

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2014
NAME OF PROVIDER OR SUPPLIER CASTLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 209 N 16TH ST HOT SPRINGS, SD 57747	
(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: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/21/14 through 4/23/14. Castle Manor was found not in compliance with the following requirements: F176, F248, and F280.	F 000	<i>Addendums noted with an asterisk per 5/8/14 telephone to facility COO.</i> <i>KEKDDOH/ME</i>	
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: 23059 Based on observation, record review, interview, and policy review, the provider failed to ensure one of seven observed residents (12) during medication pass had been assessed for his capability to self-administer medications. Findings include: 1. Observation on 4/22/14 at 5:05 p.m. of unlicensed assistive personnel (UAP) B revealed she left two oral medications on resident 12's meal tray in his room. Interview with UAP B at that time revealed she always left medications with the resident to take on his own. She stated "He always takes them by himself." She then initialed the medication administration record indicating those medications had been administered to resident 12.	F 176	F176 On 5/8/14 a Coach and Counsel was given to Employee B regarding the medication administration policy and procedure. A medication administration audit will be completed by the DON with Employee B by 5/21/14. The nursing staff was reinserviced on 4/24/14 regarding the medication administration policy. The DON or designee will complete a random medication pass audit weekly x 4, and 1 x monthly for a quarter, reporting to the QA committee monthly for a quarter, quarterly x 3 with further follow up recommended by the committee. <i>* [redacted] KEKDDOH/ME</i> <i>* to include employee B and resident 12. KEKDDOH/ME</i> <i>* Resident 12 was assessed and deemed not capable of self administration of medications. KEKDDOH/ME</i>	<i>* 05/20/14 KEKDDOH/ME</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *John Miller* TITLE *Administrator* (X6) DATE *5/29/14*

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

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F 176	Continued From page 1 Review of resident 12's medical record revealed no assessment had been completed to determine it was safe for him to self-administer medications. There was no physician's order to allow him to self-administer medications. Interview on 4/23/14 at 8:35 a.m. with licensed practical nurse A revealed there was no assessment or order for self-administration of medication for resident 12. She stated those medications should not have been left with him to take on his own. Interview on 4/23/14 at 11:15 a.m. with the director of nursing revealed it was not an acceptable practice to leave medications at a resident's bedside. She stated they did not have a policy specific to self-administration of medications. Review of the provider's 2/7/12 Medication Administration policy revealed the person administering the medications was to have remained with the resident until all medications had been taken.	F 176			
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 23059	F 248	F248 A coach and counsel was completed by the DON for each Activity Staff member 5/8/14 educating them on the deficiency and future expectations to include:		

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F 248	Continued From page 2 Surveyor: 32333 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure: *An effective activities program had been maintained for all residents within the facility. *An effective one-to-one activities program had been maintained for 3 of 11 sampled residents (1, 3, and 10). Findings include: Surveyor 23059 1. Group interview on 4/22/14 at 2:00 p.m. with eight residents in attendance revealed the activities program had been "a problem for quite some time." It was group consensus that: *Activity staff did not always carry out posted activities. *The activities white board was not always updated on a daily basis. *Residents were not always notified if activities had been cancelled. *There were no evening activities other than an occasional movie. *There were extremely limited activities on weekends. Sometimes there were no activities at all. *They were promised Bingo prizes, but none had been obtained. *Activities staff were not always available for posted activities. *Bulletin boards had not been updated to reflect current holidays or events. The bulletin board on the first floor was currently decorated for St. Patrick's Day. *There were no activities specific for men. *The provider's bus had not been available for outings as it was in need of repair.	F 248	posting and updating the activities board daily, notifying residents of cancellations, reviewing the activity calendar events monthly, scheduling weekend activities, purchasing appropriate bingo prizes, following the activity calendar, keeping bulletin boards current, having a men's group monthly, having regular bus trips, having two evening activities per week, having a variety of weekend activities to include bingo, and having a minimum of 60 hours per week of activity hours. The Activity Coordinator or designee will complete activities assessments and care plans for residents 1, 3 and 10 with input from the resident, family members, and interdisciplinary team by 6/12/14. The Activities Director or designee will complete activities assessments and care plans with all residents and <i>*to include residents 1, 3, & 10</i> interdisciplinary team by <i>6/12/14</i> <i>KE/KDD/HMF</i> The Activities Director or designee will complete activities assessments and care plans quarterly at the interdisciplinary team meetings.	

