

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702	
(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: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/25/14 through 2/26/14. Clarkson Health Care was found not in compliance with the following requirements: F241, F281, F371, F441, and F514.	F 000	Clarkson Health Care operates in a capacity ensuring quality of care and service to our residents. The facility adheres to the state and federal guidelines by staying within regulatory compliance under the direction in which we are licensed.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and admission packet review, the provider failed to ensure dignity had been maintained for: *Seven of seven diabetic residents (4, 9, 14, 15, 16, 17, and 18) who had their names posted in two of two tub rooms (Oak and Elm) and one of one shower room (Maple/Aspen). *One of twelve sampled residents (9) who had not had daily grooming as requested by the resident and resident's family. Findings include: 1. Random observations on 2/25/14 and 2/26/14 of the Maple/Aspen shower room, Oak tub room, and Elm tub room revealed: *A sign that stated "diabetic residents do not trim nails" and underneath a list of the residents' first	F 241	Items listed in this report have a coinciding correction listed in the right hand column. 1. Signage was updated in 2/2 whirlpool areas, and 1/1 shower area to indicate that nursing staff are to provide nail care for indicated room numbers, with no mention of a specific diagnosis, posted on 2/26/14. Staff in service by Director Nursing on 3/18/2014 provided to all departments to address survey findings, and outline what constitutes dignity and respect. All bathing areas will be monitored weekly x 8 wks by the DON/designee for appropriateness/confidentiality of resident information posted. Results will be reported to QA by DON/designee.	3-18-14

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

TITLE

(X6) DATE

[Signature] Director of Operations 4/16/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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.

NOTED
APR 17 2014
If continuation sheet Page 1 of 17
SD DOH L&C

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F 241	Continued From page 1 and last names including residents 4, 9, 14, 15, 16, 17, and 18 (photo 1). *The signs were visible to any resident who had used the shower room or the tub rooms. Interview and walk-through on 2/26/14 at 11:15 a.m. with the administrator and director of nursing revealed they agreed the signs had private information including a medical diagnosis. The residents' first and last names were readable by other residents. Review of the provider's December 2008 Summary of our Notice of Privacy Practices in the resident admission packet revealed "We understand that health information about you and your health care is personal. We are committed to protecting health information about you...We are required by law to make sure health information that identifies you is kept private." 2. Interview on 2/26/14 at 4:25 p.m. with resident 9 and his daughter revealed: *He would like to have been shaved every day. *He had shaved everyday when he had lived at home. *Sometimes he had not been shaved for three to four days. *The resident's daughter stated she had asked staff multiple times over the last two years to shave her father daily. Interview on 2/26/14 at 5:00 p.m. with the director of nursing revealed she would have expected staff to have shaved resident 9 daily.	F 241	2. Noted that Resident 9 had days where he refused to be shaved and we would not force a resident to be shaved against their wishes. No one is aware of any residents not being shaved for an extended period of time. Staff are well aware of the daughter's expectations and will continue to work with the resident and daughter on preferred personal hygiene for this particular resident. The care plan has been updated to reflect this resident being shaved as he wishes. Resident 9 will be monitored weekly x 8 wks by DON/designee for hygiene completion and findings will be reported to QA by DON/designee. Staff education provided by DON on 3/18/14 regarding daily personal hygiene expectations.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 2</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy review, the provider failed to follow facility protocol for skin assessment and skin care for one of two residents (8) with an identified pressure ulcer. Findings include:</p> <p>1. Review of resident 8's complete medical record revealed: *She had been admitted from the hospital on 1/15/14. *Her 1/15/14 nursing admission history and physical revealed no pressure ulcers. *On 1/16/14 there was an interdisciplinary (IDT) note that stated "Aide called this nurse into Elm shower room, to check right hallux (great toe), applied meripex (mepilex) (dressing) for comfort for resident, also skin tear to left fa (forearm), dried skin was clipped off and band aid placed over dried wound." *Their had been no skin assessment and no documentation of physician notification. *On 1/18/14 there was an IDT note that said upon assessment an old dressing was noted to the right heel with no date or signature. *A skin assessment was then completed, and the physician was notified on that date.</p> <p>Interview on 2/26/14 at 5:00 p.m. with the director of nursing revealed she would have expected the facility skin care/pressure ulcer policy to have been followed.</p>	F 281	<p>1. Residents are identified on an ongoing basis for potential skin breakdown and are assessed as indicated by the nursing staff.</p> <p>Resident 8's right heel deep tissue injury shows significant healing. Note that full body skin assessment was done upon admission. Nurse who failed to follow the entire wound care protocol was educated and entire protocol was completed on 1/18/14.</p> <p>Skin practices reviewed with nursing staff during in service on 3/18/2014 by the Director of Nursing.</p> <p>Audits will be completed weekly by DON/designee x 8 wks to ensure complete documentation of all active skin conditions and findings will be reported to QA by DON/designee.</p>	3-18-14

