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

ORIGINAL

PRINTED: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435088		07/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE CARE AND REHAB CENTER	500 VERMILLION ST CENTERVILLE, SD 57014

(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 Addendums noted with an asterisk per stability telephone to facility administrator. DK/SDDOH/MF Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/7/14 through 7/9/14. Centerville Care and Rehab Center was found not in compliance with the following requirements: F281, F311, F323, F329, F371, F388, F431, and F520.	F 000	F000 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 281 SS=D	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: 32332 Based on record review, interview, and medication administration procedure review, the provider failed to ensure professional standards were followed for: *Providing the correct medication dosage ordered by the physician for 1 of 13 random and sampled residents (11). *Notifying the resident's family member prior to initiation of an antipsychotic medication (used to treat mental disorders) for one of nine sampled residents (1). Findings include: 1. Observation on 7/8/14 at 9:15 a.m. of registered nurse (RN) C during a medication pass to resident 11 revealed an order on the July 2014 medication administration record for Pulmacort (used to treat asthma and breathing problems) 0.5 milligrams (mg)/2 milliliters (ml) to have been	F 281	F281 Resident 11's medication administration record and physician orders were reviewed to ensure correct medication dosages are being provided as ordered by the physician. All other residents' medication administration records and physician orders were reviewed to ensure correct medication dosages are being provided as ordered by the physician. Resident 1's medications were reviewed with the family to ensure they are aware of all the medications their family member is receiving. All other residents' medications will be reviewed with family at their next scheduled care conference to ensure they are aware of all the medications their family member is receiving. *DON or designee will provide education on physician orders process & policies for staff responsible for the task on 8/19/14. DK/SDDOH/MF	8/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Emergency Permit Holder (X6) DATE: 8/4/14

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 281	Continued From page 1 given twice daily (BID). Observation at that time revealed RN C pulled a vial of Pulmacort from resident 11's medication drawer. The dosage on that vial package was 0.25 mg/2 ml BID. Review of resident 11's physician's orders revealed the physician had seen her on 6/26/14 and had increased the Pulmacort from 0.25 mg/2 ml to 0.5 mg/2 ml BID. Phone call on 7/9/14 at 9:20 a.m. by RN C to the pharmacy revealed the pharmacy had not received the Pulmacort order change. Interview with RN C at that time revealed: *The resident had not received the correct dosage since the medication order had changed. *She had received twenty-four incorrect doses. Interview on 7/9/14 at 1:50 p.m. with the director of nursing (DON) revealed her expectation was the nursing staff would check each medication for the correct dose prior to administering it. Review of the provider's October 2009 Administration of Medication policy revealed nursing staff were to have administered medications to the resident according to the "five rights:" *Right drug. *Right dose. *Right route. *Right time. *Right resident. 2. Review of resident 1's medical record revealed:	F 281	DON or designee will audit all new physician orders once per week for four weeks and monthly for two more months to ensure medications are accurate and that family members have been notified. DON or designee will present findings from these audits at the monthly QAPI meetings for review* until resolved. DK/SD/DOH/MF	

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F 281	Continued From page 2 *A 3/14/14 order for the medication Seroquel (an antipsychotic used to treat schizophrenia [a mental disorder]). *No documentation in the record to indicate her family had been notified of the order. Interview on 7/9/14 at 1:50 p.m. with the DON revealed the provider sometimes notified family members of changes if they indicated they wanted to be notified. It was not the normal procedure to notify family members of medication changes. Review of the provider's October 2009 Administration of Medication Procedure revealed: *"Inform the resident and/or legal representative of new medication orders and the risk/benefit of the medications. Document the discussion in the interdisciplinary progress."	F 281		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to ensure recommendations from the therapy department had been followed for four of nine sampled residents (1, 2, 4, and 7) who were to have received restorative exercises. Findings include:	F 311	F311 Residents 1, 2, 4, and 7 interdisciplinary care plans and restorative therapy programs were reviewed to ensure therapy department recommendations are being followed. All other residents' interdisciplinary care plans and restorative programs who are receiving restorative exercises were reviewed to ensure therapy department recommendations are being followed.	8/28/14

