

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10638</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/26/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKE ANDES HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>740 EAST LAKE STREET, PO BOX 130 LAKE ANDES, SD 57356</b>
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S 000	<p>Initial Comments</p> <p>Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/24/14 through 3/26/14. Lake Andes Health Care Center was found in compliance.</p>	S 000		

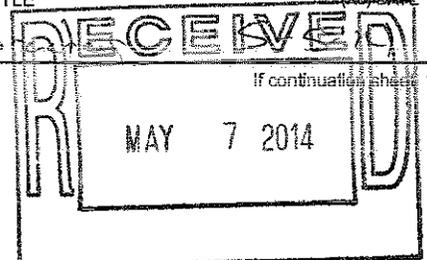
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*[Signature]*

Executive Director



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/26/2014</b>
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F 000	INITIAL COMMENTS  Surveyor: 12218	F 000		
F 323 SS=E	<p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/24/14 through 3/26/14. Lakes Andes Health Care Center was found not in compliance with the following requirements: F323, F371, and F441.</p> <p><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to have a program in place to supervise ten of ten residents (7, 11, 12, 13, 14, 15, 16, 17, 18, and 19) receiving active range of motion exercises in one of one restorative room. Findings include:</p> <p>1. Observation on 3/26/14 at 8:10 a.m. of resident 12 on the NuStep exercise bike in the restorative room revealed there had been no staff person present to supervise the exercise activity. Interview with resident 12 at that time revealed: *She stated "I do the exercises myself, I do it all myself."</p>	<p><i>Addendums noted with an asterisk per. 5/15/14 telephone to facility DON.</i> <i>MJH/SDOH/MF</i></p> <p><b>F323</b></p> <p><b>1. Residents 7, 11, 12, 13, 14, 15, 16, 17, 18 and 19 have been removed from the active restorative program. All were assessed by the DNS. MJH/SDOH/MF</b></p> <p><b>2. Individual residents will continue to be assessed by the DNS prior to use of equipment for safe and independent use for exercise, with a change of condition and quarterly. Care plans will be reviewed and revised by the DNS. MJH/SDOH/MF</b></p> <p><b>3. Clinical staff will be re-educated to this process by the DNS on April 21, 2014.</b></p> <p><b>4. DNS and/or her designee will monitor independent resident use of exercise equipment three times per week for 2 months and then</b></p>	May 9, 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ben ...</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>April 23 2014</i>
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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 75 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.

**DISCLOSED**  
**APR 24 2014**

If continuation sheet Page 1 of 9  
**SD DOH L&C**

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F 323	<p>Continued From page 1</p> <p>*She put herself on the exercise bike. *She transferred herself off the bike when she was done.</p> <p>Random observations from 3/24/14 through 3/26/14 revealed there was not a staff person who was stationed in the restorative room. There was no staff monitoring the exercise and safety of residents that were exercising in there.</p> <p>Review of the provider's personnel list revealed the director of nursing (DON) was also the restorative nurse. Review of the provider's 3/26/14 daily staff assignment sheet revealed a restorative staff member had not been assigned to supervise the exercise activity.</p> <p>Review of the individual March 2014 restorative records for residents 7, 11, 12, 13, 14, 15, 16, 17, 18, and 19 revealed staff members had documented the number of minutes each resident had exercised and signed each record.</p> <p>Interview on 3/26/14 at 2:00 p.m. with the DON revealed: *There had been no restorative aide since September 2013 due to staff cuts. *The residents performed the active range of motion exercises (including the exercise bicycle and wall pulleys) themselves in the therapy room. *The restorative responsibilities had been given to the certified nurse aides (CNA). *The CNA would instruct each resident when it was time to do their exercises. *The resident would go to the restorative room and perform exercises on their own. *Only one resident received assistance on and off the the exercise equipment. *Resident 14 exercised during the night. He</p>	F 323	<p><b>weekly thereafter. DNS and/or her designee will audit three residents records for completed assessments and care plan updates for independent use of exercise equipment three times per week for two months and then one resident weekly thereafter. DNS and/or her designee will report the data to the quarterly Quality Improvement Committee for review and further recommendations.</b></p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 2 would leave a note on the DON's door informing her how long he had exercised. *The CNAs were unable to remain in the room to supervise the resident exercising because they had duties on the floor.	F 323		
F 371 SS=E	Review of the provider's undated Restorative Nursing Care Policy and Procedures had no mention of staff supervision or resident safety. 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: 12218 Based on observation, interview, and policy review the provider failed to develop a system for monitoring: *Who was responsible for checking temperatures in two of two resident supply refrigerators and three of four individual resident (2, 4, 15, and 22) room refrigerators. *When and how often refrigerator temperatures for the above were checked and documented by the designated staff member. Findings include:	F 371	<b>F371</b>  <b>1. Facility guidance was reviewed/revised for system changes regarding monitoring daily temperatures of resident use refrigerators, individual resident refrigerator temperatures and cleaning of refrigerators. Designated staff position responsible is assigned. Resident use refrigerators will have daily temperature checks documented on the individual temperature log for that refrigerator including cleaning daily by</b>	May 9, 2014