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F 281	Continued From page 3 Review of the provider's 10/29/12 Skin Care/Pressure Ulcer policy revealed: *All residents would have a full-body skin assessment upon admission/readmission to the facility with findings documented in the resident's chart. *Resident's family and physician were to have been notified of changes in the resident's skin integrity as needed. *The nurse discovering the skin condition would seek an appropriate treatment order when notifying the physician.	F 281			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to maintain the kitchen in a sanitary manner for the following: *Two of three air gaps (under the dishwasher and the ice machine) had been improperly maintained. *Three of four sides of the deep fat fryer were sticky and debris was present. *One of one sugar bin and and one of one flour	F 371	In-service held on 3/19/2014 by the Director of Dining to educate staff on corrections and updated cleaning schedules. Audits being performed by Director of Dining or designee weekly for completion of tasks for 12 weeks, then monthly x 3 months. - Cleaniness of fryer, flour and sugar bins, ceiling vents, integrity of surfaces, and the completion of the dietary cleaning schedules.	3-19-14	

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F 371	<p>Continued From page 4</p> <p>bin were sticky when touched.</p> <p>*Two of two ceiling vents over the food preparation (prep) area had one fourth inch wisps of debris on them.</p> <p>*One of one refrigerator in the food prep area had wire shelving with the protective coating missing on the ends of each of the shelves creating an uncleanable surface.</p> <p>*One of one refrigerator in the nourishment prep area had a bungee cord holding the juices in the door.</p> <p>*One of one cupboard that held pots had the finish scraped off two of two shelves creating an uncleanable surface.</p> <p>*Two of two cupboard units in the dry dish area had bare wood exposed creating an uncleanable surface.</p> <p>Findings include:</p> <p>1. Observation from 2/25/14 at 8:00 a.m. through 2/26/14 at 10:00 a.m. revealed the following areas in the kitchen had not been maintained in a sanitary manner:</p> <p>a. The air gap under the dishwasher did not have a one inch gap from the drain hole. The air gap under the ice machine had debris present around the area.</p> <p>b. The sides of the deep fat fryer were sticky, and debris was able to be scraped off the sides.</p> <p>c. Sugar and flour bins had debris on the sides and top edges and were sticky to touch.</p> <p>d. In the food prep area the ceiling vents had visible debris hanging from them. There were one-fourth inch wisps of lint and grease hanging from most of the surfaces of those vents.</p> <p>e. The refrigerator in the food prep area had wire shelving with the protective coating missing, making them uncleanable surfaces.</p> <p>f. The refrigerator in the nourishment prep area</p>	F 371	<p>a. The air gap under the dishwasher has been scrubbed and debris has been removed. A one inch gap is now present to ensure compliance with proper draining and eliminating the possibility of back flow. The air gap under the ice machine has been cleaned of debris. "Clean all drain elements and surrounding floor" has been added to the 1:00 daily aide checklist. The current dishwasher is already equipped which an additional air gap to prevent back flow.</p> <p>b. Deep fryer has been thoroughly cleaned and inspected for proper sanitation. "Clean the outside surface of the grill and fryer" has been placed on the AM Cook Daily checklist.</p> <p>c. Sugar and flower bins have been thoroughly cleaned and inspected for proper sanitation. "Counter and sink in cook area cleaned including flour and sugar containers" is currently on the PM cook daily checklist</p>	