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F 311	Continued From page 3 1. Review of resident 1's interdisciplinary care plan and May, June, and July 2014 restorative records revealed she was to have received restorative therapy for: *Active range of motion (AROM) using the Nustep (an exercise machine) for fifteen minutes daily, up to seven days per week. *Dressing therapy assistance to maintain some independence with dressing for fifteen minutes daily, up to seven days per week. *AROM for lower extremity strengthening exercises with no stated goal. Review of her May, June, and July 2014 restorative records revealed: *AROM using the NuStep had been documented as completed for zero of seventy days. -There had been no explanation of why the exercise had not occurred. *Dressing assistance therapy had been documented as completed for thirty-four of seventy days. -One day had been circled, but there had been no indication of why the exercises had not occurred. *Lower extremity exercises had been documented as completed for thirty-four of seventy days. -Five days had been circled, and the restorative aide had documented the reason why the exercises had not occurred. *The days without signatures had been left empty. On those days there had been no explanation as to why the exercises had not occurred. 2. Review of resident 2's interdisciplinary care plan and May, June, and July 2014 restorative nursing records revealed he was to have received	F 311	DON, PT, OT, and interdisciplinary team reviewed and revised as necessary the policy and procedures about the provision of restorative therapy care. This includes but is not limited to the assessment and recommendation for restorative therapy care, who will provide oversight for staff performing cares on day to day basis, who will carry out the care, appropriate education for those providing care, and care planning needs. DON or designee will provide education on the restorative therapy care process and policies for staff responsible for task* on 8/19/14. DK/SDDOH/MF DON or designee will audit resident restorative plans to ensure they are completed and following therapy recommendations one time per week for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review* until resolved. DK/SDDOH/MF	

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F 311	Continued From page 4 restorative therapy for: *Passive range of motion (PROM) exercises to his legs with fifteen repetitions, with no goal for how often that was to have occurred. *AROM/PROM to his hands with massages and stretching with no goal as to how often that was to have occurred. *PROM to his shoulders, elbows, and wrists with two sets of fifteen repetitions with no goal as to how often that was to have occurred. Review of his May, June, and July 2014 restorative records revealed: *PROM exercises to his legs had been documented as completed for fifteen of seventy days. *AROM/PROM to his hands had been documented as completed for fifteen of seventy days. *PROM to his shoulders, elbows, and wrists had been documented as completed for one of seventy days. *The restorative aide had documented resident refusals of therapy for seven days. *The days without signatures had been left empty. On those days there had been no explanation as to why the exercises had not occurred. 3. Review of resident 7's medical record revealed: *A revised 1/14/14 interdisciplinary care plan stating staff were to have provided "gentle range of motions as tolerated with daily care." *No restorative therapy record had been found. 4. Review of resident 4's medical record revealed: *A 10/23/13 focus area on the interdisciplinary	F 311		

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F 311	Continued From page 5 care plan with interventions: -"Provide gentle range of motion as tolerated with daily care." -"Passive ROM (range of motion) Program #1 during AM and HS (hour of sleep) cares." -"The resident requires passive exercises to all limbs daily during cares and with bathing." *No restorative therapy record had been found. Interview on 7/9/14 at 1:30 p.m. with the DON revealed the CNAs had provided ROM daily during morning and evening cares. She stated CNAs had not been required to document the ROM provided. 5. Interview on 7/9/14 at 1:15 p.m. with licensed practical nurse (LPN)/restorative nurse C revealed: *The physical and occupational therapists had recommended the restorative exercises for each resident. *The restorative aides were to have assisted with the exercises as the therapists had indicated. *If the days had been left blank the exercises had not occurred. *The restorative aides had verbalized concerns on how to accomplish the exercises and had been requesting a meeting. *The restorative program needed to be evaluated to monitor if the exercises remained appropriate for each resident. Interview on 7/9/14 at 1:30 p.m. with restorative aide D revealed: *There had been a decrease in staff lately. *She attempted to get the restorative exercises done, but she also needed to assist with toileting and care of residents on the floor. *If the days had been left blank the exercises had	F 311		

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F 311	Continued From page 6 not occurred. Interview on 7/9/14 at 1:50 p.m. with the director of nursing (DON) revealed: *Restorative staff were not providing exercises as the therapists had recommended. *She had been in charge of the restorative nursing department until recently and had not had the time to oversee it. Review of the provider's July 2013 Restorative Nursing policy revealed: *Measurable objectives were to have been documented in the resident's care plan and medical record. *A licensed nurse would provide periodic evaluation of each resident's restorative program and document accordingly. *Documentation would track the resident's progress or regression. *Goals and approached were to have been charted. *The care plan was to have been updated as the resident changed.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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:	F 323	F323 The mechanical room door located on Prairie Road was observed to ensure the environment remained free of accident hazards as is possible and had the ability to lock properly. All other resident areas containing doors leading to mechanical areas were observed to ensure the environment remained free of accident hazards as is possible and had the ability to lock properly.	8/28/14

