

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

ORIGINAL

PRINTED: 07/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000

INITIAL COMMENTS

Surveyor: 29162
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/8/14 through 7/9/14. Sanford Chamberlain Care center was found not in compliance with the following requirements: F170, F323, and F431.
F 170 483.10(i)(1) RIGHT TO PRIVACY - SS=C SEND/RECEIVE UNOPENED MAIL

The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.

This REQUIREMENT is not met as evidenced by:
Surveyor: 29162
Based on interview, the provider failed to ensure Saturday delivery of mail for all residents.
Findings include:

- Group interview on 7/8/14 at 1:45 p.m. with six randomly selected residents revealed:
*They had not received their mail on Saturday.
*They had been unaware they could have mail delivered on Saturday.
*The residents wanted to have their mail delivered on Saturday.

Interview on 7/9/14 at 9:00 a.m. with the social worker revealed there was not mail delivery on Saturday. She stated the resident's mail was delivered to the main hospital business office. That office was not open on Saturday and resulted in no Saturday mail delivery for the

F 000

F 170

Addendums noted with an asterisk per 8/16/14 telephone to facility administrators. KG/SDDH/MF

F-170 Letter sent to postmaster on July 31, 2014 stating mail should be delivered to Hamilton Household on Saturday. Saturday mail delivery will resume on August 2, 2014. Care Center mail will be delivered by LTC staff on Saturday. LTC staff will contact maintenance staff and maintenance will deliver hospital mail back to front office.

Delivery of Saturday mail was discussed with staff during the inservice on July 29, 2014.

Mail delivery will be reported to QMI monthly x 3 months by DON or designee.

8/2/14

KG/SDDH/MF

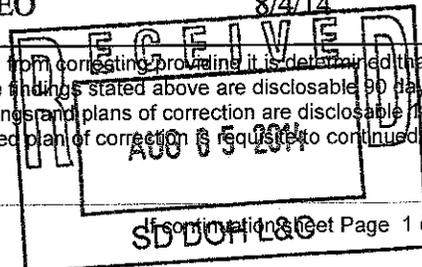
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
CEO

(X6) DATE

8/4/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are 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 required to continued program participation.



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F 170	Continued From page 1 residents. Interview on 7/9/14 at 10:15 a.m. with the activity director revealed the activity department was responsible for resident mail delivery. They had not delivered mail to the residents on Saturday, because there was no one in the business office at the hospital. Interview on 7/9/14 at 10:30 a.m. with the director of nursing confirmed there was not mail delivery for the residents on Saturday. There was nobody in the main office at the hospital to receive the mail from the post office. A policy for resident mail delivery had been requested. On 7/9/14 at 1:30 p.m. the director of nurses stated there was not a policy for delivery of resident mail.	F 170		
F 323 SS=E	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: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure an assessment was completed and documented to support the safe use of one-half side rails on the	F 323	F-323 Assessments will be completed on residents with half rails by <u>August 28, 2014</u> . Assessment/verbal consent form on these residents will be completed <u>August 28, 2014</u> . Inservice on assessment/policy will be completed by July 31, 2014. Inservice covered the use of Side Rails. XXXXXXXXXX K6/SDDCH/MF Completed side rail assessments will be monitored by MDS coordinator or designee and reported to QMI monthly x 3 months.	8/28/14

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(X4) ID PREFIX TAG F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 323	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Continued From page 2</p> <p>head of the beds used for 7 of 11 sampled residents (1, 2, 3, 4, 5, 6, and 7). Findings include:</p> <p>1. Random observations from 7/8/14 through 7/9/14 revealed residents 1, 4, and 7's beds had one-half side rails up at the head of the bed on both sides.</p> <p>2. Observation on 7/8/14 at 11:00 a.m. of personal care provided to resident 1 revealed the resident was in bed and had been rolled from side to side during the care provided. She had not attempted to grab or hold the one-half side rail during that care.</p> <p>Review of resident 1's medical record revealed no assessment for the safety of the side rails use.</p> <p>Review of the seven day look back assessment for the MDS revealed the heading "Modes of Transfer" that stated "1/2 SR [side rail] had been used for bed mobility or transfer" on the following dates: 4/28/14, 4/29/14, 4/30/14, 5/1/14, 5/3/14, and 5/4/14.</p> <p>Review of her 5/8/14 revised care plan revealed "Siderails, partial, 1/2 in bed for boundary ID [identification]." The 5/8/14 revised comprehensive care plan revealed a problem area of "ADL [activities of daily living] with an approach of "resident name has the 1/2 rails up on her bed for ID boundary."</p> <p>Review of the 11/22/13 physician's order revealed an order for "1/2 side rail for boundary ID and postioning."</p> <p>3. Observation on 7/8/14 at 12:30 p.m. of transfer</p>				

