

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

**ORIGINAL**

PRINTED: 06/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DELLS NURSING AND REHAB CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 THRESHER DR DELL RAPIDS, SD 57022</b>
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F 000	<p><i>Addendums noted with an ASHENSK per 7/14/14 telephone to facility administrator DKISDDOHMF</i></p> <p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/27/14 through 5/29/14. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: F280, F281, F309, F323, F332, F371, F386, and F441.</p>	F 000	<p>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:</p>	
F 280 SS=D	<p><b>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview,</p>	F 280	<p>Resident 11's care plan was reviewed and revised to reflect the current status of care including but not limited to diet, IV fluids, transfer ability and comfort cares.</p> <p>All other resident's care plans were reviewed and revised to reflect the current status of care including but not limited to diet, IV fluids, transfer ability and comfort cares.</p> <p>DON, administrator and Interdisciplinary Team reviewed and revised as necessary the policy and procedures about the care plan process including but not limited to the accurate and comprehensive assessment, identifying a concern or strength list, establishment of goals and desired outcomes, approach determination, success review and collaboration of hospice services.</p>	7/18/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ch. Stovach</i>	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>6/22/2014</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	<p>Continued From page 1</p> <p>and policy review, the provider failed to update a care plan to reflect the current status of one of thirteen sampled residents (11). Findings include:</p> <p>1. Random observations on 5/28/14 and on 5/29/14 of resident 11 revealed: *She remained in bed during each observation. *She had been receiving interavenous (IV) fluids (she received hydration fluids through her veins) continuously. *She was not receiving oral nutrition or medications.</p> <p>Review of resident 11's medical record revealed: *She had been hospitalized and returned to the nursing home on 5/25/14. *Her discharge orders had indicated: -Staff were have provided comfort measures. -She was unable to take any food, liquids, or medications orally. -She was to have received IV fluids and medications.</p> <p>Review of her 5/22/14 care plan revealed: *She was to have been on isolation precautions due to an infection. *She was to have received a mechanical soft diet with ground meat. *She was to have transferred between surfaces with a proassist (PAL) lift, a mechanical lift that allowed the resident to stand upright with the use of a safety belt.</p> <p>Interview on 5/28/14 at 11:40 a.m. with the director of nursing regarding resident 11 revealed: *She had not been able to eat. *She had not been receiving a meal tray. *She had no longer required isolation precautions.</p>	F 280	<p>DON or designee will provide education on the care planning process and policies for staff responsible for this task.</p> <p>DON or designee will audit resident care plans per MDS schedule or on significant change to ensure resident's current status of care one time per week for 4 weeks and once per month for two more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p>	

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F 280	Continued From page 2 *She was no longer able to use a PAL lift. Staff were using a two-person lift for transfers. *Staff would have used the care plan to direct them how to care for the resident. *The care plan had not been updated upon return from the hospital.	F 280		
F 281 SS=E	Review of the provider's undated Resident Centered Care Plans policy revealed the care plan was to have been reviewed and revised after each assessment and as needed. <b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Ensure current physician recertification orders had been updated to reflect: -The current medications for 2 of 11 residents (16 and 17) observed receiving medications. -The diet order for 1 of 15 sampled residents (2). *Medicate two residents (16 and 18) receiving omeprazole (for stomach conditions) prior to their meal. *Follow physician's orders to monitor oxygen saturations (sats:a measurement of oxygen levels) for 1 of 15 sampled residents (6). *Prime an insulin pen prior to drawing the dosage for one randomly observed resident (19) receiving insulin by pen administration. Findings include:	F 281	Residents 2, 6, 16, 17 & 18 medications regimens and physicians orders were reviewed to ensure appropriateness and accuracy.  All other residents' medication regimens were reviewed and physician orders were reviewed to ensure appropriateness and accuracy.  Resident 19 insulin pen usage protocol was updated and reviewed with licensed practical nurse E.  All other residents with insulin pens protocol were reviewed to ensure appropriate pen usage protocol are being followed.  The updated insulin pen usage protocol was presented to all other staff responsible for this task.	7/18/2014

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F 281	Continued From page 3  1a. Observation on 5/27/14 at 5:00 p.m. of a medication administration to resident 16 revealed registered nurse (RN) F gave Gabapentin (a medication for seizures or mood) 100 milligrams (mg) and Tramadol (a medication for pain) 50 mg.  Review of resident 16's medical record revealed the above medications: *Had been listed on the medication administration record (MAR). *Were not included on the 5/13/14 physician's orders.  b. Observation on 5/28/14 at 10:25 a.m. of a medication administration to resident 17 revealed RN C gave a Brovana (a medication for lung disease) nebulizer treatment.  Review of resident 17's medical record revealed the above medication: *Had been listed on the MAR. *Was not included on the 4/7/14 physician's orders.  c. Review of resident 2's 10/30/13 care plan revealed his diet was Dysphagia I (pureed foods) with honey thickened liquids.  Review of his 4/24/14 physician's recertification orders revealed a diet order of No Added Salt, regular textures.  d. Interview on 5/29/14 at 9:05 a.m. with the Minimum Data Set (MDS) coordinator revealed: *All medication administration records (MAR) were to have been updated and processed by the provider's consultant pharmacy.	F 281	DON and Interdisciplinary Team reviewed and revised as necessary policies and procedures about medication administration, receiving and clarifying physician orders, and ensuring physician certification.  DON or designee will provide education to all staff responsible for tasks relating to medication administration, receiving and clarifying physician orders, and ensuring physician certification.  DON or designee will audit the resident's medication administration regimens, physician orders, treatment administration regimens and proper administration of medications once per week for 4 weeks and monthly for two more months on all new physician orders.  DON or designee will present the audit findings at the monthly QAPI meetings for review.		

