

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

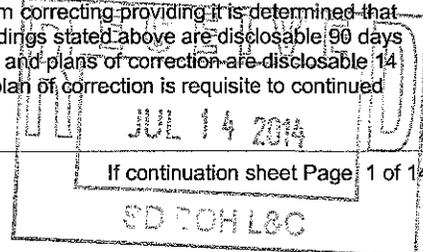
ORIGINAL

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2014
NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 32335 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. Prairie Estates Healthcare Community was found not in compliance with the following requirement(s): F166, F281, F318, F441, and F514.	F 000	F 166 Right to prompt efforts to resolve grievances A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview and bill of rights review, the provider failed to follow-up and resolve residents' grievances brought to staff attention for three of three concerns. Findings include: 1. During a confidential group interview on 5/28/14 at 11:00 a.m. residents had stated: *They had reported the following concerns to the director of nursing (DON): -Being left on toilets for forty-five minutes at a time. -Being left to sleep in wet sheets. -Urinals had not been emptied in a timely manner and had caused a resident to urinate in an incontinent pad when he could have used the urinal.	F 166	The facility has completed a formal investigation for grievances addressed during the survey process on 5-29-2014. Interview able residents have been interviewed to ensure if they had any grievances or concerns they were properly documented and investigated. This will be completed by 6-24-2014. Staff has been educated on 6-17-2014 regarding what is considered a grievance, how a grievance form is completed, and procedure for resolving grievances, follow-up, and policy review. This information has been included in our new hire orientation. The Administrator and or Resident Care Coordinator will monitor this issue by discussing any concerns or grievances Monday through Friday during the department manager's	6-24-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Hallaway TITLE: Administrator (X6) DATE: 7/11/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 166	Continued From page 1 Interview on 5/29/14 at 11:00 a.m. with the DON, administrator, and the director of clinical services revealed they: *Had not investigated or documented the allegation of residents being left on toilets for forty-five minutes. *Felt the forty-five minutes had been an exaggeration due to the specific resident making the complaint. *Had spoken to the family "a lot" about the situation. *Had not completed a formal investigation regarding the resident who had been left to sleep in wet sheets or the urinal not being emptied. -Had placed a call on 5/28/14 to the staff member who had been named in those two situations but had not heard back from her. -Were planning to speak to her on her next shift on 5/30/14. *Had not been investigating grievances regarding toileting but they "would be now." Review of the Long Term Care Facilities Resident's Bill of Rights provided to resident upon admission revealed: *Residents "may voice grievances without discrimination or reprisal." **"The grievance process must include the facility's efforts to resolve the grievance, documentation of the grievance, names of the people involved, nature of the matter and the date."	F 166	morning meeting. The administrator and or RCC will ensure all concerns are placed in the grievance log and the grievance procedure is followed. This will be done daily x 4 weeks during the Department Managers morning meeting, then weekly x 3 months in the Care Plan Conference meetings, then quarterly thereafter. The administrator and or RCC will report the findings to the QA committee monthly to determine if compliance is being met or if further interventions are needed. Completion date: 6-24-2014 Monitored by: Administrator and Resident Care Coordinator		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	Continued From page 2 This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to ensure proper feeding tube (tube used to deliver medications and nutrition into the stomach) placement for two of two sampled residents (2 and 11) prior to medication administration. Findings include: 1. Observation on 5/27/14 at 4:30 p.m. of registered nurse (RN) B who attempted to administer medication to resident 2 revealed: *He opened the port on the feeding tube and inserted a syringe filled with 10 milliliters (ml) Tylenol liquid into the port. *The medication would not go into the tube. *He stated sometimes if the resident was upset or aggravated the medication or feeding would not go in. *He withdrew the medication (after approximately two minutes) back into the syringe after he attempted to administer the Tylenol. *He stated he would try to administer the Tylenol later. *He had not checked for placement of the tube prior to administering the medication. 2. Observation on 5/28/14 at 9:08 a.m. of RN B who attempted to administer medication to resident 11 revealed he: *Opened the port on the feeding tube and inserted a syringe. *Administered 4 ml of Lasix (a medication used to flush excess fluid out of the body), 5 ml Paroxetine (an anti-depressant), and 20 ml Tylenol liquid into the port and flushed the tube with water between medications.	F 281	F 281 Services Provided Meet Professional Standards The services provided by the facility must meet professional standards of quality. Observation 1 & 2: The areas noted during the survey process are unable to be corrected after the fact. The nursing staff has been re-educated on 6-17-2014 regarding the proper professional standard of care of checking for G-tube placement prior to administering medication via the G-tube. The Director of Nursing will monitor the nursing staff monthly x 3 months and quarterly thereafter to determine proper medication administration is occurring. The Director of Nursing will report the findings to the QA committee monthly to determine if proper procedures are being met or if further interventions are needed. Completion date: 6-17-2014 Monitored by: Director of Nursing	6-17-2014

