General Guidelines policy dated September 2008 revealed medications were administered as prescribed in accordance with manufacturers' specification, good nursing principles and practices, and only by persons legally authorized to do so.</p> <p>Surveyor: 33265 3. Observation on 4/22/14 at 12:15 p.m. of certified nursing assistant/medication technician A administering a nebulizer treatment medication</p>	F 281	for four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for four (4) weeks, then quarterly for one year.	
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F 281	<p>Continued From page 4 for resident 16 revealed she: *Went into the resident's room. *Disassembled the bowl of the nebulizer. *Poured the ordered nebulizer solution into the bowl. *Reassembled the bowl and set the bowl upright. *Left the room. *Informed CNA B the nebulizer was ready to start when the resident returned to his room after lunch, and asked her to start the nebulizer.</p> <p>Interview on 4/23/14 at 3:25 p.m. with the DON revealed: *She expected the person that prepared the medications to be the staff member administering the medication. *CNA B was not a medication technician.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, MO, 2013, page 582, revealed: "Do not delegate any part of the medication administration process to nursing assistive personnel and use the nursing process to integrate medication therapy into care."</p> <p>4. Review of resident 3's entire medical record revealed three different birthdays listed. Those birthdays were: *The Brookings Health System patient release form dated 10/19/11 had 4/13/17. *The facesheet completed on admission on 10/22/11 had 4/3/17. *The physician's progress notes dated 1/10/14 had 7/13/17.</p> <p>Interview on 4/22/14 at 3:05 p.m. with resident 3 revealed her birthday was 4/13/17.</p> <p>Interview on 4/23/14 at 3:25 p.m. with the DON</p>	F 281	<p>The date of birth on resident #3 was corrected immediately. The facility is assured that upon admission of resident to facility it is required that entered information into electronic medical record is accurate. This includes but is not limited to the following: Name, date of birth, insurance information, room number, and other demographic information. This information shall be assessed by medical records representative on a continuous bases to assure and changes to information are represented correctly in the medical record. The Director of Nursing or designee is responsible for reviewing medical records information [redacted] on a weekly basis for four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for four (4) weeks, then quarterly for one year.</p> <p><i>10/12/2014</i></p> <p><i>*10% of the records</i></p>

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F 281	Continued From page 5 revealed: *She agreed the correct birthday needed to be recorded on all documents. *She had no explanation for the multiple birthdays documented within the medical record. *She would have to look into the correct birthday.  Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, MO, 2013, page 350, revealed: "High-quality documentation and reporting are necessary to enhance efficient, individualized patient care. Quality documentation and reporting have five important characteristics: they are factual, actual, complete, current, and organized."	F 281		
F 323 SS=D	<b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b>  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.  This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to provide safe storage of oxygen cylinders in one of one oxygen storage room (109). Findings include:  1. Observation on 4/22/14 at 3:30 p.m. of the oxygen storage room 109 revealed four of eight oxygen cylinders were upright on the floor without	F 323	The oxygen cylinders were secured properly upon discovery. The facility is assured that oxygen cylinders are properly secured for safekeeping and maintenance in the oxygen store room. Oxygen store room located down Southridge is to be used for storage of oxygen concentrators, oxygen cylinders, nebulizer equipment, and other oxygen therapy equipment. Oxygen Cylinders may not be left free standing. They must be securely fastened at all times. Full cylinders are distinguished with a "cap" on the top and there shall always be one full cylinder at all times. If there is only one full cylinder the Director of Nursing must be notified immediately to place a refill order. Organization of room is to be maintained by all staff that utilize the room. The Director of Nursing or designee is responsible for reviewing <del>_____</del> on a weekly basis for four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for four (4) weeks, then quarterly for one year.	6/12/2014  * MORE STORAGE OF OXYGEN SEASONAL