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F 281	<p>Continued From page 4</p> <p>*All physician's recertification orders were to have been updated by the individual nurse who received each order at the time the order had been received.</p> <p>*Residents 2, 16, and 17 had received physicians' orders for the above medications and diet, but the nurses had not updated the physicians' orders on the computer when the orders had been received.</p> <p>*The physicians' orders had not reflected the current medication or diet orders.</p> <p>2a. Observation on 5/27/14 at 5:00 p.m. of a medication administration to resident 16 revealed RN F gave omeprazole (a medication for stomach ulcers or heartburn) at the supper table. That was given just before she had been served her meal.</p> <p>Review of resident 16's May, 2014 MAR revealed the omeprazole was to have been given before the meal (AC).</p> <p>b. Observation on 5/28/14 at 7:55 a.m. of a medication administration to resident 18 revealed RN C gave omeprazole after the resident had begun eating.</p> <p>Review of resident 18's May 2014 MAR revealed the omeprazole was to have been given every morning.</p> <p>c. Interview on 5/28/14 at 2:10 p.m. with the director of nursing revealed her expectation had been the nurses would give omeprazole on an empty stomach thirty minutes before meals or at bedtime.</p> <p>3. Review of resident 6's 2/20/14 physician's orders revealed an order for oxygen at two liters</p>	F 281		

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F 281	<p>Continued From page 5 to keep oxygen sat levels above 90 percent (%).</p> <p>Review of her May 2014 treatment administration record (TAR) revealed: *An order for oxygen two liters continuously. *No order to keep the oxygen sat above 90%.</p> <p>Interview on 5/28/14 at 9:05 a.m. with the MDS coordinator revealed: *The nurse receiving the order for obtaining oxygen sats had entered the order onto the physician's orders, but had not notified the pharmacy of the new order. *The pharmacy had not updated treatment record due to no notification of the change. *The nurses had not been monitoring the oxygen sats.</p> <p>4. Observation on 5/28/14 at 9:25 a.m. of resident 19 during a medication administration of Humalog insulin using an insulin pen revealed RN C: *Attached the needle to the insulin pen. *Drew up the correct dose of ten units. *Injected that dose into the resident. *Had not primed the insulin pen with two units of insulin and performed an air-shot (injected the insulin into the air) to remove any excess air in the syringe and needle.</p> <p>Interview on 5/28/14 at 4:45 p.m. with licensed practical nurse (LPN) E regarding usage of the Humalog insulin pen revealed she had not known it was necessary to prime the insulin pens before drawing up the insulin dose.</p> <p>5. Interview on 5/29/14 at 11:40 a.m. with the director on nursing revealed: *The nurses should have updated the physicians' orders on the computer with each new order.</p>	F 281		

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F 281	<p>Continued From page 6</p> <p>*The nurses should have monitored resident 6's oxygen sats every shift.</p> <p>*The current diet for resident 2 should have been reflected on the physician's orders.</p> <p>*She had not been aware Humalog pens required priming prior to drawing up insulin doses.</p> <p>Review of the provider's 2001 Administering Oral Medications policy revealed "Verify that there is a physician's order for this procedure."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, pp. 419 and 480, revealed: **"The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm clients." **"Errors in recording can lead to errors in treatment." *(The) "record must be accurate and reliable." **"You are accountable for information you enter into the chart."</p> <p>Review of Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., Hudson, Ohio, 2011, page 1286, revealed omeprazole was best to have been given before breakfast.</p> <p>Review of "Instructions for Use of Humalog KwikPen", Eli Lilly and Company, Indianapolis, IN, revised January 2013, page 3, revealed: **"Priming your Humalog Kwikpen: Prime before each injection. Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin." *Turn dose knob to select 2 units.</p>	F 281			

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F 281	Continued From page 7 Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. *Hold your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. *A stream of insulin should be seen from the needle. *If you do not see a stream of insulin, repeat steps 5 to 7, no more than 4 times."	F 281			
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (2 and 10) had hospice integrated into their plans of care. Findings include:  1. Review of resident 2's entire medical record revealed: *She had been admitted on 1/16/14. *At the time of admission she was receiving hospice services. *She did not have a current physician's order for	F 309	Resident 2 & 10's care plans were reviewed and revised as necessary to include hospice reasoning and services, effective pain management and current physician certification.  All other resident on hospice care plans were reviewed and revised as necessary to include hospice reasoning and services, effective pain management and current physician certification.  DON, administrator and Interdisciplinary Team reviewed and revised as necessary the policy and procedures about the care plan process including but not limited to the accurate and comprehensive assessment, identifying a concern or strength list, establishment of goals and desired outcomes, approach determination, success review and collaboration of hospice services.  DON or designee will provide education on the care planning process and policies for staff responsible for this task.	7/18/2014	