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F 371	<p>Continued From page 5</p> <p>had a bungee cord holding juices in the door. That cord created an uncleanable surface.</p> <p>g. The cupboard that pots were stored in had shelves with the finish scraped off them making them uncleanable.</p> <p>h. The cupboards in the dry dish area had: *The finish coming off exposing bare wood and making uncleanable surfaces. *Under the handwashing sink there were two doors with the wood separating, exposing the layers of wood, and making it an uncleanable surface.</p> <p>Observation and interview on 2/26/14 from 10:30 a.m. through 10:50 a.m. with the administrator and dining supervisor (DS) confirmed the above findings were not appropriate. The DS stated they had verbally told the maintenance supervisor (MS) what needed to be done and he wrote it down on a legal pad. She stated she would have the MS repair items that week.</p> <p>Review of the provider's 2000 General Sanitation of Kitchen policy revealed: **"Cleaning and sanitation tasks for the kitchen will be recorded." **"Tasks will be assigned to be the responsibility of specific positions." **"Tasks will be addressed as to frequency of cleaning." **"A cleaning schedule will be posted and employees will initial and date tasks when completed."</p> <p>Review of the provider's Cleaning Schedule revealed: *The AM Cook and PM Cook daily check list stated "Clean all other equipment used." *No mention when to clean the bins for flour and</p>	F 371	<p>d. All ceiling vents have been thoroughly cleaned and inspected for proper sanitation. "Clean ceiling vents in kitchen" has been added to the monthly preventative maintenance activities on 3/20/14.</p> <p>e. The wire shelving in the refrigerator was replaced with new shelving on 3/25/14.</p> <p>f. Bungee cord was removed. Proper shelf guard was ordered and installed on 3/20/14</p> <p>g. The cupboard holding the pots was removed from operation on 3/20/14 and replaced with a wire storage rack that meets acceptable sanitation standards.</p> <p>h. The entire wood cabinet set was removed and replaced with a metal work table and shelving system on 3/20/14.</p> <p>Audits will be discontinued when monthly audits show 100% compliance x 3 months. Audit findings will be reported to QA by DOO or designee.</p>	

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F 371	Continued From page 6 sugar. *No mention when to clean the ceiling vents.	F 371		
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. (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	F 441		

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F 441	<p>Continued From page 7 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and procedure review, the provider failed to ensure: *One of two tub room (Elm) whirlpool tubs had been disinfected properly by one of two observed certified nursing assistants (CNA) (A). *Multiple resident use items had been stored in a sanitary manner in two of two tub rooms (Elm and Oak) and one of one shower room (Aspen/Maple). *Chemicals were stored away from clean resident towels and had remained locked up in one of one shower room (Aspen/Maple). *Nail clippers had been cleaned after use and stored properly in two of two tub rooms (Elm and Oak) and one of one shower room (Aspen/Maple). *Hair curlers had been cleaned and stored appropriately in the beauty shop. Findings include:</p> <p>1. Observation and interview on 2/25/14 at 10:15 a.m. in the Elm tub room with CNA A while she cleaned the whirlpool tub revealed: *She sprayed the tub and tub chair with Mastercare disinfectant. *She had not sprayed the head rest of the tub chair. *She said the disinfectant had to remain wet on the surface for about five minutes. *She removed the soiled towels from the room and said she was done.</p>	F 441	<p>1. Tub cleaning process outlined with appropriate staff during in service held by the Director of Nursing on 3/18/2014. Audits are being done weekly by Director of Nursing or designee until findings are reviewed at QA for completion by DON/designee. Audits will be completed weekly x 12 weeks. Then monthly x 3 months. Audits will be discontinued when 100% compliance is obtained x 3 months.</p>	3-25-14	