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F 323	Continued From page 7 Surveyor: 32331 A. Based on observation and interview review, the provider failed to properly secure one of one mechanical room door located in a resident hallway (Prairie Road). Findings include: 1. Observation on 7/7/14 at 2:55 p.m. in the resident hallway on the 300 wing (Prairie Road) revealed: *A door with a typed sign "Boiler Room Not an Exit." *A door with a handwritten sign "Check me, sure I am locked." *The door was unlocked. *The door was located next to an occupied resident room 301 and across from an occupied resident room 302. *This surveyor opened the door and the following were revealed: -A three and one-half foot by four foot cement landing with two cement steps leading down to a cement floor containing a boiler area, hot water heaters, an opened area on the interior wall of the room showing a crawl space with running water, an air conditioner, and a container with a red bag marked "Medical Waste." -Inside the mechanical room in close proximity to the bottom of the steps there was an unlocked exit door that lead to the parking lot with a hose running out of the door to the outside. Observation on 7/7/14 from 2:55 p.m. through 3:13 p.m. in the resident hallway on Prairie Road revealed: *No attempts by staff to lock the mechanical room. *During the above time period of eighteen minutes there had been several residents, including residents in wheelchairs, and staff that	F 323	Resident's 5 and 8 were assessed to ensure safe smoking practices and freedom from accident hazards as is possible. If deemed unsafe, each resident will receive adequate supervision to prevent accidents. *quarterly DK/SDDOH/MF All other resident smokers will be assessed to ensure safe smoking practices and freedom from accident hazards as is possible. If deemed unsafe, each resident will receive adequate supervision to prevent accidents. The environmental services director or designee will audit mechanical room doors in resident areas to ensure they are free from any hazards and locked properly one time per week for four weeks and monthly for two more months. DON or designee will audit the smoking assessments to ensure they are complete one time per week for four weeks and monthly for two more months. The environmental services director and DON or designees will present findings from these audits at the monthly QAPI meetings for review* until resolved. DK/SDDOH/MF	

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F 323	Continued From page 8 had walked by the unsecured door. Interview on 7/7/14 at 3:14 p.m. with the administrator in the resident hallway on Prairie Road in the mechanical room revealed: *He agreed the mechanical room was not locked. *He agreed the mechanical room not being locked was a safety concern. *He agreed there was a possibility for resident injury through the unlocked mechanical room door. *He agreed there was a possibility for elopement from inside the mechanical room through the unlocked exit door leading to the outside. *He stated the room was used by nursing to dispose of medical waste in the container at the bottom of the steps. *He had stated the only other staff that used the room was the environmental services director. *He stated the inside door had a push button lock on the door handle that was to have been pushed in, and the door closed tightly each time a staff person had been in the room. Interview on 7/7/14 at 10:53 a.m. with the environmental services director in the resident hallway on Prairie Road in the mechanical room revealed: *She agreed the mechanical room should have been locked. *She stated the room was opened more frequently than for maintenance as the medical waste storage container was located in the same room. *She stated the nurses had been using it to dispose of the medical waste. *The door was to have been locked each time after the room had been used. *She stated the provider did not have a policy on	F 323		

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F 323	Continued From page 9 locking the mechanical door. B. Based on observation, interview, record review, and policy review, the provider failed to properly assess two of two sampled residents (5 and 8) who smoked cigarettes on a periodic basis as per the provider's policy. Findings include: 1. Review of resident 5's medical record revealed: *He had a history of mental health issues. *He was on an antipsychotic medication (used to treat mental disorder). *He had a significant history of falling. *A Smoking Safety Screen assessment had been completed on 10/21/13. The areas reviewed on the assessment were as follows: -Cognition (mental ability). -Vision. -Dexterity (hand and eye coordination). -Frequency of smoking. -Safety with smoking. *The interdisciplinary team decision regarding smoking revealed: -He had eloped (left the facility) while smoking unattended. -He was safe to smoke with supervision. -He needed supervision to prevent him from leaving facility grounds. Interview on 7/7/14 at 4:40 p.m. with resident 5 in his room revealed he: *Enjoyed smoking cigarettes. *Stated he had needed to ask nursing for a cigarette and a lighter, and he needed assistance from staff with having the cigarette lit. *Stated he could smoke unsupervised outside after staff assisted him.	F 323		