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F 371	<p>Continued From page 3</p> <p>1. Observation on 3/25/14 at 12:25 p.m. of the resident food supply refrigerators in the Haven dining room and in the beauty shop room revealed: *Undated food items and beverages. *No temperture log record at either refrigerator.</p> <p>Interview and observation on 3/25/14 at 2:00 p.m. with the certified dietary manager regarding the above two resident supply refrigerators revealed: *Only juice and milk was supplied by dietary to the Haven refrigerator. *After the secured unit had been discontinued she had not stored any supplies other than milk and juice in that refrigerator. *She did not think she was responsible for checking or cleaning that refrigerator. *She did not know where the temperature log was kept or if one had been maintained. *She supplied the refrigerator kept in the beauty shop room with the morning, afternoon, and evening snack trays. Those snack trays were supposed to have been labeled with the date and nouishment time.</p> <p>2. Observation throughout the survey from 3/24/14 to 3/26/14 of the small refrigerators in four resident (2, 4, 15, and 22) rooms revealed there were no temperature logs on any of those refrigerators.</p> <p>Interview with the director of nursing (DON) at 1:30 p.m. on 3/26/14 revealed the activity director was supposed to have been checking the resident's refrigerators. She stated one resident kept her own daily refigerator temperature log.</p> <p>Interview at that time with resident 22 revealed she had kept a daily log and showed it to the</p>	F 371	<p><b>the Dietary Manager or her designee.</b></p> <p><b>2. Individual resident refrigerators located in resident rooms will have daily temperature checks documented on the individual temperature log for that refrigerator including daily cleaning by the Charge Nurse. Logs will include checking for dating and rotating of food/liquid items as needed. DNS and Administrator will train staff to the updated guidance and system changes on April 21, 2014. Administrator and/or his designee will audit all refrigerators both personal and supply three times per week for two months for cleanliness, documented temperatures and</b></p>	

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F 371	Continued From page 4 surveyor. The DON found seven pages of her temperature logs. She also found four other pages of "resident Fridge temperature" logs. There was no identification on those sheets as to whom the refrigerator or refrigerators belonged.  Interview with the activity director at 1:50 p.m. on 3/26/14 revealed she did not know she was supposed to have checked refrigerator temperatures daily and kept a record. She had not been doing that.  Review of the provider's November 2006 policy/procedure for cleaning/tempering resident fridges revealed: **"Tempting of fridges:" -"Temperature sheet will be put out on each fridge by Activity personel each month." -"Temperatures of each fridge will be documented daily on sheet by activity personel. Temperature will be at 38 - 41 degrees Fahrenheit or will be adjusted as needed." -"Independent residents will be allowed to document their own on sheet if, they would like." -"Maintenance supervisor will be notified if problems occur with the fridge." -"Temperature sheets that are removed will be brought to dietary manager when removed." **"Cleaning fridges:" -"Activity personel will wipe out fridge as needed when documenting temps." -"Activity personel will check for dates on food and get rid of any out dated items when doing temps." -"Housekeeping will clean fridges every month along with room sanitation."	F 371	<b>labeled/dated food/liquid items and then weekly thereafter. Administrator and/or his designee will report the data to the quarterly Quality Improvement Committee for review and further recommendations.</b>	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441	<b>F441</b>  <b>1. Disinfection of the whirlpool procedures were reviewed/revised for compliance with manufacturer recommendations and</b>	