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F 441	<p>Continued From page 8</p> <p>*She had not rinsed the disinfectant off after letting it sit on the tub.</p> <p>Review of the Mastercare disinfectant cleaner label revealed "Allow surface to remain wet for ten minutes for disinfection."</p> <p>Review of the provider's Whirlpool cleaning procedure revealed: **Spray all inside surfaces of the tub, chair and the pads and scrub with brush. *All surfaces must remain wet for ten minutes to ensure disinfection so it may require respraying with disinfectant wand. *Use the shower wand to thoroughly rinse all areas that were in contact with the disinfectant."</p> <p>2. Random observations on 2/25/14 and 2/26/14 of the Elm and Oak tub rooms revealed: *The Elm tub room had a storage basket with multiple dirty resident nail clippers and nail clippings in it (photo 2). *The Oak tub room had a plastic storage container with multiple items including gloves, dirty nail clippers, and tape together in it (photo 3).</p> <p>3. Random observations on 2/25/14 and 2/26/14 of the Maple/Aspen shower room revealed: *A plastic three drawer storage container. -The top drawer contained multiple resident use items that included a comb and pick with hair in them, lotions, deoderant, a razor, dirty nail clippers, nail clippings, and a clean incontinent brief (photo 4). -The middle drawer contained a brush and comb with hair in them, a hair dryer, and nail clippings on the bottom of the drawer (photo 5). -The bottom drawer contained three brushes</p>	F 441	<p>2. Multiple resident use items, specifically nail clippers, will be cleaned according to the process covered during an in service by the Director of Nursing on 3/18/2014.</p> <p>3. Single resident use items, such as lotion and deodorant will be kept in residents rooms and taken to bathing areas for use during that time.</p> <ul style="list-style-type: none"> • Chemical storage corrected to avoid storage near clean linens. Chemical are placed in a closed cabinet separate from clean linens as of 3/25/14. • Plastic storage containers have been removed from bathing areas as of 3/25/14. <p>Continue to next page</p>		

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F 441	Continued From page 9 used for the cleaning of the shower room (photo 6). *Above the plastic container was a towel bar with clean towels and two bottles of cleaner (Quat disinfectant and Zephair air and fabric refresher) (photo 7). *On 2/25/14 the shower room door had been opened from 8:00 a.m. through 10:00 a.m. leaving the chemicals in an unlocked area. *On 2/26/14 at 10:45 a.m. the shower room door had been opened leaving the chemicals in an unlocked area. 4. Observation and interview on 2/25/14 at 10:10 a.m. with the hair stylist revealed: *A basket of hair curlers stored with hair stuck onto them (photo 8). *She stated every so often she would take the curlers out and clean them. She did not clean them after each resident because if she did "I would never get anything done." Interview and walk-through on 2/26/14 at 11:15 a.m. with the administrator and director of nursing revealed: *They would have expected the whirlpool tub to have been cleaned per facility cleaning procedure. *Nail clippers and hair curlers should have been cleaned after each resident use. *The Maple/Aspen shower room door should have remained locked at all times.	F 441	<ul style="list-style-type: none"> Bathing areas are being audited weekly by Director of Nursing or designee until findings are reviewed at QA for completion. Items being audited include whether door is locked, appropriate chemical storage, multi resident use items clean, single resident use items removed when not in use, and staff able to verbalize appropriate cleaning process. Audits will be done weekly x 12 weeks, monthly x 3 months and will be discontinued when 100% compliance is met x 3 months. Audit findings reported to QA by DON/designee. <p>4. The hair curlers mentioned have been taken out of service and were replaced with smooth plastic curlers on 3/20/14. Hair curlers will be cleaned after each resident use. Hair stylist has been educated by DOO on proper sanitation of hair curlers. Director of Operations or designee to audit weekly for 1 month on proper cleaning of hair curlers.</p>		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514			