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F 323	Continued From page 10 Review of resident 5's 4/1/14 care plan revealed the resident: *Was a smoker. *Could smoke unsupervised after set-up. *Was to smoke out the south door on the 100 wing (Melody Avenue) to prevent elopement. *Was not able to light his own cigarette. *Had his cigarettes and lighter kept at the nurses station. Observation on 7/9/14 at 11:10 a.m. in the courtyard out the south door on the 100 wing (Melody Avenue) revealed resident 5 was out smoking a cigarette in his wheelchair. 2. Review of resident 8's medical record revealed: *He had a history of mental health issues. *He was on an antipsychotic medication. *A Smoking Safety Screen assessment had been completed on 10/21/13. The areas reviewed on the assessment were as follows: -Cognition (mental ability). -Vision. -Dexterity (hand and eye coordination). -Frequency of smoking. -Safety with smoking. *The interdisciplinary team decision regarding smoking revealed: -He was able to smoke outside independently. -Staff were to monitor the cigarette and the lighter at the nurses station and to distribute per his smoking schedule. -He was safe to smoke without supervision. -He needed to be monitored with his smoking habits. -Changes were to have been monitored. Interview on 7/7/14 at 4:40 p.m. with resident 8 in	F 323		

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F 323	Continued From page 11 his room revealed he: *Enjoyed smoking cigarettes. *Was on a smoking schedule that had been posted on his wall next to his door. *Stated he had needed to ask nursing for a cigarette and a lighter before he could smoke outside. *Stated he could smoke unsupervised outside. *Stated he had to return the lighter to nursing after he smoked his cigarette. Review of resident 8's 3/24/14 care plan revealed the resident: *Was a smoker. *Could smoke unsupervised. *Had smoking supplies stored at the nurses station. *Could have a lighter but needed reminders to return it. *Was not to give cigarettes to other residents. 3. Interview on 7/9/14 at 9:10 a.m. with licensed practical nurse A regarding resident 5's and 8's smoking assessments revealed: *They had both been last assessed on 10/21/13. *The policy was written that all resident smokers were to have been re-assessed on a quarterly basis and upon any significant change of health status. *She agreed the assessments needed to have been done on at least a quarterly basis, especially for resident 5 as he was at risk with his current health status and history of falls. Interview on 7/9/14 at 2:20 p.m. with the director of nursing (DON) regarding resident 5's and 8's smoking assessments revealed the policy was not currently being followed. The residents needed to have been assessed on at least a	F 323		

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F 323	Continued From page 12 quarterly basis as per the provider's policy. Review of the provider's October 2013 Resident Smoking policy revealed all resident smokers were to have been re-assessed by the charge nurse or the DON on a quarterly basis and upon any significant change of health status.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	F329 Resident 2's drug regimen was reviewed to ensure that it was free from unnecessary drugs such as antipsychotics unless a proper diagnosis and documentation was necessary for the administration of an antipsychotic in which gradual dose reductions and behavioral interventions were used in an effort to discontinue these drugs. All other residents' drug regimens were reviewed to ensure they were free from unnecessary drugs such as antipsychotics unless a proper diagnosis and documentation was necessary for the administration of an antipsychotic in which gradual dose reductions and behavioral interventions were used in an effort to discontinue these drugs. *DON or designee will provide education on drug regimen process and policies for staff responsible for the task on 8/19/14. DKS DDOH/MF	8/28/14

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F 329	Continued From page 13 Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to ensure: *A diagnosis had been in place for appropriate indication of an antipsychotic medication (used to treat mental disorders) for one of four sampled residents (2) receiving antipsychotic medication. *Documentation was maintained for side effects in response to antipsychotic medication use for one of four sampled residents (2) receiving antipsychotic medication with the potential for unnecessary use of drugs or physical harm related to adverse side effects of the medication. Findings include: 1. Review of resident 2's medical record revealed: *A 3/14/14 physician's order for the medication Seroquel (an antipsychotic), related to the diagnosis of "dementia (loss of brain functioning), unspecified, without behavioral disturbance." *No area on the record was used to monitor for the side effects of Seroquel. Interview on 7/9/14 at 1:50 p.m. with the director of nursing revealed: *She agreed the current diagnosis of dementia without behavioral disturbance was not an adequate diagnosis for the use of an antipsychotic medication. *She stated residents receiving antipsychotics were monitored for behaviors daily, but staff had not been monitoring daily for those side effects. Review of the provider's January 2007 Psychopharmacological Medications policy revealed: *"Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329	DON or designee will audit the drug regimens of every resident once a week for four weeks and monthly for two more months to ensure they are free from unnecessary drugs or a proper diagnosis and documentation is necessary for the administration of an antipsychotic in which gradual dose reductions and behavioral interventions will be used in an effort to discontinue these drugs. DON or designee will present findings from these audits at the monthly QAPI meetings for review* until resolved. DA/SDDOH/MF	