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F 323	<p>Continued From page 3</p> <p>assistance provided for resident 4 revealed the resident did not use the assistance of the side rail for assistance to the sitting position in the bed.</p> <p>Review of resident 4's medical record revealed no assessment for the safety of the side rail use. Review of the seven day look back assessment for the MDS revealed the heading "Modes of Transfer" that stated "1/2 SR had been used for bed mobility or transfer on 6/8/14 through 6/14/14."</p> <p>Review of the resident's 6/19/14 revised care plan revealed "Siderails, partial, 1/2 in bed for mobility." Her 6/19/14 revised comprehensive care plan revealed it had not addressed the use of side rails.</p> <p>Review of the 4/15/13 physician's order revealed an order for "1/2 side rail for boundary ID and postioning."</p> <p>4. Review of resident 7's medical record revealed no assessment for the safety of the use of side rails.</p> <p>Review of the seven day look back assessment for the MDS revealed the heading "Modes of Transfer" that stated "1/2 SR [side rail] had been used for bed mobility or transfer" on the following dates: 5/4/14, 5/5/14, 5/6/14, 5/7/14, 5/9/14, and 5/10/14.</p> <p>Review of the resident's 5/15/14 revised care plan revealed "Siderails, partial, 1/2 in bed for mobility." Her 5/8/14 revised comprehensive care plan revealed a problem area of "ADL with an approach of "She is able to assist in side to side bed mobility with the use of the 1/2 rails."</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>Review of the 8/17/12 physician's order revealed an order for "1/2 side rail for boundary ID."</p> <p>Surveyor: 28057</p> <p>5. Observation and interview on 7/9/14 at 11:18 a.m. confirmed resident 2 had a half side rail up on both sides at the head of the bed. She confirmed she used them for positioning in the bed.</p> <p>Interview on 7/9/14 at 11:19 a.m. with licensed practical nurse (LPN) B confirmed the resident had used the half side rails for positioning in bed.</p> <p>Review of her medical record revealed: *She had a physician's order for the use of the half side rail. *Her 5/22/14 care plan addressed the use of the half side rails to assist with bed mobility. *No assessment documentation was found that had addressed the safe use of the half side rail by the resident when she was in bed.</p> <p>6. Observation on 7/9/14 at 11:15 a.m. revealed resident 3's bed had a half rail up on both sides at the head of the bed.</p> <p>Review of her medical record revealed: *She had a current physician's order for the use of the half side rail. *Her 4/17/14 care plan addressed the use of the half side rails to assist with bed mobility. *No assessment documentation was found that had addressed the safe use of the half side rail by the resident when she was in bed.</p> <p>Surveyor: 29162</p>	F 323		

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F 323	<p>Continued From page 5</p> <p>7. Random observations on 7/8/14 and 7/9/14 of resident 5's room revealed he had two one-half side rails on his bed. Those one-half side rails had been in the up position at all times during the survey.</p> <p>Review of resident 5's care plan last reviewed 5/5/14 revealed "1/2 side rails for mobility and positioning."</p> <p>Review of resident 5's medical record revealed an opened ended physician's order on 9/23/13 for "1/2 side rail for boundary ID and postioning." There had not been an assessment for the safety of the side rails found in his medical record.</p> <p>8. Random observations on 7/8/14 and 7/9/14 of resident 6's room revealed she had two one-half side rails on her bed. Those one-half side rails had been in the up position at all times during the survey.</p> <p>Review of resident 6's last reviewed 5/14/14 care plan revealed "1/2 side rails for mobility and positioning."</p> <p>Review of resident 6's medical record revealed an open ended physician's order on 2/18/10 for "1/2 side rail for boundary ID and postioning." There had not been an assessment for the safety of the side rails found in her medical record.</p> <p>9. Interview on 7/8/14 at 10:40 a.m. with registered nurse C revealed there had not been safety assessments completed for the use of side rails for residents on Hamilton neighborhood.</p> <p>10. Interview on 7/9/14 at 10:30 a.m. with the director of nursing revealed there had not been a specific resident assessment completed for the</p>	F 323			