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F 309	<p>Continued From page 8 hospice services.</p> <p>Further review of resident 2's medical record revealed she had a separate binder that contained all of the hospice provider's documents.</p> <p>Review of resident 2's 1/21/14 care plan revealed: *She needed "Assistance with her activities of daily living related weakness, impaired physical abilities, urinary incontinence, and risk for pressure ulcers and falls." *She had [name of hospice agency]. *It had not: -Addressed why she was on hospice. -Identified the services hospice provided to the resident. -Identified how pain management was achieved.</p> <p>2. Review of resident 10's medical record revealed: *He had been admitted on 3/4/13. *On 3/6/13 a physician's order for hospice services was received. -That order had not been carried through on sixty-day physician renewal orders.</p> <p>Review of resident 10's 1/2/14 care plan revealed: *He needed "assistance with his activities of daily living due to physical impairment, urinary incontinence, moderate cognitive impairment, impaired skin integrity, and risk for falls." **"[Name of hospice agency] visits weekly from hospice nurse and daily from hospice aide, Monday through Friday." *It had not: -Addressed why he was on hospice.</p>	F 309	<p>DON or designee will audit resident care plans per MDS schedule or on significant change to ensure resident's current status of care one time per week for 4 weeks and once per month for two more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p>	

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F 309	Continued From page 9 -Identified the nature of the services hospice provided to the resident. -Identified how pain management was achieved.  Interview on 5/28/14 at 4:00 p.m. with the Minimum Data Set coordinator revealed: *She was responsible for coordinating resident care plans. *They had not integrated hospice care plans into their care plans. *If they needed to know what hospice was doing for a resident they looked at the hospice care plan.  Review of the provider's December 2011 Hospice program policy revealed "When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms."	F 309			
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: Surveyor: 26180 Based on observation, interview, and guideline	F 323	DON and Interdisciplinary Team reviewed and revised as necessary the policy and procedures for effective use of whirlpool tub and safety belt.  Certified Nursing Assistant A was re-educated on proper safety protocol for whirlpool chair.  All staff responsible for whirlpool usage were re-educated on proper safety protocol for whirlpool chair.	7/18/2014	

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F 323	<p>Continued From page 10</p> <p>review, the provider failed to ensure safety measures were used when residents received their whirlpool bath. Findings include:</p> <p>1. Observation and interview on 5/28/14 at 11:00 a.m. of certified nursing assistant A revealed she:</p> <ul style="list-style-type: none"> <li>*Was the dedicated bath aide.</li> <li>*Gave about ten to eleven baths and showers per day.</li> <li>*Worked five days per week.</li> <li>*Demonstrated the use of the whirlpool chair as she prepared to clean it between resident use.</li> <li>*Used the mechanical lift to put the chair over the back of the tub, so the chair was approximately four feet off the ground.</li> <li>-That was what occurred when a resident was being lifted into the tub.</li> <li>-That was required to give clearance to resident's feet coming over the top edge of the tub to get into the tub.</li> <li>*Stated she never used the belt to secure a resident in the chair when she lifted them into the tub.</li> <li>-She had not felt she had any residents that moved around a lot, so she had not used the belt.</li> <li>-Thought she would have restrained a resident if she used the belt on them, so she had not used the belt.</li> </ul> <p>Interview on 5/29/14 at 9:00 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> <li>*The safety belt should have always been used when residents received whirlpool baths.</li> <li>*She was unaware the staff had not been using the safety belt.</li> <li>*She agreed the belt was a safety measure required when residents received a bath.</li> </ul> <p>Review of the whirlpool tub manufacturer's</p>	F 323	<p>DON or designee will audit whirlpool usage once per week for 4 weeks and once per month for two more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p>		

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F 323	Continued From page 11 guidelines revealed "Transfer the patient into the Saf-kary (chair attached to a tub) using the proper nursing techniques. Secure the seat belt around the patient's lap, using the method that will provide the most safety for your patient."	F 323			
F 332 SS=E	<b>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b>  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure a less than 5 percent (%) medication error rate for three of thirty-eight residents' (16 and <del>17</del> 17) observed medication administrations. Findings include:  1a. Observation on 5/27/14 at 5:00 p.m. of a medication administration to resident 16 revealed registered nurse (RN) F gave gabapentin (a medication for seizures or mood) 100 milligrams (mg) and tramadol (a medication for pain) 50 mg.  Review of resident 16's 5/13/14 physician's orders revealed the above medications were not included on the orders.  b. Observation on 5/28/14 at 10:25 a.m. of a medication administration to resident 17 revealed RN C gave a Brovana (a medication for lung disease) nebulizer treatment.	F 332	Residents 2, 6, 16, 17 & 18 medications regimens and physicians orders were reviewed to ensure appropriateness and accuracy.  All other residents' medication regimens were reviewed and physician orders were reviewed to ensure appropriateness and accuracy.  DON and Interdisciplinary Team reviewed and revised as necessary policies and procedures about medication administration, receiving and clarifying physician orders, and ensuring physician certification.  DON or designee will provide education to RN F and RN C and all other staff responsible for tasks relating to medication administration, receiving and clarifying physician orders, and ensuring physician certification.  DON or designee will audit the resident's medication administration regimens, physician orders, treatment administration regimens and proper administration of medications once per week for 4 weeks and monthly for two more months on all new physician orders.	7/18/2014	