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F 329	Continued From page 14 drug when used: *Without adequate indications for its use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued." *"Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record."	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for a refrigeration unit in one of one activity room resulting in commingling (mixed together) of resident care items and staff food items with resident food items. Findings include: 1. Observation on 7/8/14 at 9:30 a.m. in the Roper refrigeration unit in the activity room revealed:	F 371	F371 The refrigeration unit located in the activity room was checked to ensure sanitary conditions were maintained by not commingling (mixed together) resident care items and staff food items with resident food items. All other refrigeration units available to residents were checked to ensure sanitary conditions were maintained by not commingling (mixed together) resident care items and staff food items with resident food items. DON and Activity Director collaborated to review and revise any necessary policy and procedures about maintaining refrigeration units. Education will be provided for all staff responsible for this task. The dietary manager or designee will audit the refrigeration units in resident areas to ensure sanitary conditions are maintained by not commingling (mixed	8/28/14

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F 371	Continued From page 15 *One Battle Creek Ice It blue-colored cold pack in the freezer laying next to one package of rhubarb. *One ice pack cold compress located next to an opened box of baking soda. *Multiple cloth and plastic lunch bags. *One package of deli ham slices in a plastic shopping bag. *Grapefruit juice, grape juice, and several bottled water products. *One plastic container of jam marked with resident 9's name with no date. *One bottle of coffee creamer. Interview on 7/8/14 at 10:00 a.m. with the activity director revealed: *Activities, family, and staff had been using the refrigerator for refrigerated storage items. *She stated the refrigerator had not been designated as a refrigerator for resident food items only. Interview on 7/8/14 at 2:45 p.m. with the activity director and the certified dietary manager regarding the refrigerator unit in the activity room revealed: *They agreed resident food items were mixed with staff personal food items. *They stated the ice packs in the freezer were not used by dietary or by activities, and they were unsure why they were in the freezer. *They had thought the ice packs were used for resident care. *They agreed the commingling of resident care items, staff food items, and resident food items was a sanitation concern and possible risk for contamination. Interview on 7/8/14 at 2:50 p.m. with licensed practical nurse B regarding the refrigerator unit's	F 371	together) resident care items and staff food items with resident food items one time per week for four weeks and monthly for two more months. The dietary manager or designee will present findings from this audit at the monthly QAPI meeting for review* until resolved. DK/SDDCH/MF	

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F 371	Continued From page 16 freezer in the activity room containing the ice packs revealed: *The Battle Creek Ice It blue-colored cold pack was the provider's brand used for resident care. *She stated ice packs were normally stored in the clean utility room's refrigerator with the medical supplies. *She was unsure where the ice pack cold compress had come from. *She agreed the resident care items should not have been stored with the residents' food. Observation on 7/9/14 at 9:15 a.m. in the refrigeration unit in the activity room revealed the Battle Creek Ice It blue-colored cold pack and the ice pack cold compress were still in the freezer. Interview on 7/9/14 at 11:20 a.m. with the director of nursing regarding the refrigerator unit's freezer in the activity room containing the ice packs revealed: *Resident 9 had been using one of the ice packs on her wrist and other body locations. *She agreed the ice packs should not have been stored with the residents' food. Review of the provider's May 2013 Food Storage policy revealed food was to have been stored under sanitary conditions. Review of the provider's November 2002 Ice Bag policy revealed the purpose of ice was: *To have relieved pain. *To have aided in prevention of swelling and discoloration. *To have alleviated inflammation and hemorrhage (bleeding).	F 371		
F 388	483.40(c)(3)-(4) PERSONAL VISITS BY	F 388		

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F 388 SS=D	Continued From page 17 PHYSICIAN, ALTERNATE PA/NP Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to ensure one of nine sampled residents (2) had received a physician's visit alternating with a nurse practitioner visit every sixty days. Findings include: 1. Review of resident 2's medical record revealed: *She had been admitted on 12/16/13. *Her physician had visited and examined her on 1/15/14. *The nurse practitioner had visited her on 2/13/14, 3/13/14, and 5/8//14. Interview on 7/9/14 at 1:50 p.m. with the director of nursing (DON) revealed: *The physician visited weekly to do rounds on his residents. *The physician was frequently ill, and then the nurse practitioner visited in his absence. *It became difficult for the DON to keep track of	F 388	F388 Resident 2's physician visit schedule was reviewed to ensure proper alternation between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. All other residents' physician visit schedules were reviewed to ensure proper alternation between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist. The DON reviewed and revised the physician visit rotation between physician and physician assistant, nurse practitioner, or clinical nurse specialist to ensure the proper alternation is taking place. DON or designee will audit the physician visit schedule one time per week for four weeks and monthly for two more months to ensure proper alternation is being made. DON or designee will present findings from these audits at the monthly QAPI meeting for review* until resolved. DN/SDDOH/MF	8/28/14