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F 248	Continued From page 3 Surveyor 32333 2. Review of the March and April 2014 activity calendars revealed: *March 2014: -No activities after 3:00 p.m. had been offered except church services on Mondays. -On 3/6/14 and 3/27/14 the scheduled 3:00 p.m. group activity had been one-to-one activities. -Every Saturday bingo had been scheduled at 10:00 a.m. and at 1:30 p.m. was "Activities in the dining room." *April 2014: -No activities after 3:00 p.m. had been offered except church services on Mondays. -Fourteen times a television (TV) show in the dining room had been the 3:00 p.m. scheduled activity. -Every Saturday bingo had been scheduled at 10:00 a.m. and at 1:30 p.m. was "Activities in the dining room." Interview on 4/22/14 at 3:35 p.m. with the activities director revealed: *She confirmed no staff had shown up on Saturday 4/19/14 to hold that day's activities. *She worked forty hours per week, and she had an assistant that worked twenty hours per week. *There had been no men's groups or activities offered. *The bus window had been broken out in March and prior to that the lift on the bus had been broken. *The bus had been inoperable, and they were unable to take residents on group outings outside of the facility. *If a resident requested to go shopping she would cancel the rest of the activities for that day. *She currently had four residents on one-to-one	F 248	The nursing staff was inserviced on 4/24/14 and the General Staff will be inserviced on 6-5-14 regarding the activity assessment and care plan and the need for all staff to be listening for activities and assisting residents to attend any activity they may have an interest in. The OT Consultant will review the calendar monthly and make recommendations. The MDS coordinator or designee will complete an audit to ensure assessments are completed, care plans updated, and activities documented weekly x 1 for a month, monthly x 3, and quarterly x3. The DON will report results monthly for a quarter, quarterly x 3, and receive recommendations from the QA Committee. The COO or designee will do audits weekly x 1 for a month, monthly x 3, and quarterly x 3, to ensure the daily activities calendar is updated,	

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F 248	<p>Continued From page 4 activities including residents 1 and 10.</p> <p>Observation on 4/23/14 at 9:15 a.m. of the activities white board and the bulletin board outside of the dining room revealed the prior day's activities were still listed on the white board. It had not been updated to list the current day's activities. The bulletin board had St. Patrick's Day decorations from the previous month on it and had not been changed to reflect the resident birthdays for April 2014.</p> <p>Review of the March and April 2014 time cards for the activities director and the activity assistant revealed:</p> <ul style="list-style-type: none"> *The week of March 8 the total activities hours worked had been 57.5 hours. On Thursday March 3 activities staff had only worked for three hours. *The week of March 15 the total activities hours worked had been 53.75 hours. On Saturday March 15 no hours had been worked. *The week of March 22 the total activities hours worked had been 41.5 hours. Saturday March 22 had no hours worked. *The week of March 29 the total activities hours worked had been 56.5 hours. *The week of April 5 the total activities hours worked had been 44.75 hours. *Saturday April 12 had one hour worked. *The week of April 19 the total activities hours worked had been 46 hours. Saturday March 19 had no hours worked. <p>Interview on 4/23/14 at 1:15 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *A total of sixty hours per week had been allotted for activities staff to work. *Forty hours were allotted for the activities director and twenty hours for the activities 	F 248	<p>and will attend the monthly resident council meetings to ensure adequate input is received from the residents, monitor time cards bi-weekly for a quarter to ensure adequate budgeted hours are met, and report to the QA committee monthly for a quarter, quarterly x 3, then receiving recommendations from the committee for continued monitoring.</p> <p>X [REDACTED] KHSDDOHIME</p>	<p>X 04/23/14 KHSDDOHIME</p>