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F 332	<p>Continued From page 12</p> <p>Review of resident 17's most recent 4/7/14 physician's orders revealed the above medication was not included on the orders.</p> <p>c. Interview on 5/29/14 at 9:05 a.m. with the Minimum Data Set coordinator revealed: *All medication administration records were to have been updated and processed by the provider's consultant pharmacy. *All physician's recertification orders were to have been updated by the individual nurse who received each order at the time the order had been received. *Residents 16 and 17 had received physicians' orders for the above medications, but the nurses had not updated the physicians' orders on the computer when the order had been received. *The physicians' current orders were not accurate. *There had not been a current order for those medications.</p> <p>Interview on 5/29/14 at 11:40 a.m. with the director on nursing revealed the nurses should have updated the physicians' orders on the computer with each new order.</p> <p>Review of the provider's 2001 Administering Oral Medications policy revealed "Verify that there is a physician's order for this procedure."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, Pp 419 and 480 revealed: *"The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm clients." *"Errors in recording can lead to errors in</p>	F 332	DON or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 332	Continued From page 13 treatment. *(The) "record must be accurate and reliable." **"You are accountable for information you enter into the chart."	F 332			
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, testing, and policy review, the provider failed to: *Maintain proper hot and cold food temperatures for two of three meal observations. *Ensure sanitary conditions were maintained for the floors in the dry goods storage room in the kitchen. Findings include:  1. Observation and interview on 5/27/14 at 5:23 p.m. of resident 4 with certified nursing assistant (CNA) D in the activities dining room revealed: *CNA D delivered his evening meal on a tray from an uninsulated stainless steel cart. *The uninsulated dome lid covering his hot food had numerous cracks on the lid. *CNA D agreed the dome lid had numerous	F 371	Resident 4's meal plates will be heated before food delivery. Insulated plate covers will be purchased and used for food transport on the insulated stainless steel cart to maintain proper hot and cold food temperatures. Delivery methods were adjusted to ensure the cold foods maintain proper temperatures. Pureed and thickened foods preparation steps were adjusted to help ensure food palatability.  All other residents that utilize the non-insulated stainless food cart meal plates will be heated before food delivery. Insulated plate covers will be purchased and used for food transport on the insulated stainless steel cart to maintain proper hot and cold food temperatures. Delivery methods were adjusted to ensure the cold foods maintain proper temperatures. Pureed and thickened foods preparation steps were adjusted to help ensure food palatability.  The floor in the dry goods storage room was thoroughly cleaned. All other kitchen floors were audited for cleanliness and cleaned as necessary.	7/18/2014	

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F 371	<p>Continued From page 14 cracks on the lid. *CNA D uncovered the dome lid that revealed a three-compartment plate containing pureed foods. *The menu card revealed he had the following diet: -Diabetic pureed. -Nectar thickened liquids including skim milk.</p> <p>Observation on 5/27/14 from 5:23 p.m. through 6:00 p.m. of resident 4 in the same location as the above revealed the resident needed total assistance with eating.</p> <p>Observation, interview, and testing of pureed foods with thickened liquids test tray on 5/28/14 at 12:16 p.m. with the dietary manager (DM) after the last tray was served to the residents (including resident 4) in the main dining room from the same cart as the above revealed: *The provider's dial food thermometer used by the dietary manager (DM) tested the: -Pureed squash at 102 degrees Fahrenheit (F). -Pureed chicken at 102 degrees F. -Mashed potatoes at 108 degrees F. -Thickened milk at 48 degrees F. *The temperature of the hot food items should have been no less than 140 degrees F. *The temperature of that cold food item should have been no more than 41 degrees F. *The DM taste tested the test tray's pureed foods and thickened milk and confirmed: -The temperatures were not at acceptable temperatures. -The pureed foods and the thickened milk were not palatable (agreeable to the palate or taste).</p> <p>Observation, interview, and testing of pureed foods with thickened liquids test tray on 5/28/14 at</p>	F 371	<p>The Dietary Manager and Registered Dietitian reviewed and revised policies and procedures necessary to ensure safe and sanitary conditions for food service regarding hot and cold food temperatures, foods palatability and kitchen floor cleanliness.</p> <p>Dietary Manager will provide education for facility staff regarding hot and cold food temperatures, food palatability and kitchen floor cleanliness.</p> <p>Dietary Manager or designee will perform audits on hot and cold food temperatures, food palatability and kitchen floor cleanliness weekly for 4 weeks and monthly for two more months.</p> <p>Dietary Manager or designee will present the audit findings at the monthly QAPI meetings for review.</p>		