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F 281	Continued From page 3 *Had not checked for placement of the tube prior to administering the medication. 3. Interview on 5/28/14 at 9:30 a.m. with RN B regarding the above medication administrations revealed he: *Had not checked tube placement prior to administering any medications through a feeding tube. *Had only checked for tube placement before administering tube feedings. *Was not sure why they (staff) had not checked placement but agreed it should be done. Review of the provider's revised March 2013 Checking Placement of a Stomach Tube policy revealed placement was to be checked prior to medication administration, flushing, or tube feeding. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St Louis, MO, 2005, page 1314, revealed placement check and irrigation before and after medication administration must be done to prevent complications associated with feeding tubes.	F 281	F 318 Increase/Prevent decrease in range of motion The facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Resident #4 Plan of Care for restorative nursing was reviewed and revised on June 18, 2014 by the DON and MDS coordinator. The facility reviewed and updated the restorative therapy program to state that all restorative plans of care will be reviewed and updated quarterly upon MDS review or as needed. The restorative aide has been educated on 6-17-2014 regarding reviewing of the restorative therapy plan of care and if the plan does not adequately meet the resident's needs the plan is to be reviewed with therapies and the restorative nurse and appropriate interventions will be added or removed from the restorative plan.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318	<u>interventions will be added or removed from the restorative plan.</u> The Director of Nursing and/or the restorative nurse, along with the restorative aide will review <u>20% of the restorative plans</u> monthly x 3	6-18-14 CH 7-1-14 CH 7-11-14

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F 318	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 12218</p> <p>Based on record review, observation, and interview, the provider failed to ensure one of six sampled residents (4) with contractures had been assessed and the range of motion plan of therapy was updated to the resident's current status. Findings include:</p> <p>1. Observation of resident 4 on 5/27/14 at 3:10 p.m. revealed he: *Was lying in bed at a flat level. *Had a collar pillow around his neck. *Had his hands hanging onto the pillow, arms bent at the elbows. *Was shaking a lot from his head, neck, and arms.</p> <p>Observations on 5/28/14 at 8:15 a.m. of resident 4 revealed he had been in bed. He had a neck pillow around his neck. He was awake and shaking, but not as much as the day before.</p> <p>Interview with the director of nursing (DON) on 5/28/14 at 9:20 a.m. regarding resident 4 revealed: *He preferred to stay lying down in bed. *He had too much pain in his neck for sitting up. *Moved himself around some. *He did not do much transferring or sitting up in his wheelchair.</p> <p>Interview with restorative aide F on 5/28/14 at 9:50 a.m. regarding resident 4 revealed: *He had the Tens unit (electronic massager for muscles) on his neck for one hour three times per week. *She had done passive range of motion with his</p>	F 318	<p>months and quarterly thereafter to determine proper therapeutic exercises are being performed. The Director of Nursing will report the findings to the QA committee monthly to determine if proper procedures are being met or if further interventions are needed.</p> <p>Completion date: 6-18-2014 Monitored by: Director of Nursing</p>	