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F 248	<p>Continued From page 5 assistant. *She would have expected activities staff to show up for a scheduled activity. *She confirmed 3/15/14, 3/22/14, 4/19/14 no scheduled activities occurred. *The activities white board should have been updated daily. *The activities bulletin board should have been updated monthly. *She would have expected more activities offered than what was on the calender. *She would have expected an alternative activity during the scheduled 3:00 p.m. TV show.</p> <p>3. Review of resident 1's complete medical record revealed: *She had a diagnosis of senile dementia. *She was unable to plan her own activities.</p> <p>Review of resident 1's recreational therapy detail report revealed: *Several times group activities had been documented with "no participation" in February and March 2014. *Three times in February 2014 one-to-one activities had been documented. *Three times in March 2014 one-to-one activities had been documented.</p> <p>Review of resident 1's 3/14/14 activities quarterly/annual participation review quarterly assessment revealed: *Activity related focus remained appropriate on her current care plan. *The resident's activity goals were met. *Her activity interventions had been effective in reaching her goals.</p> <p>Review of resident 1's current undated care plan</p>	F 248			

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F 248	<p>Continued From page 6 revealed:</p> <ul style="list-style-type: none"> *No activity focus area. *No goals for activities. *An intervention for her focus area of communication problem to provide activities that accommodated her communication abilities and to provide one-to-one activities. <p>4. Review of resident 10's complete medical record revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 12/23/13. *She had been diagnosed with dysphagia (difficulty swallowing) and hemiplegia (paralysis) due to cerebrovascular disease. *She had difficulty communicating. *She was unable to plan her own activities. *She had one documented progress note of being taken to an activity in April 2014. <p>Review of resident 10's recreational therapy detail report revealed she had one, one-to-one activity and one group activity documented since her admission in December 2013.</p> <p>Review of resident 10's current undated care plan revealed no mention of activities.</p> <p>5. Interview on 4/23/14 at 1:15 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She would have expected residents 1 and 10 to have activities care planned. *She would expect residents requiring one-to-one activities to have been offered one-to-one activities at least three time per week and documentation to support that. 	F 248			

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F 248	Continued From page 7 Surveyor: 28057 6. Review of resident 3's medical record revealed an activities assessment had been completed on 10/25/13. That assessment had stated resident 3 had preferences for or had participated in one-to-one activities. It had also referred to an activity related focus for the resident's care plan. Review of resident 3's current care plan last revised on 2/19/14 revealed there had been no focus for activities included in her care plan. Activity interventions had been included to address her wandering, behavior symptoms, and falls. None of those interventions had addressed one-to-one activities. Review of resident 3's progress notes from 1/18/14 through 4/3/14 revealed the activity coordinator had completed three entries for that resident. On 1/18/14 she had left books on tape with the machine in the resident's room. She had checked on the resident later that day, and the resident had been listening to them. On 1/24/14 the activity coordinator stated the resident continued to enjoy books on tape and one-to-one activities. On 4/3/14 she had documented the resident had been happy after her haircut. There had been no other entries by the activity coordinator in the progress notes during that time frame. Review of the documentation of the recreational therapy detail reports for resident 3 revealed she had no documentation of activities on the following dates: *From 11/7/13 through 11/10/13, three days. *From 11/22/13 through 11/27/13, five days.	F 248			

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F 248	<p>Continued From page 8</p> <ul style="list-style-type: none"> *From 11/29/13 through 12/3/13, five days. *From 12/5/13 through 12/9/13, five days. *From 12/14/13 through 12/21/13, eight days. *From 2/15/14 through 2/27/14, thirteen days. *There had been no documented one-to-one activities for the above months. <p>Observations during the survey from 4/22/14 through 4/23/14 revealed resident 3:</p> <ul style="list-style-type: none"> *On 4/22/14 at 11:00 a.m. was seated in her wheelchair in the hallway. *She complained of hunger and was offered a cookie. *On 4/23/14 from 10:30 a.m. through 11:00 a.m. she had been in the dining room. *She had slept or watched as other residents participated in a ball toss activity. *She had not actively participated in that activity. *She frequently spent time in the hallway in her wheelchair dozing or watching others. <p>Surveyor: 32333</p> <p>7. Review of the activity director position description revealed:</p> <ul style="list-style-type: none"> **"The activity director ensures the coordination, development, implementation and evaluation of the therapeutic activity program for all residents." **"Assesses each resident's needs for specialized activities and normalization to maintain as normal lifestyle as possible." **"Develops and implements a care plan for each resident based on his/her assessed needs." <p>Review of the provider's revised 10/24/13 Activities Department policy revealed:</p> <ul style="list-style-type: none"> *The purpose of the activities department was to provide a program that would meet the physical, intellectual, social, spiritual, and emotional needs of the residents. 	F 248			