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F 371	<p>Continued From page 15</p> <p>5:25 p.m. with the DM after the last tray was served to the residents (including resident 4) in the same location as the above revealed:</p> <ul style="list-style-type: none"> <li>*The provider's dial food thermometer used by DM tested the: <ul style="list-style-type: none"> <li>-Thickened milk at 68 degrees F.</li> </ul> </li> <li>*The temperature of that food item should have been no more than 41 degrees F.</li> <li>*The DM taste tested the test tray's thickened milk and confirmed: <ul style="list-style-type: none"> <li>-The temperature was not at an acceptable temperature.</li> <li>-The thickened milk was not palatable.</li> </ul> </li> </ul> <p>Review of the provider's May 2012 Food Holding policy revealed:</p> <ul style="list-style-type: none"> <li>*Hot foods were to have been held at the required temperature of 160 degrees F or higher.</li> <li>*Cold foods were to have been held at 41 degrees or less.</li> <li>*Milk temperatures at point of service (received by residents) was to have been no more than 50 degrees F.</li> <li>*Pureed food temperatures at point of service was to have been no less than 120-130 degrees F.</li> </ul> <p>Review of the provider's May 2012 Food Preparation policy revealed:</p> <ul style="list-style-type: none"> <li>*Food prepared in advance of serving was to have been held at temperatures of approximately 140 degrees F or above.</li> <li>*Food held between 45 degrees F and 140 degrees F provided optimum conditions for the growth of bacteria.</li> <li>*Food preparation should have been carefully timed to allow minimum holding time before serving.</li> <li>*During meal service potentially hazardous food</li> </ul>	F 371		

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F 371	<p>Continued From page 16 should have been held at room temperature only for a minimal amount of time.</p> <p>Review of the provider's May 2012 Food Quality policy revealed: *Food was to have been prepared in the most acceptable and appealing method possible. *Food was to have been palatable, attractive, and served at the proper temperature.</p> <p>Surveyor: 16385 2. Interview on 5/28/14 from 11:00 a.m. to 11:45 a.m. with a group of residents revealed the hot foods served during meal services were not always hot and had needed to be sent back to the kitchen to reheat those food items.</p> <p>Surveyor:32331 3. Observation on 5/27/14 from 2:40 p.m. through 3:05 p.m. and on 5/29/14 at 8:40 a.m. in the kitchen in the dry goods storage room revealed the following: *The floor under the shelving units had many visible tan, black, and brown spots and debris. *The floor between the freezer units and the door in the dry goods storage area had the same as the above.</p> <p>Interview on 5/29/14 at 9:10 a.m. with the DM regarding the dry goods storage room revealed: *The floor was to have been mopped every night. *The cleaning schedule had not been followed. *She agreed the floor needed to have been cleaned.</p> <p>Review of the provider's May 2012 Sanitation and Safety Department Cleaning policy revealed: *The dietary department was to have been maintained in a sanitary condition.</p>	F 371			

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F 371	Continued From page 17 *The director of dietary services was responsible for developing cleaning procedures.  Review of the provider's May 2012 Sanitation and Safety Walls, Floors, and Ceilings policy revealed: *Cleaning floors was to have been completed as follows: -Sweep well. -Wash with hot water and no-suds cleaning solution. -Rinse well using mop. -Remove as much water as possible. -Let air dry. -Wipe with sanitizer. -Permit to air dry. -Place "Wet floor" signs to warn others of potential danger.  Review of the provider's May 2012 Sanitation and Safety Cleaning Schedule revealed the dry store room floor was to have been thoroughly cleaned weekly.	F 371			
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS  The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.  This REQUIREMENT is not met as evidenced	F 386	Residents 6, 7, 8, 10 and 12 physician reviews were reviewed for timeliness.  All other residents' physician reviews were reviewed for timeliness.  Physician review process was reviewed and revised as necessary to ensure timeliness of physician reviews.  DON or designee will audit all <input checked="" type="checkbox"/> physician orders for timeliness once per month for 3 months.	7/18/2014  <i>*IKW 04/02/14</i>	