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F 388	Continued From page 18 when the physician had last visited. *Her expectation was the physician would alternate each resident visit with the nurse practitioner visit. Review of the provider's February 2005 Physician Services policy revealed "The physician will do the initial visit personally, but may have the option of alternating further required visits between personal visits and visits by a physician's assistant, nurse practitioner or state-licensed clinical nurse specialist."	F 388		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	F431 The emergency drug kit located in the medication room was checked to ensure it was properly secured. The zip-locks used to seal the box will be numbered and documentation will be completed following opening of the box. Resident's 2, 12, 13, and 14 medication administration records and medication cassettes were reviewed to ensure an accurate account of PRN medications were documented as given. All other residents' medication administration records and medication cassettes were reviewed to ensure an accurate account of PRN medications were documented as given.	8/28/14

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F 431	Continued From page 19 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Maintain secure storage of a schedule II narcotic (government controlled and highly diverted [stolen] medication) in one of one emergency drug kit. *Maintain an accurate account for schedule III and IV (government controlled and highly diverted medication) for four of nine sampled residents (2, 12, 13, and 14) receiving PRN (as needed) medications. *Ensure all medications were secured when not in direct vision of the nursing personal in: -One of one medication cart. -One of one nursing station. Findings include: 1. Observation on 7/9/14 at 10:30 a.m. of the emergency drug kit in the medication room revealed: *The box was sealed with a zip-lock. *The medications on the emergency drug list included morphine sulfate (a narcotic used for severe pain or shortness of breath). *The zip-lock had no writing or numbers that	F 431	Nurses' station shelving and medication carts were checked to ensure they were free of any medications accessible to residents and could be properly secured. The DON and Licensed Pharmacist reviewed and revised necessary policy and procedures about medications. Education will be provided to all staff who are responsible for these tasks* on 8/19/14. DK/SDDOH/MF DON or designee will audit the emergency drug kit one time per week for four weeks and monthly for two more months to ensure it is secured properly and documented. DON or designee will audit the medication administration records and medication cassettes one time per week for four weeks and monthly for two more months to ensure an accurate amount of PRN medications are documented as given. DON or designee will audit the nurses' station shelving and medication carts one time per week for four weeks and monthly for two more months to ensure they are free from any accessible medications and are properly secured. DON or designee will present findings from these audits at the monthly QAPI meeting for review* until resolved. DK/SDDOH/MF	

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F 431	Continued From page 20 could have been used to identify when the kit had been opened. *There were several unused zip-locks available in the medication room that could have been used to reseal the emergency kit if it had been opened. *There was no documentation present to identify who had used the kit last or what had been removed, if anything. Interview at that time with registered nurse (RN) C and the director of nursing (DON) revealed: *All nurses and the unlicensed assistive personal had access to the medication room. *The nurses removed emergency medications when they were needed, and then faxed the pharmacist for replacements. *The nurses replaced the emergency medications after the pharmacist sent the replacement drug. *The pharmacist checked the emergency kit once monthly. *They agreed if medication had been stolen from the emergency box there would have been no way to tell when it had been removed. *There had been no system to mark who had replaced the zip-lock since all zip-locks were unmarked. 2. Observation on 7/9/14 at 9:15 a.m. of schedule III and IV PRN medications in the medication cart revealed: a. Resident 2 had two medication cassettes (used to store individual medications) for PRN hydrocodone/APAP (for moderate pain) 10-325 milligrams (mg). *Both cassettes containing eight tablets had been issued from the pharmacy on 2/19/14. -One tablet had been removed from the first cassette.	F 431		