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F 514	<p>Continued From page 10</p> <p>standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy review, the provider failed to ensure: *The appropriate documentation of the reason for having been given, use of pain scale, and effectiveness of as needed (PRN) medications that had been administered to 11 of 12 sampled residents (1, 2, 3, 4, 5, 7, 8, 9, 10, 11, and 12). *The appropriate documentation of activities for 1 of 12 sampled residents (12). Findings include:</p> <p>1. Review of resident 1's December 2013, January 2014, and February 2014 medication administration records (MAR) revealed: *December 2013: -PRN medication had been given thirty-nine times with no documentation of the effectiveness. -Twenty-nine times no reason had been documented why the medication had been given. *January 2014: -PRN medication had been given twenty-two times with no documentation of the effectiveness. -Fourteen times no reason had been documented why the medication had been given.</p>	F 514	<p>PRN medication use and documentation and process evaluated with nursing staff, consultant pharmacist, medical director, and IT staff.</p> <p>1. Staff education completed on PRN medication documentation by Director of Nursing during an in service on 3/18/2014. Weekly audits are being conducted by Director of Nursing or designee to determine compliance with charting complete dose information, indication for giving medication, and follow up. Audit findings will be reported to QA for completion.</p>	3-24-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702	
(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 514	<p>Continued From page 11</p> <p>*February 2014: -PRN medication had been given twenty-two times with no documentation of the effectiveness. -Three times no reason had been documented why the medication had been given.</p> <p>2. Review of resident 8's January 2014 and February 2014 MARs revealed: *January 2014: -PRN medication had been given nine times with no documentation of the effectiveness. -Five times no reason had been documented why the medication had been given. *February 2014: -PRN medication had been given two times with no documentation of the effectiveness. -Two times no reason had been documented why the medication had been given.</p> <p>3. Review of resident 9's January and February 2014 MARs revealed: *January 2014: -PRN medication had been given one time with no documentation of the effectiveness. -The only reason documented for giving the medication was per resident's request. *February 2014: -PRN medication had been given two times with no documentation of the effectiveness. -One time no reason had been documented why the medication had been given.</p> <p>4. Review of resident 11's February 2014 MAR revealed: *PRN medication had been given four times with no documentation of the effectiveness. *Two times no reason had been documented why the medication had been given.</p>	F 514	<p>Audits process will include all residents in facility @ time of audit, including residents specifically mentioned in this report.</p> <p>Audits will be done weekly x 12 weeks, monthly x 3 months and will be discontinued when 100% compliance is met x3 months. Findings will be reported by DON or designee to QA committee.</p>	

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702		
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F 514	<p>Continued From page 12</p> <p>Surveyor: 23059</p> <p>5. Review of resident 2's December 2013, January 2014, and February 2014 MARs revealed:</p> <p>*December 2013:</p> <ul style="list-style-type: none"> -PRN medications had been given fifty times. -Nine times no reason had been documented for giving the medication. -Twenty-one times the effectiveness of the medication had not been documented. <p>*January 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given fifty-seven times. -Twenty times no reason had been documented for giving the medication. -Twenty-two times the effectiveness of the medication had not been documented. <p>*February 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given thirty-two times. -Twenty-one times no reason had been documented for giving the medication. -Fourteen times the effectiveness of the medication had not been documented. <p>Surveyor: 17911</p> <p>6. Review of resident 4's December 2013, January 2014, and February 2014 MARs revealed:</p> <p>*December 2013:</p> <ul style="list-style-type: none"> -PRN medications had been given eleven times. -Three times no reason had been documented for giving the medication. -Three times the effectiveness of the medication had not been documented. <p>*January 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given eight times. -Three times no reason had been documented for giving the medication. 	F 514			