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F 386	<p>Continued From page 18</p> <p>by: Surveyor: 32332</p> <p>Based on record review and interview, the provider failed to ensure:</p> <p>*A physician had evaluated 1 of 13 sampled residents (6) for the appropriateness of care every sixty days.</p> <p>*A physician had written, signed, and dated progress notes after each visit for 4 of 13 sampled residents (7, 8, 10, and 12).</p> <p>Findings include:</p> <p>1. Review of resident 6's medical record revealed: *Her last documented physician's visit had been 2/20/14. *Her most recent physician's recertification orders had been dated 2/20/14.</p> <p>Interview on 5/28/14 at 2:10 p.m. with the director of nursing (DON) regarding resident 6 revealed: *The resident had not had a physician's visit since 2/20/14. *Her expectation was that she should have been seen every sixty days of the previous visit.</p> <p>Surveyor: 26180</p> <p>2a. Review of resident 7's physician's progress notes revealed: *She had been seen on 5/7/13. -A progress note from that visit had not been received until 7/1/13, eight weeks after the visit. *She had been seen on 7/15/13. -A progress note had not been received until 8/30/13, seven weeks after the visit. *She had been seen on 11/26/13. -A progress note had not been received until 1/14/14, eight weeks after the visit.</p>	F 386	DON or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 386	<p>Continued From page 19</p> <p>*She had been seen on 1/28/14. -A progress note had not been received until 5/20/14, nearly three months after the visit.</p> <p>b. Review of resident 10's physician progress notes revealed: *He had been seen by the physician on 10/25/13. -A progress note from that visit was not received until 12/17/13, seven weeks after the visit. *He had been seen by the physician on 12/20/13. -A progress note from that visit was not received until 1/16/14, one month after the visit.</p> <p>c. Interview on 5/29/14 at 2:45 p.m. with licensed practical nurse B revealed: *She was responsible for scheduling the physicians visits for the residents. *She agreed it was not beneficial to have received those progress notes up to two months after the visit. *They always had problems getting the physician progress notes from the physicians who saw residents 7 and 10. *They had not involved their medical director in trying to resolve that problem.</p> <p>Surveyor: 32331</p> <p>d. Review of resident 12's medical record revealed: *She had been admitted on 5/02/06. *Her physician had visited her on 11/26/13 for her periodic nursing home visit. -The progress note for the 11/26/13 visit was electronically signed by the physician on 1/14/14, nearly two months after the visit. -The progress note was noted by nursing on 1/20/14. *Her physician had visited with her on 1/28/14 for</p>	F 386			

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F 386	Continued From page 20 her periodic nursing home visit. -The progress note for the 1/28/14 visit was electronically signed by the physician on 5/20/14, nearly four months after the visit. -The progress note was noted by nursing on 5/28/14.  Interview on 5/29/14 at 10:08 a.m. with the director of nursing (DON) regarding resident 12's progress notes revealed she agreed they had not been completed in a timely manner.  Surveyor: 16385 e. Review of resident 8's medical record revealed: *She had been admitted on 1/10/14. *No physician's progress notes were in the medical record.  Interview on 5/29/14 at 8:00 a.m. with the DON and the Minimum Data Set (MDS) coordinator confirmed the medical record had no physician's progress notes. Further interview at 8:15 a.m. with the MDS coordinator revealed she had called the clinic and confirmed the physician had not dictated her progress notes.  On 5/29/14 at 9:30 a.m. the MDS coordinator provided this surveyor with: *The 3/18/14 physician's visit progress note for resident 8 with an electronic physician's signature dated 5/29/14. *The 4/18/14 physician's visit progress note for resident 8 with an electronic physician's signature dated 5/29/14.	F 386			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	*12's delirium Resident [redacted] isolation precautions were reviewed and revised to ensure appropriateness.	7/18/2014	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DELLS NURSING AND REHAB CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 THRESHER DR DELL RAPIDS, SD 57022</b>
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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 441	<p>Continued From page 21</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>All other resident's on isolation precautions were reviewed and revised as necessary to ensure appropriateness.</p> <p>DON, Administrator and Interdisciplinary Team reviewed and revised as necessary the policies and procedures regarding infection prevention and control including but not limited to proper whirlpool tub disinfection and proper storage of clean resident use items.</p> <p>All staff responsible for isolation procedures, whirlpool tub disinfection and proper storage of clean resident use items will be educated on current policies and procedures.</p> <p>DON or designee will audit isolation precautions, whirlpool disinfection and proper storage of clean resident use items once per week for 4 weeks and once per month for two more months.</p> <p>DON or designee will present the audit findings at the monthly QAPI meetings for review.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>DELLS NURSING AND REHAB CENTER INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 THRESHER DR DELL RAPIDS, SD 57022</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Preceptor: 26180</p> <p>Based on observation, interview, record review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> <li>*Follow infection control policy related to isolation precautions for one of one sampled residents' (13) room.</li> <li>*Properly disinfect one of one whirlpool tub.</li> <li>*Ensure clean resident use items were properly stored.</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of resident 13's 5/27/14 laboratory results revealed she had tested positive for Clostridium difficile (C. diff.) (a contagious bowel infection where germs were spread through the stool).</li> </ol> <p>Random observations from 5/28/14 through 5/29/14 regarding resident 13 revealed:</p> <ul style="list-style-type: none"> <li>*She had been placed in a private room.</li> <li>*A magnet with a flower had been placed on the door frame of her room.</li> <li>*There was nothing alerting visitors there were any isolation precautions.</li> </ul> <p>Interview on 5/29/14 at 10:00 a.m. with resident 13 revealed a housekeeper had been in to clean her room and bathroom that morning. The housekeeper had worn gloves but not a gown when she cleaned her room.</p> <p>Interview on 5/29/14 at 11:00 a.m. with housekeeper G revealed she:</p> <ul style="list-style-type: none"> <li>*Had worn gloves to clean resident 13's room and bathroom but had worn no gown.</li> <li>*Had not worn a gown to clean the room as "It</li> </ul>	F 441		

