

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

ORIGINAL

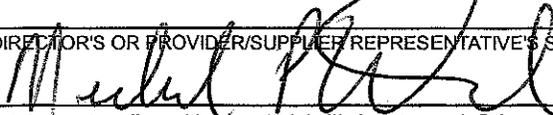
PRINTED: 10/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2014
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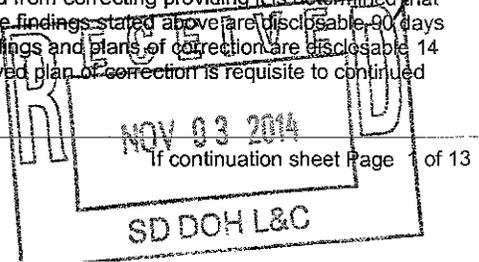
NAME OF PROVIDER OR SUPPLIER ESTELLINE NURSING AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 FJERESTAD AVENUE EAST POST OFFICE BOX 130 ESTELLINE, SD 57234
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F 000	INITIAL COMMENTS Surveyor: 32333 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/6/14 through 10/8/14. Estelline Nursing and Care Center was found not in compliance with the following requirements: F176, F280, F371, and F441.	F 000	Addendums noted with an asterisk per 11/5/14 telephone to facility administrator and DON. JD18DDOH/MF	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, policy review, and interview, the provider failed to assess and care plan self-administration of medication for two of nine sampled residents (2 and 7). Findings include: 1. Review of resident 2's medical record revealed: *A physician's order dated 8/11/14 for self-administration of nebulizer treatments after nursing set-up. *The October 2014 treatment administration record had stated, "nursing to evaluate appropriateness every day shift every monday." *There had not been a self-administration assessment available. *Self-administration had not been addressed on	F 176	Upon request of resident to self administer meds, an assessment will be done. See assessment form and policies attached. The assessment will be done quarterly and/or prn with the MDS schedule by DON or MDS Coordinator. After completed assessment and resident is appropriate for self administration of meds, an order from the resident's physician will be obtained, which will be added to the care plan. Self administration of meds was discussed at the RN/LPN meeting held on 10.30.14. This will be monitored through QA monthly for one year and data will be reported to the DON and presented at monthly and quarterly QA meetings. This will address Resident #2 and Resident #7 and any other resident in facility that may self administer meds.	*10/31/14 JD18DDOH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/30/14
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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.



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F 176	Continued From page 1 her care plan. Surveyor: 32333 2. Review of resident 7's complete medical record revealed: *A 9/1/14 physician's order for self-administration of her nebulizer treatments after nursing set-up. *No assessment had been completed to ensure the resident had been safe to self-administer her medications. *There was no mention of self-administration of medication on her 8/23/14 care plan. 3. Interview on 10/8/14 at 12:20 p.m. with the director of nursing revealed she agreed self-administration of medication should have been assessed, documented, and added to the care plan. Review of the provider's reviewed and revised August 2014 Monitoring and Recording Medications Which Are Self-Administered policy revealed "The decision that a resident has the ability to self-administer medications is placed on the resident's care plan. The above decision is subject to periodic re-evaluation by the interdisciplinary care team should there be a change in the resident's status."	F 176			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. A comprehensive care plan must be developed	F 280	*to reflect the resident's current status. JKSDDH/MF Short term care plans for Residents # 1, 2, 7, 11, 12, and 13 were updated. On 10.27.14, DON and ADON met with interdisciplinary team (social worker, dietary manager, activity director) to review updated care plan policies. SEE NEXT PAGE ...	*10/31/14 JKSDDH/MF	