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NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702		
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F 514	<p>Continued From page 13</p> <p>-Five times the effectiveness of the medication had not been documented.</p> <p>*February 2014:</p> <p>-PRN medications had been given thirteen times.</p> <p>-One time no reason had been documented for giving the medication.</p> <p>-Two times the effectiveness of the medication had not been documented.</p> <p>7. Review of resident 7's December 2013, January 2014, and February 2014 MARs revealed:</p> <p>*December 2013:</p> <p>-PRN medications, none had been given.</p> <p>*January 2014:</p> <p>-PRN medications had been given seven times.</p> <p>-One time no reason had been documented for giving the medication.</p> <p>-Five times the effectiveness of the medication had not been documented.</p> <p>*February 2014:</p> <p>-PRN medications had been given eight times.</p> <p>-One time no reason had been documented for giving the medication.</p> <p>-Two times the effectiveness of the medication had not been documented.</p> <p>Surveyor: 32572</p> <p>8. Review of resident 3's December 2013, January 2014, and February 2014 MARs revealed:</p> <p>*December 2013:</p> <p>-PRN medications had been given seventeen times.</p> <p>-Two times no reason had been documented for giving the medication.</p> <p>-Three times the effectiveness of the medication had not been documented.</p> <p>*January 2014:</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702		
(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 514	<p>Continued From page 14</p> <ul style="list-style-type: none"> -PRN medications had been given seventeen times. -Three times no reason had been documented for giving the medication. -Five times the effectiveness of the medication had not been documented. <p>*February 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given twenty-two times. -Seven times no reason had been documented for giving the medication. -Seven times the effectiveness of the medication had not been documented. <p>9. Review of resident 5's December 2013, January 2014, and February 2014 MARs revealed:</p> <p>*December 2013:</p> <ul style="list-style-type: none"> -PRN medications had been given thirteen times. -Five times no reason had been documented for giving the medication. -Seven times the effectiveness of the medication had not been documented. <p>*January 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given thirteen times. -Four times no reason had been documented for giving the medication. -Three times the effectiveness of the medication had not been documented. <p>*February 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given nineteen times. -Two times the effectiveness of the medication had not been documented. <p>10. Review of resident 10's December 2013 and January 2014 MARs revealed:</p> <p>*December 2013:</p> <ul style="list-style-type: none"> -PRN medications had been given twenty-three 	F 514			

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NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702		
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F 514	<p>Continued From page 15 times.</p> <ul style="list-style-type: none"> -Two times no reason had been documented for giving the medication. -Sixteen times the effectiveness of the medication had not been documented. -Eight times the pain scale had not been used to assess the resident's pain. <p>*January 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given twenty times. -Twelve times no reason had been documented for giving the medication. -Four times the effectiveness of the medication had not been documented. -Five times the pain scale had not been used to assess the resident's pain. <p>11. Review of resident 12's February 2014 MARs revealed: *February 2014:</p> <ul style="list-style-type: none"> -PRN medications had been given thirteen times. -Eleven times no reason had been documented for giving the medication. -Six times the effectiveness of the medication had not been documented. <p>12. Interview on 2/26/14 at 4:00 p.m. with the director of nursing confirmed she would have expected a pain score to have been documented when a pain medication had been administered. She confirmed the reason for the pain medication should have been documented. She confirmed there should have been follow-up documentation after any PRN medication had been given.</p> <p>Review of the provider's November 2011 Preparation and General Guidelines policy revealed "When PRN medications are administered, the following documentation is provided:</p>	F 514			