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F 441	<p>Continued From page 23</p> <p>was not that bad." -She explained there was no visible stool on the toilet. *Stated when she completed cleaning a room she had sometimes washed her hands with soap and water and sometimes used hand gel after removing her gloves.</p> <p>Interview on 5/29/14 at 11:30 a.m. with the director of nursing (DON) revealed she: *Would have expected hands were always washed with soap and water and gowns were worn when cleaning an isolation room. *Was not aware public notification of isolation was necessary.</p> <p>Review of the provider's undated policy on C. diff. revealed: **"Contact precautions should be used." **"Hands should be washed frequently with soap and water. An alcohol based hand cleanser is not effective." **"Gloves and gowns should be worn when physical contact with the resident or the resident's environment is anticipated." **"The facility should have a system in place for alerting healthcare workers and visitors that a resident is on isolation precautions without compromising that resident's privacy."</p> <p>2. Observation and interview on 5/28/14 at 10:30 a.m. with certified nursing assistant (CNA)/bathaide A revealed she: *Sprayed Betco AF79 (disinfectant) on the inside of the whirlpool tub and fixtures. She then left the disinfectant on for one minute before rinsing it off. *Stated they had switched disinfectants approximately one year ago. *Stated one minute contact time (time it takes to</p>	F 441		

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F 441	<p>Continued From page 24</p> <p>kill organisms) with the current disinfectant was all that was necessary.</p> <p>Interview on 5/28/14 at 11:00 a.m. with the housekeeping supervisor revealed the contact time of the above disinfectant was five to ten minutes.</p> <p>Interview and Betco AF79 product information review on 5/28/14 at 11:15 a.m. and at 12:10 p.m. with the director of maintenance revealed: *Product information for the Betco AF79 showed a contact time for all organisms was ten minutes. *He agreed the contact time should have been ten minutes.</p> <p>3. Random observations on 5/27/14 through 5/29/14 of the three soiled utility rooms revealed: *Multiple clean resident use items including wash basins and emesis basins were stored in cupboards. *The room also contained wheelchairs and clean commodes. *A graduate measuring container waiting to be cleaned was noted in the sink.</p> <p>Interview on 5/29/14 at 9:00 a.m. with the DON revealed she agreed clean items should not have been stored in the soiled utility rooms.</p> <p>Interview on 5/29/14 at 9:30 a.m. with the director of maintenance revealed: *He had not been aware there was a problem with keeping clean items in a soiled utility room. *No policy for this existed.</p>	F 441		

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**ORIGINAL**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DELLS NURSING AND REHAB CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 THRESHER DR DELL RAPIDS, SD 57022</b>
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K 000	<p><i>Addendum noted with an asterisk per 7/18/14 telephone to facility administrator. TN JS000/HMF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/29/14. Dells Nursing and Rehab Center Inc. was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 5/29/14 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K020 and K021 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>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:</p>	
K 020 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25107 Based on observation, testing, and interview, the provider failed to maintain the latching feature for one of two laundry chute doors (top door).</p>	K 020	<p>Latching feature for top door of laundry chute was adjusted to ensure latching feature.</p> <p>All other laundry chute doors were audited and adjusted to ensure latching features.</p> <p>Environmental Services Director or designee will audit the latching feature on the laundry chute doors once per month for three months.</p> <p>Environmental Services Director will report the results of the audits at the monthly QAPI meetings for review.</p>	7/18/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Chad St. ...</i>	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>6/22/2014</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER  <b>DELLS NURSING AND REHAB CENTER INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 THRESHER DR DELL RAPIDS, SD 57022</b>		
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K 021	<p>Continued From page 2 Surveyor: 25107 Based on observation, testing, and interview, the provider failed to maintain the latching feature for:</p> <p>*Two of six cross corridor doors: -The bottom latch on the north door located in the Happy Trails hall would not latch. -The bottom latch on the east door located in the Garden Terrace hall would not latch.</p> <p>*One of one soiled utility door located in the Rising Sun hall would not latch with the self-closing feature. Findings include:</p> <p>1. Observation, testing, and interview on 5/29/14 from 12:15 p.m. through 12:35 p.m. with the maintenance director of the cross-corridor doors revealed: *The bottom latch on the north door located in the Happy Trails hall would not latch. The latch from the door could not reach the hole in the floor that it was supposed to latch into. *The bottom latch on the east door located in the Garden Terrace hall would not latch. The latch from the door could not reach the hole in the floor that it was supposed to latch into. *There had recently been carpet installed where both doors were located. *The maintenance director had adjusted the bottom door latches to compensate for the addition of the carpet. He had not adjusted them correctly.</p> <p>2. Observation, testing, and interview on 5/29/14 at 1:15 p.m. with the maintenance director of the door to the soiled utility room located in the Rising Sun hall revealed: *The door would not latch with the self-closing feature. The door would latch when force closed. *He was not aware the door was not latching.</p>	K 021			