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F 323	Continued From page 6 safety of the use of side rails. There was a quarterly summary completed that indicated the use of the side rails, it had not been done as a safety assessment. Review of the provider's last reviewed March 2014 Side Rails policy revealed side rails: *Could be used to facilitate mobility in and out of bed and with repositioning. *Could also be used as a restraint for safety. *Would be used as assistive devices. -If during the assessment the use of the side rails was determined to be a restraint the restraint policy should have been implemented. Review of the user manual for Resident LTC Bed From Hill-Rom product No. P870, MAN 136 REV 5, revealed: *Safety Tips: -"It is very important to obey the safety information in this manual." -"Make sure side rails are fully latched when in the raised position. Failure to do either of these could cause serious injury or death." -Hill-Rom had recommenced that medical persons determine the correct methods to have made sure a patient remained safely in bed.	F 323			
F 431 SS=D	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.	F 431	See page 8		

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F 431	<p>Continued From page 7</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure a system was in place to account for controlled medications (any drug commonly understood to include narcotics, with a potential for abuse or addiction, which is held under strict government control)) awaiting destruction in two of two medication rooms. Findings include:</p>	F 431	<p><i>* attached to wall in medication rooms KE/SDDH/MF</i></p> <p>F-431 Locked sharp boxes were placed on both households on July 28, 2014. <i>KE/SDDH/MF</i></p> <p><i>7/29/14</i></p> <p><i>Nursing will place narcotics to be wasted in locked box. Pharmacist will retrieve from locked box. Pharmacist has only key to open. Current practice of putting note in Matrix on narcotics wasted, printing and rubber banding around narcotics placed in locked box will continue. Nursing was educated on need to do this at inservice on July 29, 2014. KE/SDDH/MF</i></p> <p><i>X Pharmacist or designee will monitor that a note is printed on all narcotics placed in locked box. This will be reported in QMI monthly X 3 and then quarterly x 3* by pharmacist or designee. KE/SDDH/MF</i></p>	

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F 431	<p>Continued From page 8</p> <p>1. Observation on 7/9/14 at 1:45 p.m. of the Hamilton household medication room and nurses's station revealed: *A locked cupboard within the medication room. *That cupboard had contained: -Two schedule II medications and one schedule III medication awaiting destruction. *Those medications had been counted and signed for by two nurses on a narcotic (drug that alters perception, induces sense of well being) accountability form. The form had been wrapped around the medication packages. They were laying on the shelf in the locked cupboard. *The nurse on duty had the key to the cupboard.</p> <p>Interview on 7/9/14 at the same time with licensed practical nurse B revealed she: *Was not sure when the pharmacist would come to destroy the medications. *Had not known if the pharmacist had been notified there were medications awaiting destruction. *Stated, "I doubt if she (pharmacist) has been called." *Confirmed: -There was not an ongoing list for the nurses to document on when they placed the narcotics awaiting destruction into the locked cupboard. -The nurse on duty had the key to the locked cupboard and could open it at anytime. *She agreed narcotics awaiting destruction could have been diverted before the pharmacist came to destroy them.</p> <p>2. Observation on 7/9/14 at 2:00 p.m. of the Mueller household medication room and nurses's station revealed: *A locked cupboard within the medication room. *That cupboard had contained:</p>	F 431		