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F 441 SS=E	Continued From page 5 <b>SPREAD, LINENS</b>  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. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	<b>procedures. On 3/25/2014 all bath aides were re-educated to manufacturer recommendations and procedures for disinfection of the whirlpool tub. All clinical staff and maintenance staff will be re-educated to the whirlpool disinfection procedures and manufacturer recommendations and procedure on April 21, 2014. DNS and/or her designee will monitor three staff three times per week for proper disinfection of the whirlpool tub for two months and then weekly thereafter. The data will be presented to the quarterly Quality Improvement Committee for review and further direction.</b>	May 9, 2014

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F 441	Continued From page 6  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to: *Follow the manufacturer's recommendation for disinfection of one of one whirlpool bathing tub. *Ensure aseptic (clean) technique was used for two of three residents (20 and 21) receiving dressing changes by one of one nurse performing dressing changes. *Ensure clean resident use supplies were stored in a sanitary environment. *Maintain proper storage for resident's personal care supplies for all residents receiving baths. Findings include:  1. Observation on 3/25/14 at 11:00 a.m. of CNA B disinfecting a whirlpool tub revealed she: *Turned the tub selector to fill the jets with the pre-cleaner. She stated she allowed it to remain on for "a couple minutes." *Then turned the switch to apply the disinfectant. *Brushed the tub down with a scrub brush. *Stated she allowed the disinfectant to remain in the tub "a minute or so" before she rinsed the tub with water.  Review of the provider's Apollo Air Spa Bath Disinfecting Process located on the side of the tub revealed the disinfectant solution was to remain on the tub surface and chair for ten minutes for proper disinfection.  2. Observation on 3/26/14 at 2:35 p.m. of a dressing change for resident 20 revealed RN A: *Placed the resident's dressing supplies including scissors, tape, and gauze on a quilt resting on the	F 441	<b>2. Nurse was observed placing resident dressing supplies identified on the arm of the recliner with no clean barrier under the supplies. The identified nurse was re-educated by the DNS on 3-26 regarding proper clean wound care and infection control procedures. All nurses will be educated on proper wound care procedures on April 21, 2014. The DNS and/or her designee will monitor two nurses weekly for clean wound dressing and infection control procedures for two months and then one nurse weekly thereafter. The data will be presented to the quarterly Quality Improvement Committee for review and further direction.</b>  <b>3. Soiled utility room across from the nurse's station</b>		

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F 441	<p>Continued From page 7</p> <p>arm of her recliner. *Had not placed a clean barrier under the supplies. *Then used the supplies to dress the wound.</p> <p>Observation on 3/26/14 at 3:30 p.m. of a dressing change for resident 21 revealed RN A: *Placed the bandage scissors on the footrest of her recliner. *Removed the gauze dressing from the package and placed it directly on the resident's bedside table. *Then placed the gauze dressing on the wound site. *Used the scissors to cut tape to apply to the wound. There had been no clean barrier between the supplies and the furniture.</p> <p>Review of the provider's undated Clean Wound Care Policy and Procedure revealed the nurse was to gather and set-up supplies in the resident's care area, and establish a clean field using either linen or plastic.</p> <p>3. Observation on 3/26/14 of the soiled utility room across from the nurses' station revealed the following nursing supplies were in the room including: *Oxygen tanks. *Oxygen concentrators. *Suction machines. *Nebulizer machines. *Suction tubing. *Oxygen tubing. *Clean urine collection hats. *Clean bath basins. *Two gallons of distilled water stored under the sink that was to have been used with oxygen</p>	F 441	<p>revealed clean nursing supplies stored in soiled utility room which also contained a soiled laundry chute. All clean items identified were removed from the soiled utility room on April 21, 2014 and placed in a new clean storage room. All staff will be in serviced on the proper storage on soiled and clean items in the proper utility room on April 21, 2014. Soiled utility rooms will only be used for soiled items and clean utility room will only be used for clean items. The ED will monitor compliance with the clean * or designee MCH/BDW/ME and soiled utility room for proper storage two time per day three times per week for two months and then two times per week there after. The data will be</p>	