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F 318	<p>Continued From page 5 arms, elbows, knees, and legs. *He was encouraged to get up in his wheelchair for five minutes per day.</p> <p>Interview with the activities director on 5/28/14 at 1:30 p.m. revealed resident 4 had not been out to any activities since February 2014. She stated he had pain in his neck, and it was difficult for him to be up in his wheelchair.</p> <p>Review of resident 4's treatment records for physical therapy, occupational therapy, and restorative therapy revealed: *Encourage resident to self-feed appropriate foods. -April 2014 treatment sheet showed seventeen times he had therapy, and seventeen times he had refused. -May 2014 treatment sheet showed twelve times he had this therapy, and twelve times he had refused. *Encourage resident to sit up in wheelchair for five minutes with soft neck brace. -April 2014 treatment sheet showed seventeen times he had therapy and had refused that exercise. -May 2014 treatment sheet showed twelve times he had refused that exercise. *Bilateral upper extremities with green therapy band with one pound weights for arms, wrist, and fifteen repetitions. -Resident completed seventeen times in April 2014. -Resident completed twelve times in May 2014.</p> <p>Interview with restorative aide F on 5/29/14 at 11:00 a.m. revealed she agreed resident 4 had not completed several exercises that had been planned for him. Review of the Restorative</p>	F 318			

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F 318	Continued From page 6 Referral sheet dated 12/6/13 revealed: *Current functional status: -Resident can self feed finger foods seated in bed with head of bed at 90 degrees, table over waist and weighted bowl. -Maximum assist with transfer in and out of bed, minimum to stand by assist support to sit. *Program recommendations: -Encourage resident to self-feed appropriate foods. -Encourage resident to sit in wheelchair times five minutes with soft neck brace. -Bilateral upper extremities with green therapy band with one pound weights at wrist, abdomen, shoulder, and arm. -Three times per week. *Goals: -To maintain bilateral upper extremities arm strength to assist with dressing, bed mobility, and transfers. *Those exercises had been recommended back in December 2013. *He had been admitted on 11/6/13. *She confirmed an assessment of his abilities had not been completed. A revised and updated range of motion therapy plan had not been done since the original one on 12/6/13 to reflect his current exercise abilities.	F 318	F 441 Infection Control <u>Actions noted in observation #1 are not able to be corrected at this time, as it is after the fact for providing care to resident #5 by not removing contaminated gloves and properly cleansing their hands and re-gloving during to a dressing change to a wound.</u> 2. Provide proper sanitizing and disinfecting of the whirlpool. The staff have been re-educated on 6-17-2014 regarding the proper procedure for glove usage when providing care to residents. Proper sanitizer and disinfectant had been placed in the whirlpool on 5-31-2014 to ensure proper ratio of sanitizer to water for effective disinfecting of the whirlpool. The Maintenance Supervisor and staff have been reeducated on 6-12-2014 regarding proper procedure for cleaning the whirlpool and to ensure the proper ratio of disinfecting chemical is being used in the whirlpool to prevent cross contamination. The Director of Nursing or assigned nursing staff will monitor 15% of	CH Tink 6-17-14 CH Tink 7-11-14
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		

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F 441	<p>Continued From page 7</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, manufacturer's guidelines, record review, and policy review, the provider failed to ensure: *Appropriate hand washing technique and glove use for one of one sampled resident (5) with a dressing change.</p>	F 441	<p><i>7-11-14 CH</i></p> <p><u>nursing staff providing care monthly x 3 months then quarterly thereafter to ensure proper hand hygiene is occurring. The Director of Nursing will report the findings to the QA committee monthly to determine if compliance is being met or if further interventions are needed. The Administrator and Maintenance Supervisor will monitor the sanitizing and disinfecting of the whirlpool weekly to ensure proper sanitizing and disinfecting chemical and procedure is being performed and the Administrator will report the findings to the QA committee monthly. The Director of Nursing will continue to monitor for occurrence of infection and control breakouts using the current recording tool to determine trends and she will report the findings to the QA committee monthly.</u></p> <p><i>7-11-14 CH</i></p> <p>Completion date: 6-17-2014 Monitored by: Director of Nursing, Administrator, and Maintenance Supervisor</p>	