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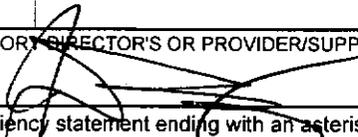
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702	
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F 514	<p>Continued From page 16</p> <p>-'Complaints or symptoms for which the medication was given.' "</p> <p>13. Review of resident 12's 2/19/14 care plan indicated she did not initiate her own activities of choice.</p> <p>*The goal for the care area revealed "I would like to receive activity services of my choice through my next review (5/20/14)."</p> <p>*The interventions were:</p> <p>- "My interests are cards, music, reading, spiritual/religious activities, spending time outdoors, watching TV and movies, talking/conversing, parties/social events, and keeping up with the news."</p> <p>- "Please invite me to activities of interest and assist me, as appropriate, to the activities area."</p> <p>Review of the Daily Charting for resident 12 for February 11, 2014 through February 26, 2014 revealed she had attended only one activity program. The charting did not indicate she had been invited or refused any other activities at other times.</p> <p>Interview on 2/26/14 at 3:00 p.m. with the activity coordinator revealed resident 12 "Doesn't attend activities because of therapy."</p> <p>Interview on 2/26/14 at 4:00 p.m. with the director of nursing revealed resident 12 had visitors both in the a.m. and p.m. She stated the resident did not like to attend group activities because of the extra stimulation that occurred. Staff had stopped in and visited with her, but it had not been documented. She confirmed when those activities were done it should have been documented.</p>	F 514	<p>13. Education with the activity department by DOO to address which residents are identified to be at need for 1 to 1 activities. An audit will be completed monthly by the activity coordinator or designee to review the current 1 to 1 caseload for 4 months with findings reported to QA by DOO or designee. Audits will be discontinued when monthly audits show 100% compliance for 2 months.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435037	(X2) MULTIPLE CONSTRUCTION A. BUILDING 1A - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 02/25/2014
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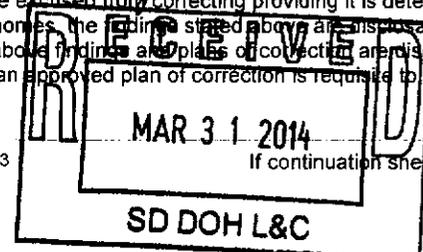
NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/25/14. Clarkson Health Care was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Director of Operations</i>	(X6) DATE <i>3/28/14</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 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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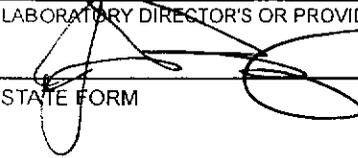
SOUTH DAKOTA DEPARTMENT OF HEALTH

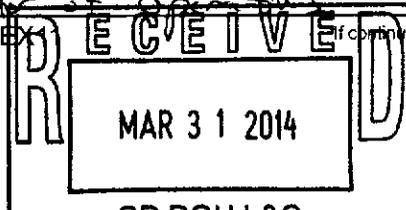
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10666	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57701
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S 000	Initial Comments Surveyor: 20031 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/25/14 through 2/26/14. Clarkson Health Care was found not in compliance with the following requirement: S166.	S 000		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		3-18-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Director of Operations</i>	(X6) DATE <i>3/28/14</i>
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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10666	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2014
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S 166	<p>Continued From Page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Rule is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to follow occupant safety regulations required by the Department of Health. A chair pad that would provide heat and massage was found in use in one randomly observed resident room (29). Findings include:</p> <p>1. Observation at 3:00 p.m. on 2/25/14 revealed a black chair pad on the recliner in resident room 29. That chair pad was electrical and had off and on settings. Interview with the maintenance manager (MM) at the time of the observation confirmed that finding. He stated he was not aware of the chair pad and was not aware if it was for heat or massage. Continued interview at 3:15 p.m. on that same day with the MM revealed he had spoken with family who had supplied the chair pad. They stated the pad would produce heat and also provide massage properties. The MM revealed he instructed the family the device could not be used at the facility. The MM was aware heat producing devices could not be used but was not aware of the</p>	S 166	<p>1. Staff educated at in service by Director of Operations on 3/18/2014 on the findings of this tag and given examples of similar items. Reviewed current process at which staffs inquire about appropriateness of electrical items in resident rooms.</p> <p>Family removed the item discussed the day it was found. Family has been educated on items that are not allowed in the facility as well as who to contact if they have any questions. Director of Operations or designee will audit resident rooms for inappropriate devices weekly. Continue next page</p>	

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 166	Continued From Page 2 installation of the chair pad on the recliner.	S 166	Findings will be brought to QA for review and completion. Staff have been educated to report questions, concerns, or inquiries to Director of Operations, Maintenance Director, or Director of Nursing for review if item is appropriate to be in the facility. JB	