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F 323	Continued From page 6 being secured.  Observation and interview on 4/23/14 at 3:25 p.m. with the director of nursing revealed: *The same condition of the oxygen cylinders as identified above. *She agreed the four unsecured oxygen cylinders were not being safely stored.  Review of the provider's January 2010 oxygen safety policy revealed the oxygen cylinders should have been stored in racks with chains, sturdy portable carts, and/or approved stands.	F 323		
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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	<i>* Education was provided to all laundry staff, including laundry assistants D and E on laundry storage and transport. SJS/SDH/ME</i>  The personal clothing items on hangers using a wheeled cart were completely and properly covered upon discovery. The facility is assured that all hanging personal linens will be covered fully during delivery to all neighborhoods.*  To ensure prevention of spreading infections and the delivery of personal clothing in a sanitary manner to all neighborhoods laundry staff will cover all hanging garments with moisture proof cover. Laundry staff will make sure all garments are fully covered during delivery. The laundry/housekeeping supervisor or designee is responsible for documenting proper delivery pursuant to policy on a weekly basis for four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for four (4) weeks, then quarterly for one year.	<i>6/12/2014</i>

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F 441	<p>Continued From page 7</p> <p>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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331</p> <p>Surveyor: 32335</p> <p>Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to: *Deliver personal hanging clothing items in a sanitary manner for three of four neighborhoods (Sunshine, Southridge, and Robin's View). *Ensure appropriate cleaning of nebulizer (used to deliver inhaled medication into the lungs) equipment for one of two resident's observed nebulizer treatments. Findings include:</p> <p>1a. Observation on 4/22/14 at 2:50 p.m. in the Sunshine neighborhood revealed laundry assistant D delivered personal clothing items on hangers using a wheeled cart. A partly folded sheet covered the tops of some of the hangers down to approximately shoulder length of the</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>shirts. Some of the clothing on the end of the cart had no covering.</p> <p>Interview at that time with laundry assistant D revealed: *She folded and delivered the clean laundry. *That had been her normal procedure for the laundry delivery.</p> <p>Interview on 4/23/14 at 11:00 a.m. with laundry assistant E revealed: *The above cart was used to deliver hanging laundry to all of the neighborhoods. *The personal items were to have been covered with a sheet while they were being delivered. *The sheets had not been large enough to cover all of the clothing during delivery.</p> <p>Surveyor: 32335 b. Observation on 4/22/14 at 2:30 p.m. in the Southridge neighborhood revealed an unidentified laundry assistant delivered personal clothing to residents' rooms with a wheeled cart. The personal clothing had been on hangers. There had been two multi-colored sheets which remained partly folded, covering the tops of some of the hangers down to approximately shoulder length of the shirts. Clothing on the ends of the wheeled cart had no covering.</p> <p>Surveyor: 32331 c. Observation on 4/22/14 at 2:55 p.m. in the Robin's View neighborhood revealed laundry assistant D delivered personal clothing items on hangers using a wheeled cart to residents' rooms 313 through 326. There had been one multi-colored sheet which remained partly folded and covered the tops of some of the hangers down to approximately shoulder length of the</p>	F 441			

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F 441	<p>Continued From page 9</p> <p>shirts. Clothing on the ends of the wheeled cart had no covering.</p> <p>Surveyor: 32332 d. Interview on 4/23/14 at 2:30 p.m. with the laundry supervisor revealed: *The personal laundry items were to have been fully covered. *The cloth sheet covering the clothing items had not been moisture-proof.</p> <p>The provider had not been able to provide a laundry delivery policy when it was requested prior to the survey team exit.</p> <p>Review of the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) manual, 3rd Ed., Washington, DC, 2009, page 101-6, revealed: When transporting freshly laundered items, the cart was to have been covered or wrapped for protection from contamination during transport. It was to have remained covered so as not to expose the contents to common traffic.</p> <p>Surveyor: 33265 2. Observation on 4/22/14 at 3:50 p.m. in resident 17's room revealed licensed practical nurse C had: *Found the nebulizer pieces in an unclean condition. *Rinsed the nebulizer parts with bottled distilled water that she had retrieved from the storage room. *Prepared the medication for administration. *Administered the medication and waited for completion of the nebulizer treatment. *Rinsed out the nebulizer parts with water from</p>	F 441	<p>There was direct and immediate response to resident #17 nebulizer treatment to prevention the spreading of infections and the delivery in a sanitary manner. The facility is assured provide guidelines in administrating nebulizer cleaning.</p> <ol style="list-style-type: none"> <li>1. Wash hands.</li> <li>2. Obtain equipment (nebulizer kit, nebulizer machine, medication)</li> <li>3. Explain procedure to resident.</li> <li>4. Open nebulizer kit and instill solution into cup, attach top and tubing then attach to machine.</li> <li>5. Administer treatment.</li> </ol>	4/23/2014	