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F 441	<p>Continued From page 8</p> <p>*Proper disinfection and sanitizing for one of one whirlpool.</p> <p>*Appropriate infection control monitoring had been used to identify possible sources of infection.</p> <p>Findings include:</p> <p>1. Observation on 5/28/14 at 8:50 a.m. with registered nurse (RN) B and licensed practical nurse (LPN) C while they performed a dressing change on resident 5's coccyx (where the buttocks and lower back meet) revealed:</p> <p>*LPN C provided positioning support for resident 5 while he was on his right side.</p> <p>*RN B put on gloves after sanitizing his hands outside the room at the medication cart. He then:</p> <p>-Removed the dressing to the resident's coccyx that had been soiled with a bowel movement (BM).</p> <p>-Carried the soiled dressing to the garbage can across the room.</p> <p>-Grabbed the personal wipes package with his visibly soiled gloves and brought it back across the room and laid it on the resident's bed sheets.</p> <p>-Cleaned up the BM, and then handed the container of personal wipes with his dirty gloves to LPN C who set them on the resident's bedside end table.</p> <p>-Removed and discarded his soiled gloves.</p> <p>-Proceeded to put on clean gloves without sanitizing his hands and completed the dressing change.</p> <p>Interview on 5/28/14 at 9:30 a.m. with RN B regarding the above dressing change revealed he agreed he should have:</p> <p>-Removed his soiled gloves.</p> <p>-Used hand sanitizer or washed his hands.</p> <p>-Put on new gloves prior to touching the personal</p>	F 441			

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F 441	<p>Continued From page 9 wiper.</p> <p>Review of the Center for Disease Control's Guideline for Hand Hygiene in Health-care Settings, MMWR 2002; vol. 51, no. RR-16, <http://www.cdc.gov/handhygiene/download/hand_hygiene_core.pdf> revealed: Hand washing or hand sanitizing should be completed when hands are visibly soiled, before and after glove use, or when gloves or hands are visibly soiled.</p> <p>Review of the provider's April 9, 2014 Standard Precautions policy revealed hand hygiene was to be performed prior to and after glove use.</p> <p>2. Observation, demonstration, interview, and manufacturer's guidelines review on 5/29/14 at 8:48 a.m. with certified nursing assistant (CNA) A and the maintenance supervisor (MS) in the whirlpool tub room revealed: *CNA had been asked to perform whirlpool tub disinfection and sanitizing by this surveyor. *She had not put on gloves prior to cleaning the whirlpool tub. *She revealed the steps to clean the whirlpool tub were: -"Start the water. -Turn on the disinfectant until it came out of the lower jets. -Turn off the disinfectant. -Fill the whirlpool tub just over the upper jets. -Scrub the whirlpool with the whirlpool brush and let soak for ten minutes, drain, and rinse." *She was unsure what type of cleaning and sanitizing product was used for the whirlpool tub or what the manufacturer's guidelines were for the product. *The MS opened the locked cabinet on the</p>	F 441			