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F 431	Continued From page 21 -Seven tablets had been removed from the second cassette. Review of resident 2's February 2014 through July 2014 medication administration records (MAR) revealed six tablets had been documented as given. Two tablets had not been accounted for. b. Resident 12 had one medication cassette for PRN lorazepam (for anxiety) 0.5 mg. *The cassette containing eight tablets had been issued on 5/7/14. -Four tablets had been removed from the cassette. Review of resident 12's May 2014 through July 2014 MARs revealed two tablets had been documented as given. Two tablets had not been accounted for. c. Resident 13 had one medication cassette for PRN lorazepam 0.5 mg. *The cassette containing eight tablets had been issued on 12/16/13. -Four tablets had been removed from the cassette. Review of resident 13's December 2013 through July 2014 MARs revealed one tablet had been documented as given. Three tablets had not been accounted for. d. Resident 14 had one medication cassette for PRN hydrocodone/APAP 5-325 mg. *The cassette containing eight tablets had been issued on 4/29/14. -Six tablets had been removed from the cassette. Review of resident 14's April 2014 through July	F 431		

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F 431	Continued From page 22 2014 MARs revealed four tablets had been documented as given. Two tablets had not been accounted for. 3a. Random observations on 7/7/14 beginning on the initial tour of the facility through 7/8/14 at 8:15 a.m. of the nurses station revealed a shelf containing prescription eye drops and three topical medicated powders and gels (for the skin). The medications were in an unsecured hallway used by residents, visitors, and non-nursing staff. They had not been monitored by nursing staff. b. Observations on 7/7/14 during medication administrations revealed: *At 5:10 p.m. licensed practical nurse (LPN) B wheeled the medication cart to resident 15's door. -She removed insulin from the medication cart. -She left the cart unlocked in the hallway and entered the resident's room to administer the medication. -The unsecured cart had not been within the nurses line of vision. *At 5:15 p.m. LPN B wheeled the medication cart to resident 16's door. -She removed insulin from the medication cart. -She left the cart unlocked in the hallway and entered the resident's room to administer the medication. -The unsecured cart had not been within the nurses line of vision. *At 5:50 p.m. in the dining room LPN A: -Prepared resident 17's medication at the medication cart. -Left the medication cassettes on top of the cart and walked across the dining room to administer the medication to the resident.	F 431		

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F 431	Continued From page 23 -Had not secured the medication prior to leaving the cart. *At 5:55 p.m. in the dining room LPN A: -Prepared resident 8's medications. -Left the medication cassettes on top of the cart and walked across the dining room to administer the medication to the resident. -Walked to the sink next to the kitchen and washed her hands. The medication cart had been behind a dividing wall, and not in the nurses line of vision. 4. Interview on 7/9/14 at 1:50 p.m. with the DON revealed her expectation had been: *Nursing would sign out all medication at the time it was administered. *Nursing would secure all medications at all times. *Nursing would not leave the medication cart unsecured when not directly with the medication. Review of the provider's May 2011 Acquisition, Receiving, and Dispensing of Medications policy revealed: *Medications were to have been stored in the medication room or the medication cart. *Schedule II drugs and other drugs subject to possible abuse were to be stored in separate, locked, permanently fixed compartments, except when a single, unit dose package was used. If the medication required a refrigerator they needed to be locked in a separate container. Those drugs would be reconciled at least daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist.	F 431		
F 520	483.75(o)(1) QAA	F 520		

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F 520 SS=D	Continued From page 24 COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on interview and policy review, the provider failed to ensure quality assessment and assurance (QAA) meetings were held on a quarterly basis and with a physician in attendance at those meetings. Findings include: 1. Interview on 7/9/14 at 10:00 a.m. and at 10:40 a.m. with the administrator revealed:	F 520		

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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
F 520	Continued From page 25 *A QAA meeting had been held on 6/10/14, 5/27/14, 4/30/14, 3/25/14, 3/05/14, 2/25/14, 1/29/14, 12/23/13, 11/26/13, and 10/3/13. *There was no documentation QAA meetings had been held prior to the last survey on 5/22/13 to the QAA meeting held on 10/3/13 which had been a total of five months. *The QAA meetings were currently being held monthly. *A physician had attended the QAA meeting on 3/5/14. *A physician had not attended or received documentation from any other QAA meetings. *He agreed there was no documentation of any QAA meetings being held prior to 10/3/13 since the last survey on 5/22/13. *He agreed a physician had not been in attendance at QAA meetings except on 3/5/14. *He stated there was no documentation the physician had received information of any other scheduled QAA meetings. Review of the provider's undated Quality Assurance Performance Improvement (QAPI) policy revealed the QAPI committee met monthly except the medical director and the pharmacist met with the committee quarterly.	F 520	F520 Quality assessment and assurance meetings are held on a monthly basis with the committee consisting of the director of nursing and at least three other staff members. Meetings with the physician are held on a quarterly basis following the calendar year with the same attendees. Administrator will audit the quality assessment and assurance committee monthly for 3 months to ensure committee meetings are being held. Administrator will audit the quality assessment and assurance committee quarterly meeting with physician in attendance for the next two quarters to ensure meetings are being held. Administrator will present findings from these audits at the monthly QAPI meeting for review* until resolved. DK/SDOH/MF	8/28/14