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

PRINTED: 05/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/23/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNITED RETIREMENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 FIRST AVE BROOKINGS, SD 57006</b>	
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F 441	Continued From page 10 the same bottle of distilled water. *Poured the rinse water in the waste basket at the side of the bed. *Disassembled the nebulizer pieces and placed them on a dry white cloth towel that had been laying on the bedside stand. *Poured the rest of the distilled water from the bottle over the pieces and onto the towel and the top of the bedside stand.  Interview on 4/23/14 at 3:25 p.m. with the director of nursing confirmed the above procedure was not an appropriate way to have cleaned the pieces of the nebulizer equipment.  Review of the provider's July 2003 nebulizer treatments policy revealed: *To clean nebulizer equipment, rinse container with fresh tap water. *Rinse mouthpiece. *Place equipment on clean paper towel to air dry.	F 441	6. After treatment, disconnect tubing from machine. 7. To clean nebulizer equipment, rinse equipment out with sterile water (excluding tubing) and air dried after every use. 8. Discard nebulize The Director of Nursing or designee (Casemanagers) is responsible for observing nebulizer treatments <del>on a weekly basis</del> on a weekly basis for four (4) weeks then quarterly through the QAPI process. QAPI results will be reported to the Administrator weekly for four (4) weeks, then quarterly for one year.	4/23/2014

*10% plus resident ITS*

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

ORIGINAL

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/23/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNITED RETIREMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 FIRST AVE BROOKINGS, SD 57006</b>
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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/23/14. United Retirement Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 4/23/14.  Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 020 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain the one hour fire resistive rating of vertical openings in two randomly observed areas (elevator shaft on each level). Findings include:	K 020		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sally Brown</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/19/2014</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 disposable 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 disposable 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 020	Continued From page 1 1. Observation at 11:00 a.m. on 4/23/14 revealed the elevator separation doors on the first floor and in the basement were hollow metal doors with wire glass vision panels. The doors did not have identification tags to indicate a fire resistive rating. This deficiency affected the service wing smoke compartment only and should not affect resident safety. Review of previous survey data revealed that condition had existed since the original construction of the building.  The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 020			

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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10601</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/23/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>UNITED RETIREMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 1ST AVE BROOKINGS, SD 57006</b>
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S 000 Initial Comments

Surveyor: 32332  
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/22/14 through 4/23/14. United Retirement Center was found not in compliance with the following requirements: S301, and S475.

S 000

Addendums noted with an asterisk per 615.114 telephone to facility administrator. SB/SDDOH/MF

6/12/2014

S 301 44:04:07:16 Required dietary inservice training

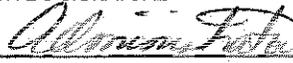
The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing inservice training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.

S 301

The Dietary Manager and Dietary Clerk corrected the staff on duty to ensure food safety upon discovery. The facility is assured that All food handlers, including dietary, nursing, and activity staff, at United Living Community shall be trained, the Director of Dietary Services on the following areas: food safety, hand washing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. Proper education, by the Director of Dietary Services, over the above topics using the information sheet marked S301. Education will be provided to all Dietary, Nursing, and Activity staff. All information will be located in the Food Handler Education binder located in the employee breakroom. Staff will review the binder, complete a quiz, and return to their supervisor when completed. The Director of Dietary Services will compile. Annual training will begin on June 1<sup>st</sup> of each year and must be completed by July 1<sup>st</sup> of that same year. All staff hired into these positions subsequent to initial training will have training on these subjects at orientation and then annually after that. Initial training will begin on May 12<sup>th</sup>, 2014. The Director of Nutrition Services or designee is responsible for reviewing proper use of the facilities hands-free paper towel