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F 280	<p>Continued From page 2</p> <p>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: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans reflected the residents' current status for 6 of 13 sampled residents (1, 2, 7, 11, 12, and 13). Findings include:</p> <p>1. Observation on 10/6/14 at 4:15 p.m. revealed resident 12 had been sitting in his recliner with a towel laying on his right ankle. His pant leg had been pulled up to his knee. An open area was noted on that exposed leg approximately two inches long by one-half inch wide. It was draining a clear colored liquid and all of the exposed skin had a bright red rash.</p> <p>Observation on 10/7/14 at 12:55 p.m. during personal care revealed resident 12 had a bright red rash on the abdomen, pelvic area, and both legs. Interview with the resident at that time indicated the leg had been causing him pain, and the rash itched "terrible."</p>	F 280	<p>At RN/LPN meeting on 10.30.14, updated care plan policies were reviewed and discussed.</p> <p>[REDACTED] QA will monitor 10% of the residents' charts weekly x 4 weeks; if no problems, then every 2 weeks x 2 months; then monthly for 9 months for compliance with the policy. Data will be reported to DON and presented at the monthly and quarterly QA meetings. This will address Residents # 1, 2, 7, 11, 12, and 13 and all other residents in the facility.</p> <p>*The comprehensive care plan, the short term care plan, and the short term care plan form were revised to ensure care plans reflected the residents' current status. JJKDDH/MF</p>	

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F 280	Continued From page 3 Review of resident 12's medical record revealed a 10/3/14 nurses progress note revealed the diagnosis of cellulitis (infection), and he had been on antibiotic therapy. A nurses note on 10/6/14 at 2:00 p.m. indicated the resident had been allergic to the Clindamycin (antibiotic) he had been on, and it was to have been added to his list of allergies. *The undated wound documentation sheet revealed an entry dated 10/2 [no year] by nurse "RN" that stated resident 12 had "2 dime sized blisters on R [right] shin with no drainage and the treatment was to have been Mepilex [brand name wound dressing] to areas." The undated temporary care plan revealed: *Allergies had been "Penicillin, Sulfa, Sulbactam." It did not list Clindamycin. *He had an infection "10/7 cellulitis" it did not indicate where the cellulitis had been. It also stated he had been put on "10/ Keflex [antibiotic] 500 mg PO [oral] TID [three times a day] X (times) 10 days." *There had been no indication he had been on Clindamycin for the cellulitis, and that it had been determined he had been allergic to that medication. Review of the revised 8/7/14 comprehensive care plan revealed: *Allergies to "Penicillin, Sulfa antibiotics." It did not list Clindamycin. *A focus area of "At risk for skin breakdown." *The goal had been "Intact skin, free of redness, blisters or discoloration." *There had been no documentation about the open area on the right lower leg or the rash on	F 280		

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F 280	<p>Continued From page 4 the body.</p> <p>2. Review of resident 13's medical record revealed she had been admitted on 9/12/14 with a wound on her right foot and developed a wound on her left inner buttock after admission.</p> <p>Review of the undated wound documentation sheet indicated: *On "9/19 [no year]" an open area on the "left inner buttock by coccyx (tail bone)." -It had been a stage two (blister or shallow crater) ulcer (open area). *The wound had been documented as "healed" on "9/28 [no year]."</p> <p>Review of the undated temporary care plan indicated diagnoses of: **"R [right] foot ST [soft tissue] infection." **"Diabetic foot ulcer." **"Abscess SP[status post (after)] debridement." **"DM [diabetes mellitus]-insulin dependent." *She had a "R [right] foot ulcer with a wound vac [vacuum]." *It did not indicate an open area on the left inner buttock.</p> <p>Review of the 9/25/14 care plan revealed: *A focus area "__ [resident name] has a stage two pressure ulcer on the left inner buttock." *According to the wound documentation sheet that area was currently healed.</p> <p>Interview on 10/8/14 at 9:45 a.m. with the director of nursing confirmed she would have expected the temporary or the comprehensive care plans to reflect the current status of the residents.</p> <p>Surveyor: 32333</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>3. Review of resident 1's complete medical record revealed: *An 8/28/14 care plan revealed: -A problem area of a stage II ulcer on his right coccyx area. -A goal he would have no skin breakdown by 11/26/14. -Multiple interventions related to skin breakdown. *A wound documentation form revealed his pressure ulcer had been documented as healed on 9/16/14. *His care plan had not been updated to reflect his healed stage II ulcer.</p> <p>4. Review of resident 11's complete medical record revealed: *She had been admitted on 9/25/14. *She had a peripherally inserted central catheter (PICC) line (intravenous access) in her right arm. *A temporary care plan with no interventions on how to care for her PICC line.</p> <p>5. Review of resident 7's complete medical record revealed: *A 9/1/14 physician's order for self-administration of her nebulizer treatments after nursing set-up. *There was no mention of self-administration of medication on her care plan. Refer to F176, finding 2.</p> <p>Surveyor: 32573</p> <p>6. Review of resident 2's complete medical record revealed: *A physician's order dated 8/12/14 for self-administration of nebulizer treatment after nurse set-up. *Self-administration of nebulizer after nurse set-up had not been included in the care plan.</p>	F 280		