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F 441	<p>Continued From page 8 equipment. That soiled utility room also contained a soiled laundry chute.</p> <p>4. Observation on 3/26/14 of the medication room revealed residents' personal care supplies were being stored under the sink that included: *Hair conditioner. *Razors. *Mouthwash. *Deodorant. *Two gallons of distilled water.</p> <p>5. Interview on 3/26/14 at 11:00 a.m. with the director of nursing revealed: *Her expectation would have been the disinfectant would have remained on the whirlpool tub for at least ten minutes. *Her expectation would have been for dressing supplies to have been placed on a barrier to prevent cross-contamination. *She agreed clean supplies should not have been stored in a soiled utility room. *She agreed resident's personal care items should not have been stored under the sinks.</p>	F 441	<p><b>presented to the quarterly Quality Improvement committee for review and further direction* by the DNS. MJH/SDD/HMF</b></p> <p><b>4. Medication Room revealed residents personal supplies. Items identified in the medication room were immediately removed and have been placed in the clean storage room. The distilled water was also immediately disposed of. No personal items will be stored in the medication room and all nurses have been educated on the proper storage of resident personal items on April 21, 2014. The data will be presented to the quarterly Quality Improvement Committee for review and further direction* by the DNS. MJH/SDD/HMF</b></p>	

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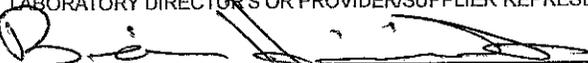
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/25/14. Lake Andes Health Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/25/14 upon correction of the deficiency identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K038 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p><b>K020</b></p> <p><b>2. The identified laundry chute door will be removed and replaced with a new UL fire resistive assembly door with a 1 ½ fire resistive ability. The UL fire resistive rated chute door is currently on order and will be installed upon arrival.</b></p> <p><b>3. Administrator will monitor for completion and compliance with standards. Data will be presented to the quarterly Quality Improvement Committee for review and further direction</b></p>	May 9, 2014
K 020 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to ensure two of two vertical openings (stair enclosure and laundry chute)</p>	K 020		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Executive Director</b>	(X6) DATE <b>5-8-2014</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435097</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/25/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKE ANDES HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 020	Continued From page 1 were protected with one hour fire resistive construction. Findings include:  1. Review of the previous survey report revealed the stair enclosure walls were constructed with gypsum board sheathing only on the corridor side of the stair enclosure above the lay-in ceiling on the ground floor. Interview at 11:30 a.m. on 3/25/14 with the maintenance supervisor revealed that condition still existed. This deficiency affected one smoke compartments.  2. Review of the previous survey report revealed the laundry chute door did not contain a label identifying the chute door was a 60 minute fire resistive assembly. Interview at 11:30 a.m. on 3/25/14 with the maintenance supervisor revealed that condition still existed. This deficiency affected one smoke compartments.	K 020			
K 038 SS=E	The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to install a paved path of exit discharge to	K 038	<b>K038</b>  <b>1. Bids have been obtained and contractors are approved for completion of identified paved paths required within 30 days pending weather and temperature.</b>  <b>2. Administrator will monitor for completion and compliance with standards. Administrator Data will be presented to the quarterly Quality Improvement Committee for review and further direction.</b>	May 9, 2014	