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F 248	Continued From page 9 *The activity director should have provided an activity care plan. *The activity director would coordinate outside trips for residents of a recreational nature. *Careplans should have had activity goals and plans for each resident. Surveyor: 28057 Interview on 4/23/14 at 1:35 p.m. with the director of nursing confirmed she had expected at least weekly documentation to have been completed by the activity coordinator. That documentation should have included the resident's involvement and needs related to activities.	F 248			
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 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.	F 280	F280 A coach and Counsel was completed by the DON with each of the activities staff on 5/8/14 educating them on the deficiency and future expectations. The Activity Coordinator or designee will complete activity assessments and update the care plans of residents 1,2,3, and 10 by 5/21/14 with the assistance from the resident, family members and the interdisciplinary team. The Activity Coordinator or designee will complete updated activity assessments and care plans on all residents with assistance from the interdisciplinary team. KEROCHIME	* 05/14/14 KEROCHIME	

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F 280	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to review and revise 4 of 11 sampled residents' (1, 2, 3, and 10) care plans to reflect their current activity status. Findings include:</p> <p>1. Review of resident 2's last revised 4/17/14 care plan revealed no focus area, goal, or interventions for activities. He had been admitted on 10/2/13. There had not been an activity care plan implemented at that time.</p> <p>Interview and observation on 4/23/14 at 9:00 a.m. with resident 2 while walking in the hallway and standing at the nurses desk on second floor revealed: *He enjoyed: -Putting mechanical things together. -Fishing. -Walking. -Movies. -Chess. -Reading, particularly educational and instructional manuals. Writing. *He stated he: -Sometimes watched movies in his room. -Walked in the halls. -Would like to walk other places in the building and go for a walk outside. -No one had offered to take him on walks outside or off the unit. -Went to some activities, but no one had asked him what he would like to do.</p>	F 280	<p>The Activity Coordinator or designee will complete activity assessments and update care plans quarterly on all residents with assistance from the interdisciplinary team. The MDS coordinator or designee will complete activities audits to ensure assessments and care plans are updated quarterly with any significant changes and activities are offered weekly. Audits will be completed weekly x 4 for a month, monthly x 3, quarterly x 3 and then per QA recommendations. The DON or designee will report result to the QA committee monthly x 3, quarterly x 3, and then per QA recommendations.*</p>	<p>x 04/23/14 KLS/SD/DMF</p> <p>KLS/SD/DMF</p>	