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F 441	<p>Continued From page 10</p> <p>whirlpool to reveal Classic Whirlpool Cleaner and Disinfectant (that was not the recommended solution by the whirlpool manufacturer). *He stated he "followed the solution manufacturer's guidelines by using an empty one gallon container of the cleaner, and added two ounces of the cleaner to one gallon of water." That would be placed in the cupboard with a hose coming out for automated dispensing. *It would be used multiple times to clean the whirlpool tub. *He was trained to follow those instructions when he started with the facility approximately one year ago. *He had been unaware that the solution was not to be diluted with water prior to using in the whirlpool nor how much was needed to properly sanitize and disinfect the whirlpool tub. *He had been unaware he only added enough disinfectant to properly clean and disinfect one gallon of water at a time. *He agreed there had not been adequate solution to disinfect approximately forty-five to sixty gallons of water each time it had been cleaned. *CNA A stated she thought most residents received a whirlpool tub bath.</p> <p>Interview on 5/29/14 at 10:10 a.m. and again at 2:45 p.m. with the director of nursing and the director of clinical services regarding the whirlpool tub cleaning revealed: *They were unaware the whirlpool tub had been incorrectly cleaned for an undetermined amount of time. *She had wondered if the urinary tract infections were a result of improper cleaning. *She had observed staff's technique but had not thought about the proper cleaning solution. *She made a list of twelve residents of the facility</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/29/2014
NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025		
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F 441	<p>Continued From page 11</p> <p>that she was aware used the whirlpool tub.</p> <p>*Of those twelve residents one resident (3) had a suprapubic catheter (permanent tube leading through the abdomen into the top of the bladder for urine removal) and had a history of chronic bladder infections. He would have been at high risk with exposure to bacteria from the whirlpool tub.</p> <p>*They agreed that was a widespread problem that had the potential for serious health concerns and risks for infection.</p> <p>*They were unaware CNA had stated of all the residents the majority of residents received a whirlpool bath on a regular basis.</p> <p>*They reported having had infection control surveillance monitoring in place but had not noticed a pattern of infections other than they were mostly bladder infections.</p> <p>Random review of the medical records for residents who used the whirlpool tub revealed six had active bladder infections in May 2014. One resident also had an open sore that contained staph (a type of bacterial infection). Multiple infections were listed in the randomly selected records since January 2014.</p> <p>Review of the manufacturer's tub cleaning guideline dated February 2005 revealed: *Disinfecting and sanitizing was to be performed after each resident use when the [whirlpool] manufacturer's cleaner was not used. *The "chemical injection orifice" was programmed to deliver one ounce of disinfectant per gallon of water used. "Be sure to read and carefully follow your disinfectant manufacturer's instructions for dilution ratios."</p> <p>Review of the provider's April 9, 2014 Infection</p>	F 441		

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F 441	Continued From page 12 Prevention Program Overview policy revealed: *One goal was to "monitor for occurrence of infection and control outbreaks and cross contamination." **"Compliance with infection prevention practices is monitored and documented by staff evaluation and observation of practices."	F 441	F 514 Resident records- complete/accurate/ accessible <u>Resident Care Coordinator and/or Activities Director will meet with Resident #6 weekly to allow the time to discuss concerns and to provide one-to-ones for support.</u>	<i>CH</i> <i>7/11/14</i>
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to ensure documentation was completed regarding non-pharmacological interventions attempted and mood and behaviors displayed for one of three sampled residents (6) with depression. Findings include: 1. Review of resident 6's medical record revealed: *She had been admitted on 4/9/14.	F 514	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Staff has been educated to ensure that documentation in records is accurate and reflects the services provided. Staff should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to residents in the future. <u>The Administrator will review 10% of residents Social Service and activity related documentation provided by Resident Care Coordinator and Activity Director monthly x 3 months then quarterly thereafter to ensure adequate documentation is occurring. The</u>	<i>6-17-2014</i>