6/12/2014

This Rule is not met as evidenced by:  
Surveyor: 32331  
Based on record review, interview, and policy review, the provider failed to ensure:  
\*Six of nine required annual inservice training sessions (food safety, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, and time and temperature controls for food preparation and service) were offered yearly for food-handling staff. Findings include:  
1. Record review of the required inservice

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 
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STATE FORM 021199 P93N11

SD DOH L&C

MAY 22 2014

If continuation sheet of 3

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 301	<p>Continued From Page 1</p> <p>training sessions for 2013 and 2014 for all food handling staff revealed: *Those staff had received no training on the following: -Food safety. -Food handling and preparation techniques. -Food-borne illnesses. -Serving and distribution procedures -Leftover food handling policies. -Time and temperature controls for food preparation and service.</p> <p>Interview on 4/23/14 at 10:00 a.m. with the dietary manager revealed food handling staff were identified as dietary, nursing, and activities staff.</p> <p>Interview on 4/23/14 at 11:20 a.m. with the director of nursing and registered nurse F confirmed: *Food handling staff were identified as dietary, nursing, and activities staff. *There had not been inservices on the above food handling topics.</p> <p>Interview on 4/23/14 at 1:00 p.m. with the dietary manager revealed the provider did not have a policy on required inservice training sessions for dietary staff and all food handlers.</p> <p>Review of the provider's February 2011 Continuing Education policy revealed proper education was to have been ensured on skills to complete career related tasks.</p>	S 301	<p>All completed education will be filed in Director of Education's office. Each department manager will be responsible for assuring that all of their respective staff have completed the training and the report will be compiled for review at the quarterly QAPI.</p>	6/12/2014
S 475	<p>44:04:18:13 Supervision of Students</p> <p>Students in a nurse aide training program may not perform any services unless they have been</p>	S 475		6/12/2014

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 475 Continued From Page 2

trained and found to be proficient by the instructor. Students in a training program may perform services only under the supervision of a licensed nurse.

This Rule is not met as evidenced by:  
Surveyor: 33265  
Based on record review and interview, the provider failed to provide direct supervision of certified nursing assistant (CNA) students by a licensed nurse for sixteen hours of clinical time. Findings include:

1. Review of the provider's CNA training program revealed:  
\*Eight hours were spent on review of skills with students practicing on each other with the registered nurse instructor present.  
\*Eight hours were spent on the floor under the supervision of a CNA.  
-The CNA was under the supervision of a licensed nurse.

Interview on 4/23/14 at 9:50 a.m. with CNA instructor/registered nurse F revealed:  
\*The above sixteen hours were considered under supervision of a licensed nurse.  
\*There were no hours spent with a licensed nurse directly supervising the CNA student in the clinical practice setting.

Review of curriculum standards 483.152 (a) (1) identified there should have been sixteen hours of supervised practical nursing in which the student demonstrated their skills under direct supervision of a licensed nurse.

S 475

The Director of Education, Director of Human Resource and Director of Nursing corrected the staff training process upon discovery. Students will be provided with 16 hours of supervised time by the CNA instructor (licensed nurse). CNA class was restructured a bit to include the 16 hours with a licensed nurse. Each CNA class that is held will have this standard. CNA instructor reviewed rules, and got clarification from the SDBON [redacted] to ensure program was up to standards and it is. CNA class is re-applied for approval from the South Dakota Board of Nursing every 2 years. The CNA instructor will ensure these standards are met with all new CNA students.

The Director of Education will report any changes to the CNA curriculum to the Director of Nursing and the South Dakota Board of Nursing. The Director of Nursing with Human Resource and Director of Education is responsible for ensuring C.N.A. training records reflect proper orientation per policy. The Director of Education or designee will document each C.N.A training hours after each class.

*\* will monitor the program monthly and will*

*\*The director of education will report OAPI results to the administrator monthly for one year.*

*4/12/2014*

*SB/SDD/HMF*