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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 280	<p>Continued From page 11</p> <p>Interview on 4/23/14 at 1:45 p.m. with the director of nurses (DON) confirmed resident 2 should have had an activites care plan.</p> <p>Surveyor: 28057</p> <p>2. Review of resident 3's last revised 2/19/14 care plan revealed no focus area, goal, or interventions for activities. She had been admitted on 5/13/13. There had not been an activity care plan implemented at that time.</p> <p>Observations during the survey from 4/22/14 through 4/23/14 revealed resident 3:</p> <p>*On 4/22/14 at 11:00 a.m. was seated in her wheelchair in the hallway.</p> <p>*She complained of hunger and was offered a cookie.</p> <p>*On 4/23/14 from 10:30 a.m. through 11:00 a.m. she had been in the dining room.</p> <p>*She had slept or watched as other residents participated in a ball toss activity.</p> <p>*She had not actively participated in that activity.</p> <p>*She frequently spent time in the hallway in her wheelchair dozing or watching others.</p> <p>Interview on 4/23/14 at 1:35 p.m. with the DON confirmed she had expected at least weekly documentation to have been completed by the activities coordinator. That documentation should have included the resident's involvement and needs related to activities.</p> <p>Surveyor: 32333</p> <p>3. Review of resident 1's complete medical record revealed:</p> <p>*She had a diagnosis of senile dementia.</p> <p>*She was unable to plan her own activities.</p> <p>Review of resident 1's 3/14/14 activities</p>	F 280			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2014
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F 280	<p>Continued From page 12</p> <p>quarterly/annual participation review quarterly assessment revealed: *Activity related focus remained appropriate on her current care plan. *The resident's activity goals had been met. *Her activity interventions had been effective in reaching her goals.</p> <p>Review of resident 1's current undated care plan revealed: *No focus area for activities. *No goals for activities. *An intervention for her focus area of a communication problem and to provide activities that accommodated the resident's communication abilities and to provide one-to-one activities.</p> <p>4. Review of resident 10's complete medical record revealed: *She had been admitted on 12/23/13. *She had been diagnosed with dysphagia (inability to speak) and hemiplegia (paralysis to one side) due to cerebrovascular disease (stroke). *She was unable to plan her own activities.</p> <p>Review of resident 10's current undated care plan revealed no mention of activities.</p> <p>5. Interview on 4/23/14 at 1:15 p.m. with the DON revealed she would have expected residents 1 and 10 to have activities care planned.</p> <p>Review of the provider's last revised 4/14/13 Care Planning policy revealed care plans were to have been individualized, comprehensive, and have included measurable objectives. Timetables to meet the resident's medical, nursing, mental, and psychological needs were to have been included.</p>	F 280			

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F 280	Continued From page 13 The care plans were to have: *Been built on resident's strengths and wishes. *Reflect the resident's wishes. *Aid in preventing or reducing declines in the resident's functional status or functional levels. *Included ongoing resident assessments and be revised as the resident changed.	F 280			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2014
NAME OF PROVIDER OR SUPPLIER CASTLE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 209 N 16TH ST HOT SPRINGS, SD 57747	
(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
K 000	INITIAL COMMENTS Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/23/14. Castle Manor 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 upon correction of deficiencies identified at K012 and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 6/10/14 telephone to facility administrator. CW/SDDH/MF	
K 012 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to meet the minimum construction standards of the 2000 Life Safety Code (LSC). The Type II (111) building had automatic sprinkler system hanger penetrations in the ceiling of the laundry room which provided the required structural member protection. Sixteen of twenty-two hangers were not sealed to maintain the fire resistive rating. Findings include: 1. Observation at 11:35 a.m. on 4/24/14 revealed the building was a three story, noncombustible,	K 012	K012 The holes in the laundry have been repaired. A monthly walk through will be done by the maintenance supervisor, COO, or designee to include checking for holes that may need sealing. The general staff will be inserviced 6-5-14 regarding the system for filing maintenance requests to enlist everyone's help with ongoing repairs to include holes in any surface that my need sealing. The COO or designee will report the results of the walk through to the QA Committee monthly for a quarter, quarterly, and receive recommendations by the committee. X [redacted] CW/SDDH/MF	X 06/10/14 CW/SDDH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *John Miller* TITLE: *Administrator* (X6) DATE: *5/20/14*

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

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NAME OF PROVIDER OR SUPPLIER CASTLE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 209 N 16TH ST HOT SPRINGS, SD 57747
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K 012	Continued From page 1 Type II (111) structure with a complete automatic sprinkler system. Holes had been drilled in the ceiling of the laundry room approximately two to three inches in diameter for the bolts of the hangers for the automatic sprinkler system. Sixteen of those holes in the ceiling had not been sealed around the bolts. Interview with the maintenance manager at the time of the observation confirmed that finding. He stated he was not aware those holes had not been sealed.	K 012		
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor 20031.</p> <p>Based on observation and interview, the provider failed to install permanent wiring for two of two randomly observed resident rooms (26 and 48). Power strips were found in-use for a nebulizer in resident room 26 and for two fans in resident room 48. Findings include:</p> <p>1. Observation from 9:30 a.m. to 11:35 a.m. on 4/24/14 revealed a power strip in-use for a nebulizer in resident room 26. Another power strip was found in-use for two fans in resident room 48. Interview with the maintenance manager at the time of the observations confirmed those conditions. He stated he and staff were aware power strips were not allowed for medical equipment and as an extension for temporary wiring.</p>	K 147	<p>K147 The medical equipment was plugged in to outlets approved for use. The power strips will continue to be monitored on a monthly walk through. The general staff will be reinserviced on 6-5-14 regarding the appropriate use of power strips. The COO or designee will report the results of the walk through to the QA Committee monthly for a quarter, quarterly, and receive recommendations by the committee.</p> <p><i>CKV/SDDC/HMF</i></p>	<p><i>* 04/24/14</i> <i>CKV/SDDC/HMF</i></p>