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F 431	<p>Continued From page 9</p> <p>-One schedule II medication and one schedule III medication.</p> <p>*Those medications had been counted and signed for by two nurses on a narcotic accountability form. The form had been wrapped around the medication packages.</p> <p>*The nurse on duty had the key to the cupboard.</p> <p>Interview on 7/9/14 at the same time with registered nurse A revealed she:</p> <p>*Was not sure when the pharmacist would come to destroy the medications.</p> <p>*Had not known if the pharmacist had been notified there were medications awaiting destruction.</p> <p>*Stated, "We are suppose to let her know when there are medications to be destroyed. I don't know if she has been told or not."</p> <p>*Confirmed:</p> <p>-There was not an ongoing list for the nurses to document on when they put the narcotics awaiting destruction into the locked cupboard.</p> <p>-The nurse on duty had the key to the locked cupboard and could open it at anytime.</p> <p>*She agreed narcotics awaiting destruction could have been diverted before the pharmacist came to destroy them.</p> <p>3. Interview on 7/9/14 at 2:30 p.m. with the director of nursing revealed:</p> <p>*Schedule II and II medications that were awaiting destruction were to have been counted by two nurses and recorded in the residents' progress notes.</p> <p>*There was not an ongoing list for the nurses to document on and co-sign when they put the narcotics awaiting destruction into the locked cupboard.</p> <p>*The nurse on duty had the key to the locked</p>	F 431		

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F 431	<p>Continued From page 10 cupboard and could open it at anytime. *She hesitantly agreed narcotics awaiting destruction could have been diverted before the pharmacist came to destroy them.</p> <p>Interview on 7/9/14 at 2:50 p.m. with the consultant pharmacist revealed there was not an ongoing list the nurses recorded the narcotic medication awaiting destruction on. She stated she looked in the progress notes to verify the medication count for disposal was accurate. She agreed there could have been narcotic drug diversion before she came to destroy them.</p> <p>Review of the provider's last revised April 2014 Drug Disposal policy revealed: *Discontinued schedule II and III drugs were to have been destroyed as soon as the pharmacist had been available. *Documentation of the discontinued medication was to have included the medication, prescription number, and the amount remaining. That was to have been recorded in the resident's progress notes.</p>	F 431		

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 7/10/14. Sanford Chamberlain Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for new health care occupancies upon correction of deficiencies identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 8/11/14 telephone to facility DON. LFSDDOH/MF</p>	
K 062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition, and it was inspected and tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection, testing, and maintenance</p>	K 062	<p>Additional required / periodic testing LFSDDOH/MF</p> <p>K-062* [redacted] will be added to preventative maintenance by August 28, 2014 to meet requirements of NFPA-25. [redacted] All periodic testing [redacted] will be reported by Maintenance director or designee to QMI on an ongoing monthly basis.</p> <p>8/28/14</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 8/4/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/10/2014
NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325		
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K 062	Continued From page 1 reports revealed an annual inspection was performed by Howe Plumbing and Heating on 8-19-13. Further review indicated no documentation of the required additional periodic testing. Interview with the maintenance supervisor at the time of the review revealed he was not aware of the other inspection, testing, and maintenance requirements for the water-based sprinkler system. He further explained he was performing the quarterly flow testing on the wet sprinkler system but did not document the testing. This deficiency affected three of three smoke compartments.	K 062			

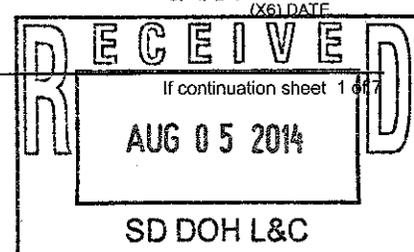
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2014
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NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325
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S 000	Initial Comments Surveyor: 28057 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/8/14 through 7/10/14. Sanford Chamberlain Care Center was found not in compliance with the following requirement: S166.	S 000	<i>Addendums noted with an asterisk per 8/15/14 telephone to facility administrator. KG/000H/MF</i>	
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	S-166 It should be noted that the surveyor was stopped by hospital staff twice when she walked around with the dietary aide. Material Management staff stopped her at the hospital kitchen doors and asked if she needed help. Surveyor replied "Nope, I am just pretending to be a resident trying to escape." Dietary manager also stopped surveyor and asked if she needed help and she received the same reply. It's important to note this because the surveyor did not make it out of the facility without being stopped, a resident would have been redirected. POC: 1. Adjust M-F main hospital door lock and unlock times from 8am-5pm. Completed July 31, 2014 2. Adjusted main and hospital door lock/unlock alarm times for Saturday	8/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE **CEO** 8/4/14 (X6) DATE