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F 280	Continued From page 6 Refer to F176, finding 1. 7. Review of the revised July 2013 Resident Overall Plan Of Care (OPC) policy revealed: **All care plans are to be reviewed and pertinent changes made as the resident's condition changes or as goals and objectives have been made." *An accurate face page should be complete. *The care plan should be reviewed and revised as required.	F 280			
F 371 SS=D	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: 32573 Based on observation, interview, and policy review, the provider failed to ensure: *Ready-to-eat foods were handled in a sanitary manner by two of two cooks (H and I) for two of two observed meal services. *Dry goods were stored in a sanitary manner in the kitchen. Findings include: 1. Observation on 10/7/14 at 11:10 a.m. of the	F 371	<i>*to include scoops and measuring cups not to be stored in the storage bins with the dry foods. All staff were immediately notified and the policy was posted as a reminder. JDSDDH/MF</i> Scoop was immediately removed from sugar bin. CDM reviewed and updated the policy. _____ Policy will be reviewed at dietary inservice on 10.29.14. _____ . Cooks and dietary aides were immediately reminded and instructed on proper serving procedures, including keeping a physical barrier between clean hands and the ready to eat food. If wearing gloves, wash hands, put on gloves, remove gloves when contaminated, rewash hands, and put on clean gloves. The break times of dietary aides were changed to allow other cook to assist with noon meal as needed (such as having one cook only serving the baked potatoes). Dietary staff reminded and instructed to wash hands when re-entering kitchen from dining room if hands were contaminated. SEE NEXT PAGE ...	<i>*10/30/14 JDSDDH/MF</i>	

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F 371	Continued From page 8 gloves. They had been unsure of the best way to handle ready-to-eat foods. The scoop should not have been stored in the bag of sugar. She agreed the cooks should not have left the immediate serving area and returned without washing their hands and putting on new gloves. Review of the revised March 2012 dietary policies revealed food should not be touched directly with hands, and tongs or gloves should be used to serve ready-to-eat foods. There had not been instructions on when to replace gloves. There had not been instructions on where to store scoops for dry goods.	F 371	* to include proper hand hygiene and glove use, appropriate disinfection of the blood glucose meter, and the proper use of a barrier. JD/SSDOH/MF	
F 441 SS=D	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 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	* including RNA and LPN B JD/SSDOH/MF DON and ADON immediately reviewed with all nurses proper hand hygiene, glove use, and medication administration. [REDACTED] JD/SSDOH/MF Revised Care of Assure Platinum and Performing a Blood Glucose Test with the Assure Platinum Meter policies. [REDACTED] JD/SSDOH/MF * [REDACTED] All of these policies were discussed at the RN/LPN meeting held 10.30.14. For the next year, at the all staff meetings, will review Hand Hygiene and Glove Use. All staff will be monitored, through QA, for proper hand hygiene quarterly for one year (see QA form). Through QA, licensed nurses will be observed bi-monthly for proper administration of eye SEE NEXT PAGE ...	*10/31/14 JD/SSDOH/MF