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K 021	Continued From page 3 *The new carpet was affecting the door when it closed.	K 021			
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2  This STANDARD is not met as evidenced by: Surveyor: 25107 Based on observation and document review, the provider failed to maintain at least two conforming exits from each floor level of the building. The basement had only one conforming exit. Findings include:  1. Observation at 12:01 p.m. on 5/29/14 revealed the basement had only one conforming exit directly to the exterior of the building. The second exit routes were through hazardous areas (the boiler and laundry rooms) to an area well equipped with a fixed ladder. Review of previous survey data confirmed that condition had existed since the original construction.  The building meets the FSES. Please mark and "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 032		* F TN/SCH/MP	

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>DELLS NURSING AND REHAB CENTER INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 THRESHER DR DELL RAPIDS, SD 57022</b>
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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 5/27/14 through 5/29/14. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: S235 and S301.	S 000	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 235	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Each facility shall develop criteria to screen healthcare workers...or residents for Mycobacterium tuberculosis based on the guidelines issued by Centers for Disease Control and Prevention. Policies and procedures for conducting Mycobacterium tuberculosis risk assessment shall be established and should include the key components of responsibility, surveillance, containment, and education. The frequency of repeat screening shall depend upon annual risk assessments conducted by the facility.  This Rule is not met as evidenced by: Surveyor: 34030 Preceptor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of one admitted residents (1) who had a history of a positive Tuberculin (TB) (a contagious respiratory disease) Mantoux (test for TB) had received a chest x-ray at the time of admission. Findings include:	S 235	Resident 1 chest X-ray due to history of positive Tuberculin Mantoux was completed.  All other residents charts were audited to ensure all other residents with positive Tuberculin Mantoux on admission received a chest X-ray.  Staff responsible for this task were re-educated on the necessity of a chest X-ray of residents' with history of positive Tuberculin Mantoux on admission.  DON or designee will complete monthly audits for three months to ensure that any new admissions with a history of positive Tuberculin Mantoux receive a chest X-ray.  DON or designee will present the findings from these audits at the monthly QAPI meetings for review.	7/18/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chad Strosch</i>	TITLE <i>ADMINISTRATOR</i>
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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 235	Continued From Page 1  1. Review of resident 1's medical record revealed she had: *Been admitted on 5/23/13. *Been a TB reactor (had a positive test for TB). *Not had a chest x-ray at the time of admission or in the past year.  Interview on 5/29/14 at 9:00 a.m. with the director of nursing regarding resident 1 revealed: *A chest x-ray had never been done. *She would have expected a chest x-ray to have been done on every resident admitted who was a positive TB reactor.  Review of the provider's undated Tuberculin Screening policy revealed "A new employee or resident who has documentation of a positive reaction to the Mantoux skin test shall have a medical evaluation and chest x-ray to determine the presence or absence of the active disease."	S 235			
S 301	44:04:07:16 Required dietary inservice training  The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing inservice training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.  This Rule is not met as evidenced by: Surveyor: 32331	S 301	Dietary Manager or designee will ensure required inservice training sessions are completed on food safety, food handling and preparation techniques, food-borne illness, serving and distribution procedures, leftover food handling, and time and temperature controls for food preparation and service to all food-handling staff.  Dietary Manager or designee will audit personnel records to ensure all food-handling staff receives the required annual inservice training sessions. These audits will be performed once per month for three months. The Dietary Manager or designee will present the results of the audits at the monthly QAPI meetings for review.	7/18/2014	

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 301	<p>Continued From Page 2</p> <p>Based on record review, interview, and policy review, the provider failed to ensure six of nine required annual inservice training sessions (food safety, food handling and preparation techniques, food-borne illness, serving and distribution procedures, leftover food handling policies, and time and temperature controls for food preparation and service) were offered yearly for food-handling staff. Findings include:</p> <p>1. Record review of the required inservice training sessions for 2013 and 2014 for all food-handling staff revealed those staff had received no training on food safety, food handling and preparation techniques, food-borne illness, serving and distribution procedures, leftover food handling policies, and time and temperature controls for food preparation and service.</p> <p>Interview on 5/28/14 at 4:30 p.m. with the director of nursing revealed *Food-handling staff were identified as the dietary, nursing, and activities staff. *There had not been training on the above listed inservices offered yearly for food-handling staff.</p> <p>Interview on 5/29/14 at 2:15 p.m. with the dietary manager revealed: *Food-handling staff were identified as dietary, nursing, and activities staff. *There had not been training on the above listed inservices offered yearly for food-handling staff.</p> <p>Review of the provider's May 2012 Personnel Management policy revealed the consulting dietitian and the dietary manager should have worked out an inservice training program.</p>	S 301		