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/10/2014
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S 166	<p>Continued From page 1</p> <p>(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.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 28057 Based on observation, record review, interview, and policy review, the provider failed to ensure two of six exit doors (the front entry door and the fire doors leading to the hospital) had been alarmed, locked, or attended at all times. Findings include:</p> <p>1. Observation on 7/8/14 at 7:15 a.m. revealed the main entry doors had not been alarmed when the surveyors entered the building.</p> <p>Observation on 7/9/14 at 7:15 a.m. revealed the main entry doors had not been alarmed when the surveyors entered the building. Both of those mornings staff happened by a few minutes after the surveyors had entered the building. However they had not come in response to the surveyors having entered the building.</p> <p>Observation on 7/8/14 from 7:15 a.m. through 7:00 p.m. and on 7/9/14 from 7:15 a.m. through</p>	S 166	<p>Continued from page 1</p> <p>& Sunday to be locked from 5pm Friday to 8am on Monday. Completed July 31, 2014 3. Move MDS Coordinator office to front conference room and conference room to former MDS Coordinator office. This was completed on July 30, 2014. 4. Educate staff with direct view of front door to not leave area unattended during unlocked/unalarmed door times (Monday – Friday 8am-5pm). Activities director, activities assistant & MDS Coordinator educated on July 29, 2014. DON or designee will monitor 8am-5pm personnel monitoring front area and report to Core QMI monthly x 3 and then quarterly x 3. 5. All staff educated on door monitoring on July 29, 2014. 6. Code only access for back hall door to be completed by August 28, 2014.</p>	