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F 441	<p>Continued From page 9</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 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: 32333 Based on observation, interview, and policy review, the provider failed to ensure: *Appropriate hand hygiene and glove use by two of two observed nurses registered nurse (RN) (A) and licensed practical nurse (LPN) (B) while administering medication and checking blood sugar. *A blood glucose (sugar) meter had been disinfected after each use by two of two observed nurses (RN) (A) and (LPN) (B). *A barrier had been used when bringing the blood glucose kit into multiple residents' rooms by two of two observed nurses (RN) (A) and (LPN) (B). Findings include:</p> <p>1. Observation on 10/7/14 at 9:20 a.m. with RN A while she prepared to administer eye drops to resident 16 revealed she: *Put her gloves on. *Locked her medication cart.</p>	F 441	<p>drops and blood glucose testing for 3 months. If no problems, then will do monthly for 9 months. This data will be reported to the DON and be presented at the monthly and quarterly QA meetings.</p>		

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F 441	<p>Continued From page 10</p> <p>*Knocked on the resident's door.</p> <p>*Administered the resident's eye drops.</p> <p>2. Observation on 10/7/14 at 10:50 a.m. with RN A while she checked resident 13's blood sugar revealed she:</p> <p>*Put gloves on and had not performed hand hygiene.</p> <p>*Set her blood sugar testing supply container on the resident's bedside table.</p> <p>*Had not used a barrier underneath of the container.</p> <p>*Checked the resident's blood sugar.</p> <p>*Wiped the blood glucose meter with a Super Sani-cloth wipe with those same soiled gloves on.</p> <p>*Immediately put the blood glucose meter in its case.</p> <p>*Removed her soiled gloves.</p> <p>*Sanitized her hands.</p> <p>*Obtained supplies including insulin and a syringe out of her medication cart.</p> <p>*Drew up the insulin dose.</p> <p>*Put gloves on and had not washed or sanitized her hands.</p> <p>*Administered the dose of insulin.</p> <p>*Removed her gloves.</p> <p>*Documented the medication administration in the resident's medication administration record.</p> <p>3. Observation on 10/7/14 at 4:55 p.m. with LPN B while she checked resident 17's blood sugar revealed she:</p> <p>*Put gloves on.</p> <p>*Knocked on the resident's door.</p> <p>*Carried the blood glucose container into the resident's room.</p> <p>*Set her blood sugar testing supply container on the resident's bedside table.</p> <p>*Had not used a barrier underneath the container.</p>	F 441			

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F 441	<p>Continued From page 11</p> <p>*Opened the resident's bathroom door. *Turned on the faucet and wetted a cotton ball. *Checked the resident's blood sugar. *Wiped the blood glucose meter with a Super Sani-Cloth wipe with those same soiled gloves on. *Immediately put the blood glucose meter into its case.</p> <p>4. Review of the Super Sani-Cloth manufacturer's label revealed: *All blood and body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open and unfold the first germicidal wipe to remove heavy soil. Use a second germicidal wipe to thoroughly wet the surface. Allow to remain wet two minutes, let air dry.</p> <p>Interview on 10/8/14 at 12:20 p.m. with the director of nursing revealed she agreed: *Appropriate hand hygiene and glove use should have been done. *A barrier should have been used when transporting the blood glucose supply container between residents' rooms. *The blood glucose meter should have been properly disinfected according to the manufacturer's label after each use.</p> <p>Review of the provider's July 2012 Hand Hygiene policy revealed: *When to have used waterless antiseptic: -Before resident care. -Between resident contact. -After touching environmental surfaces or equipment near residents. -After contact with potential contaminated surfaces and objections in all other locations.</p>	F 441			

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

PRINTED: 10/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2014
NAME OF PROVIDER OR SUPPLIER ESTELLINE NURSING AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 FJERESTAD AVENUE EAST POST OFFICE BOX 130 ESTELLINE, SD 57234		
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F 441	Continued From page 12 -After removing gloves. -After contact with body fluids. Review of the provider's reviewed and revised September 2013 Care of Assure Platinum (blood glucose meter) policy revealed it had not addressed the specific procedure to disinfect the device. It did state to clean it by using a "Purple Top PDI Sani-Cloth.	F 441			