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

ORIGINAL

PRINTED: 07/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435088		07/08/2014

NAME OF PROVIDER OR SUPPLIER
CENTERVILLE CARE AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
500 VERMILLION ST
CENTERVILLE, SD 57014

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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 7/8/14. Centerville Care and Rehab 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 7/8/14 upon correction of the deficiencies identified below. 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	K000 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to ensure there were at least two conforming exits from the basement. Findings	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Emergency Permit Holder 8/4/14

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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AUG 06 2014
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	435088		**07/08/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERVILLE CARE AND REHAB CENTER	**500 VERMILLION ST** **CENTERVILLE, SD 57014**

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K 033	Continued From page 1 include: 1. Observation at 10:00 a.m. on 7/8/14 revealed the basement had only one conforming exit. The east exit discharged into the main level corridor system. A one hour fire resistive path of egress was not maintained to the exterior of the building. Review of previous survey data identified that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 033		

ORIGINAL

PRINTED: 07/17/2014
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	10605		07/09/2014

NAME OF PROVIDER OR SUPPLIER: CENTERVILLE CARE AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 500 VERMILLION, CENTERVILLE, SD 57014

(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 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/7/14 through 7/9/14. Centerville Care and Rehab Center was found not in compliance with the following requirement: S166.	S 000	S000 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166	S166 The exit door alarms associated with the West entrance/exit, 400 wing near therapy room, Vestibule/kitchen [main entrance/exit], and 100 wing were checked to ensure they were properly activated. All other exit door alarms were checked to ensure they were properly activated. Education will be given to all staff on reactivation of alarm system following the reset of an alarm. Environmental services director or designee will audit the exit door alarms one time per week for four weeks and monthly for two more months to ensure they are properly alarmed. Environmental services director or designee will present findings of audits at the monthly QAPI meeting for review.	8/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Emergency Permit Holder (X6) DATE: 8/4/14

STATE FORM 6899 LL1711 If continuation sheet 1 of 4

RECEIVED AUG 06 2014 SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10605		07/09/2014

NAME OF PROVIDER OR SUPPLIER
CENTERVILLE CARE AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
500 VERMILLION
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S 166	Continued From page 1 (7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 16385 Based on observation and interview, the provider failed to ensure four of eight exit door alarms (West entrance/exit, 400 wing near therapy room, Vestibule/kitchen [main entrance/exit], and 100 wing) were activated for unattended exit doors. Findings include: 1. Observations during the survey from 7/7/14 through 7/9/14 revealed: *On 7/7/14 at 3:15 p.m. door alarm panel switches were in the off position for four of eight exit doors: -West entrance/exit. -400 wing near therapy room. -Vestibule/kitchen (main entrance/exit). -100 wing. *There was not a staff member monitoring the west entrance, 400 wing, or 100 wing exit doors. *On 7/8/14 at 11:30 a.m. door alarm panel switches were in the off position for three of eight exit doors:	S 166		

South Dakota Department of Health

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S 166	Continued From page 2 -West entrance/exit. -400 wing near therapy room. -Vestibule/kitchen (main entrance/exit). *There was not a staff member monitoring the west entrance or 400 wing exit doors. Interview on 7/8/14 at 11:30 a.m. with the environmental services director revealed the alarms for the three doors above were in the off position during the day. She stated the alarms were activated around 10:00 p.m. when most of the certified nursing assistants (CNA) had left after their shifts. On 7/9/14 at 7:50 a.m. door alarm panel switches were in the off position for three of eight exit doors: -West entrance/exit. -400 wing near therapy room. -Vestibule/kitchen (main entrance/exit). *There was not a staff member monitoring the west entrance or 400 wing exit doors. Interview on 7/9/14 at 8:00 a.m. with the administrator confirmed the door alarms were not activated and audible during the day. He stated alarms were in the off position, because staff would need to reset the alarms at the nurses station when alarms sounded instead of at the doors. On 7/9/14 at 9:30 a.m. the door alarm panel switches were in the off position for four of eight exit doors: -West entrance/exit. -400 wing near therapy room. -Vestibule/kitchen (main entrance/exit). -100 wing. *There was not a staff member monitoring the west entrance, 400 wing, or 100 wing exit doors.	S 166		

South Dakota Department of Health

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