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S 166	<p>Continued From page 2</p> <p>4:00 p.m. confirmed the director of nursing (DON) had not always been in her office or in sight of the front doors. She had not been at the facility until 7:30 a.m. or later on 7/8/14.</p> <p>Random observations on 7/8/14 from 7:15 a.m. through 7:00 p.m. and on 7/9/14 from 7:15 a.m. through 4:30 p.m. revealed:</p> <ul style="list-style-type: none"> *The front entry doors had alarmed. *The alarm had been in response to a resident with a Wanderguard bracelet (a bracelet that activates the door alarm when it gets to within a few feet of the door). *The bracelet activated the alarm when that resident walked by within a few feet of the door if the door was opened at that time. *The doors had not alarmed otherwise when opened during those time frames. <p>Interview on 7/9/14 at 1:30 p.m. with the maintenance supervisor confirmed the fire doors in the hallway that go to the hospital from the nursing home were alarmed from 7:00 p.m. until 6:00 a.m. everyday. The rest of the time the alarms were not activated, and the doors were not closed or locked. That door had a Wanderguard system in place.</p> <p>Interview on 7/9/14 at 1:35 p.m. with the DON confirmed the front entry doors were alarmed and locked from 10:00 p.m. until 6:00 a.m. everyday. The rest of the time the alarms were not activated, and the doors were not closed or locked. She further confirmed the fire doors in the hallway to the hospital were not closed, locked, or alarmed during the day. She believed it had been too distracting and upsetting to the residents to have the alarms sounding frequently during the day if activated from 6:00 a.m. until 10:00 p.m. She stated one resident went over to the hospital</p>	S 166	<p>7. Camera will be placed directly on LTC front area and camera monitor will be placed on Hamilton Household by August 28, 2014.</p> <p>8. Door Alarms & Monitoring were discussed during the inservice on July 29, 2014 [REDACTED] [REDACTED] KE/SDDCH/MF</p>	
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S 166	<p>Continued From page 3</p> <p>everyday independently to visit. If the doors had been alarmed or locked he would not have been able to do that without assistance from the staff at the nursing home. He walked past the front desk of the hospital when he went over to the hospital. He had not worn a Wanderguard bracelet. She confirmed the doors had a Wanderguard system in place, and it had been on at all times. She agreed it only sounded if a resident with a Wanderguard had activated the system. That would occur if they had tried to go out or if someone had opened the door when they had been within a few feet of the door. She agreed it had not activated if a resident without a Wanderguard had gone out the doors when the alarms were not activated. She also reminded this surveyor the building had security cameras that monitored the outside of the hospital and some of the nursing home. She agreed it had not been able to view the main entry doors of the nursing home. It had covered some of the parking lot on the nursing home side of the building.</p> <p>Observation 7/9/14 at 2:10 p.m. and again at 2:35 p.m. revealed no staff present in the hallway behind the hospital front desk. That hallway by-passed the receptionist at the front desk and the front doors that were in sight of the cameras. No alarms had sounded, and no staff responded to this surveyor having opened that door. This surveyor had spoken to an unidentified dietary aide the second time of traveling the hallways alone. (That aide had been in the hallway leading to the nursing home. She had been bringing snacks over for the residents. The hallway went past the kitchen door, but no staff were in view of that door.) The surveyor had the dietary aide walk with her to that door. The surveyor and the dietary aide had opened the door and gone outside. The door had locked behind them and re-entry had</p>	S 166		
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S 166	<p>Continued From page 4</p> <p>been prevented. At that point they had been behind the walk-in coolers and were not visible from the sidewalk. From there they had been able to go around the coolers, across the grass, and onto the sidewalk on the east side of the parking lot. The dietary aide stated she had never used that door and had not known where it had gone. No alarms had sounded, and no staff had responded to this surveyor and the dietary aide having gone out that door.</p> <p>Interview on 7/9/14 at 1:55 p.m. with the activities manager confirmed she had usually come to work at 8:30 a.m. and worked until 5:30 p.m. at the latest. Her assistant had come to work at 9:30 a.m. and worked until 3:00 p.m. The assistant had worked part-time only on Tuesday, Wednesday, and Thursdays. She agreed they were not in the activity room at all times and in direct sight of the front entry doors.</p> <p>The Minimum Data Set (MDS) nurse confirmed she had usually come to work sometime between 7:00 a.m. and 7:30 a.m. She had not always been at her desk and in sight of the entry doors during the day.</p> <p>No other offices were in sight of the entry doors.</p> <p>Interview on 7/9/14 at 2:20 p.m. with the chief operating officer whose office had been in the hallway leading to the hospital and located immediately after the fire doors confirmed his usual working hours. His hours had been from 7:50 a.m. through 4:45 p.m. and he had not routinely worked weekends.</p> <p>Interview on 7/9/14 at 2:20 p.m. with the financial consultant located in that same hallway confirmed her working hours. Her hours had been from 8:00</p>	S 166		
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S 166	<p>Continued From page 5</p> <p>a.m. through 4:30 p.m. Monday through Friday.</p> <p>Interview on 7/9/14 at 2:20 p.m. with the receptionist at the front desk of the hospital confirmed the front desk had not been covered from 5:00 p.m. until 8:00 a.m. She had worked from 8:00 a.m. until 5:00 p.m.</p> <p>No other staff had been present to interview in the other offices located in the hallways from the nursing home to the hospital exit doors identified above.</p> <p>Review of the above staff hours and of the times the alarms were activated revealed there had been times with no staff consistently present, the doors were unlocked, and no alarms activated. Those times for the front entry doors had been from approximately 7:30 p.m. until 10:00 p.m. and from 6:00 a.m. until 7:00 a.m. The times for the hallway with the fire doors had been from 6:00 a.m. until 7:00 a.m. and from 5:00 p.m. until 7:00 p.m.</p> <p>Observation in the hospital on 7/9/14 at 2:30 p.m. revealed the health unit coordinator (HUC) was standing in a small room located behind the nurses desk. With her back to the cameras video monitor and engaged in conversation with another staff person, this surveyor waited a few minutes to interview her.</p> <p>Interview on 7/9/14 at 2:33 p.m. in the hospital with the HUC who had monitored the security cameras for the building confirmed she:</p> <ul style="list-style-type: none"> *Had been expected to answer patient call lights. *Assisted with patient care on the floor. *Had to monitor the patient telemetry monitors at the same time. *Could be gone for five minutes at a time. 	S 166		

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S 166	<p>Continued From page 6</p> <p>*Knew the cameras had not been attended all of the time.</p> <p>Interview on 7/9/14 at 4:10 p.m. with the chief operating officer confirmed it had been "quite alarming" to realize how far this surveyor had been able to go in the hospital without being observed or discovered by the staff. She had not realized no one had been present in the offices located in the hallway behind the hospital receptionist's desk. She believed someone should have been there at that time.</p> <p>Review of the provider's 9/11/13 Door Alarms policy revealed: *The purpose of the door alarms had been to ensure the safety of all the residents that exited the facility. *Unattended doors were to have audible alarms activated to alert staff if someone exited the building. *Unattended doors were to have automatic activation of the alarms typically at 7:00 p.m. and 6:00 a.m.</p>	S 166		