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

ORIGINAL

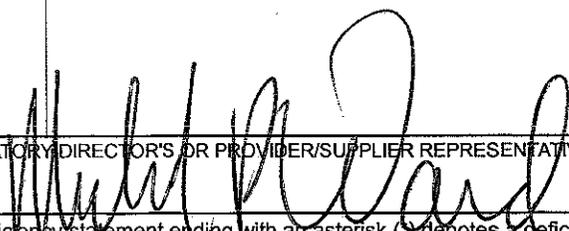
PRINTED: 10/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435099	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2014
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NAME OF PROVIDER OR SUPPLIER ESTELLINE NURSING AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 FJERESTAD AVENUE EAST POST OFFICE BOX 130 ESTELLINE, SD 57234
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/8/14. Estelline Nursing and Care Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/13/14
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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.

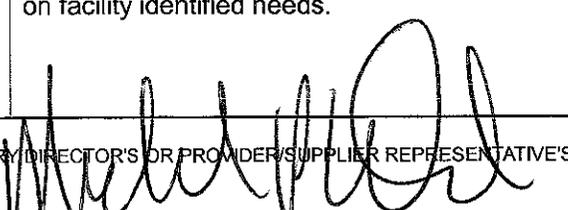
ORIGINAL

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2014
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NAME OF PROVIDER OR SUPPLIER ESTELLINE NURSING AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 205 FJERESTAD AVE E POST OFFICE BOX 130 ESTELLINE, SD 57234
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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) COMPLETE DATE
S 000	Initial Comments Surveyor: 32573 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 10/6/14 through 10/8/14. Estelline Nursing and Care Center was found not in compliance with the following requirement: S206.	S 000	Addendums noted with an asterisk per 11/5/14 telephone to facility administrator and DON. JDKSDDH/ME	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	New employee formal orientation program was revised to include: 1. Fire prevention and response. 2. Emergency procedures and preparedness. 3. Infection control and prevention. 4. Accident prevention and safety procedures. 5. Proper use of restraints. 6. Resident rights. 7. Confidentiality of resident information. 8. Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. 9. Care of residents with unique needs. 10. Dining assistance, nutritional risks, and hydration needs of residents. Ongoing education will continue to address these subjects. * [REDACTED] see page 2. JDKSDDH/ME This will be monitored through QA. * [REDACTED] All new employees' charts SEE NEXT PAGE...	* 10/9/14 JDKSDDH/ME

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adenustobae (X6) DATE 10/20/14
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2014
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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32573</p> <p>Based on record review and interview, the provider failed to ensure all mandatory education for five of five sampled staff members (C, D, E, F, and G) had been completed and documented. Findings include:</p> <p>1. Record review on 10/8/14 of employees' files of those hired between June 2014 and August 2014 revealed staff C, D, E, F, and G had not received mandatory training on the following topics when hired:</p> <ul style="list-style-type: none"> *Incidents and diseases subject to mandatory reporting. *Dining assistance, nutritional risks, and hydration needs of residents. *Care of residents with unique needs. <p>Interview on 10/8/14 at 1:00 p.m. with the director of nursing (DON) revealed different training had been given depending on which area of the nursing home the employee worked in. The topics noted above were part of annual training but had not been included in general orientation given to all employees upon being hired.</p>	S 206	<p>will be monitored quarterly for one year. The data will be reported to the Administrator and presented at monthly and quarterly QA meetings.</p> <p>*The policy and orientation form have been updated to include all of the above listed topics. JD/SDDH/MF</p> <p>*by the QA coordinator. JD/SDDH/MF</p> <p>*Staff members C, D, E, F and G received the mandatory training as listed above including: incidents and diseases subject to mandatory reporting; dining assistance, nutritional risks, and hydration needs of residents; and care of residents with unique needs. JD/SDDH/MF</p>	
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