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10630	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2014
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S 000	<p>Initial Comments</p> <p>Surveyor: 28057 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/21/14 through 4/23/14. Castle Manor was found not in compliance with the following requirements: S210 and S236.</p>	S 000	<p>Addendums noted with an asterisk per 5/19/14 telephone to facility COO. <i>KG/SDOH/MP</i></p>	
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S 210	<p>44:04:04:06 EMPLOYEE HEALTH PROGRAM</p> <p>The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.</p> <p>This Rule is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy review, the provider failed to ensure one of two sampled dietary aides (C) had received a health assessment within fourteen days of his hire date. Findings include:</p>	S 210	<p>S210 Employee C had an employee health assessment completed on 4-23-14. The management team will be inserviced on the mandatory employee health assessment on 5-21-14 to ensure that all managers understand that prior to starting employment, new employees must have a health assessment. The office manager will do an audit on all new employee files to ensure a health assessment has been completed. The COO or designee will report to the QA Committee monthly for a quarter, quarterly, and receive recommendations by the committee. <i>X [redacted] KG/SDOH/MP</i></p>	<p><i>X 06/18/14 KG/SDOH/MP</i></p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *John Miller* TITLE: *Administrator*

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 210	<p>Continued From Page 1</p> <p>1. Review of dietary aide C's employee file revealed he had been hired on 3/29/14. No health assessment had been documented in his file.</p> <p>Interview on 4/23/14 at 11:40 a.m. with the dietary manager confirmed she had not been able to find a health evaluation for dietary aide C.</p> <p>Interview on 4/23/14 at 4:00 p.m. with the director of nursing confirmed she had just completed the health evaluation for dietary aide C. It had not been completed during the fourteen day window from his hire date on 3/29/14.</p> <p>Review of the provider's revised 4/15/13 Employee Health policy revealed an employee was to have completed a health information assessment prior to final hiring.</p>	S 210		
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S 236	<p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin</p>	S 236	<p>S236 A two step TB screening for dietary aide C has been completed. The management team will be inserviced on 5-21-14 regarding the mandatory TB screening that must be completed on all new employees. The office manager will do an audit on all new employee files to ensure a TB screening or appropriate documentation has been obtained. The COO or designee will report to the QA Committee monthly for a quarter, quarterly, and receive recommendations by the committee. X</p> <p><i>[Signature]</i></p>	
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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 236	Continued From Page 2 test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Rule is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy review, the provider failed to ensure one of two sampled dietary aides (C) had received a two-step tuberculin (TB) screening within fourteen days of his hire date. Findings include: 1. Review of dietary aide C's employee file revealed he had been hired on 3/29/14. No two-step TB screening had been documented in his file. Interview on 4/23/14 at 11:40 a.m. with the dietary manager confirmed she had not been able to find a two-step TB screening for dietary aide C. She had spoken to him, and he had a two-step TB screening done in the last year at his last place of employment. She confirmed she had no documented record of that screening in his employee record. Interview on 4/23/14 at 3:55 p.m. with the dietary manager confirmed she had requested and just received a copy of dietary aide C's two-step TB screening from his previous employer by facsimile. Review of the provider's revised 4/15/13 Employee Health policy revealed an employee was to have completed a two-step tuberculin TB screening within fourteen days of employment. It had also stated any two documented two-step TB screening completed within a twelve month period prior to employment would be considered adequate. It had not addressed that	S 236		

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S 236	Continued From Page 3 documentation had been required of a prior two-step TB screening.	S 236			