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F 514	<p>Continued From page 13</p> <p>*On her 4/16/14 Minimum Data Set assessment she had been minimally depressed.</p> <p>*On 5/16/14 according to a mood interview she had been mildly depressed.</p> <p>*A fax on 5/20/14 to the physician regarding her being depressed and sad in therapies and asking to review medications and advise.</p> <p>*A reply from the physician asking if she would want to try an anti-depressant medication.</p> <p>*No activity documentation from 5/13/14 through 5/28/14 for twenty-four out of twenty-nine times.</p> <p>*No documentation of one-to-one activity with her.</p> <p>*No documentation on her daily moods and behaviors.</p> <p>*No documentation on non-pharmacological interventions attempted regarding her depression.</p> <p>Interview on 5/29/14 at 9:05 a.m. with the patient care coordinator regarding resident 6 revealed:</p> <p>*She had provided one-to-one activity with the resident.</p> <p>*She had encouraged her to work on puzzles she liked to do.</p> <p>*The resident had been crying more frequently and stated she was sad.</p> <p>*She had been thinking more about a daughter she had lost over twenty years ago that made her sad.</p> <p>*She had not documented any of the above information in the resident's medical chart.</p>	F 514	<p>Administrator will report to the QA committee monthly to determine if compliance is being met or if further interventions are needed.</p> <p>Completion date: 6-17-2014 Monitored by Administrator</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435065	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2014
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NAME OF PROVIDER OR SUPPLIER PRAIRIE ESTATES HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 600 SOUTH FRANKLIN ST POST OFFICE BOX 486 ELK POINT, SD 57025
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/28/14. Prairie Estates Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 5/28/13 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
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: 14180 Based on observation and document review, the provider failed to maintain at least two conforming exits from each floor of the building. Two of three basement exits (boiler room and laundry room) did not meet the standard for a means of egress.	K 032		"F"

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheryl Hallaway</i>	TITLE Administrator	(X6) DATE 6/19/14
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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.

JUN 23 2014

If continuation sheet Page 1 of 2

SD DOH L&C

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K 032	Continued From page 1 The deficient practice affected one of one smoke compartment and staff. Findings include: 1. Observation at 12:30 p.m. on 05/28/14 revealed the basement was not provided with two approved means of egress. The boiler room and the laundry room exits were through a hazardous area. Review of previous survey data indicated that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 032		"F"	

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 206	Continued From Page 1 This Rule is not met as evidenced by: Surveyor: 33488 Based on interview and record review, the provider failed to ensure contracted laundry and housekeeping staff had appropriate infection control training prior to working in the facility. Findings include: 1. Interview and record review on 5/28/14 at 9:40 a.m. and again later that day with the contracted housekeeping and laundry supervisor D regarding infection control in housekeeping and laundry revealed she: *Had been employed by the contractor for one month. *Had no previous experience in medical facilities. *Was unaware what to do for infection control in laundry for example if there was an outbreak of Clostridium difficile (C-diff, a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon) in the facility. *Had received no formal training in infection control. *Received and provided this surveyor with a fax dated 5/28/14 labeled housekeeping in-service on C-diff infections from her corporate office and had given her staff an in-service an hour earlier that same afternoon. *Agreed since she lacked the necessary training herself it would be difficult for her to appropriately train other staff on infection control. Interview and record review on 5/29/14 at 8:30 a.m. with the contracted housekeeping and laundry district manager E regarding the above contracted employee revealed: *He had been unaware she lacked the necessary training for infection control prior to this survey. *Agreed proper training should have been provided to laundry supervisor D.	S 206		6-17-14 CH 7-11-14

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S 206	Continued From Page 2 *Agreed she would not be able to adequately train the staff she supervised without the necessary training. *Agreed she had no training in her personnel file with the contractor on infection control. Interview on 5/29/14 at 2:45 p.m. with the director of nursing, the administrator, and the director of clinical services regarding the contracted housekeeping and laundry staff revealed they: *Were unaware of any training laundry supervisor D had received regarding infection control. *Assumed contracted staff received appropriate education and training from the contractor. *Agreed it had been their responsibility to make sure any staff, contracted or direct hire, had the necessary mandatory training before employment within their facility. They had no policy regarding training of contracted staff working in their facility.	S 206		6-17-14 CA 7-11-14