

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

**ORIGINAL**

PRINTED: 03/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WESTHILLS VILLAGE HEALTH CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 TEXAS ST RAPID CITY, SD 57701</b>
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F 000

INITIAL COMMENTS

F 000

Addendums noted with an asterisk per 4/1/14 email from facility administrator.  
KW/SDD/H/MF

Surveyor: 26632  
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/10/14 through 3/12/14. Westhills Village Health Care Facility was found not in compliance with the following requirements: F281, F431, and F441.

F 281  
SS=D

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

F 281

The services provided or arranged by the facility must meet professional standards of quality.

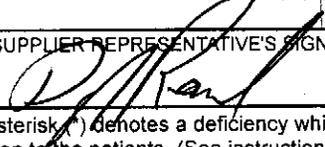
The Director of Nursing/Assistant Director of Nursing has provided the necessary follow up on each example given to assure the Physicians Order is correct and relevant information relayed to the chart for nursing staff to perform their duties. An in-service was held and conducted by the Director of Nursing, Assistant Director of Nursing and consultant pharmacist that reviewed the policy and procedure in place about ensuring clarification of Physicians Orders, appropriate documentation of medication administration and documentation of PRN follow up. They specifically reviewed the examples here as well as others and the Assistant Director of Nursing is checking other charts for appropriate follow up to be reported at the next Quality Assurance Committee Meeting.

This REQUIREMENT is not met as evidenced by:  
Surveyor: 32333  
Based on observation, interview, and record review, the provider failed to ensure:  
\*The as needed (PRN) medication effectiveness had been documented for 1 of 10 sampled residents (6).  
\*The appropriate documentation of a medication for one observed resident (12) by 1 of 4 observed unlicensed assistive personnel (UAP)(A) giving medications had been completed.  
\*Clarification of physician orders for PRN medications for 3 of 11 sampled residents (2, 7, and 10). Findings include:

1. Review of resident 6's March 2014 medication administration record (MAR) revealed the effectiveness of a PRN medication had not been documented twelve times.
2. Observation on 3/11/14 at 8:55 a.m. of UAP (A)

Cont'd...

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



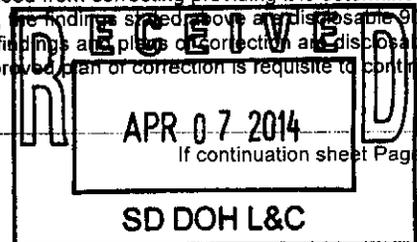
TITLE

CEO

(X6) DATE

4-4-14

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 281	<p>Continued From page 1</p> <p>while giving medications to resident 12 revealed she:</p> <ul style="list-style-type: none"> <li>*Offered the resident his Miralax (medication to relieve constipation) that had been mixed into a glass of water.</li> <li>*The resident agreed to drink half the glass of the Miralax mixture.</li> <li>*The other half of the mixture had been disposed of down the drain.</li> </ul> <p>Review of resident 12's 3/11/14 MAR revealed:</p> <ul style="list-style-type: none"> <li>*Miralax had been documented as given.</li> <li>*There had been no other documentation to clarify that only half of the dose had been given.</li> </ul> <p>3. Interview on 3/12/14 at 1:40 p.m. with the director of nursing revealed she would have expected:</p> <ul style="list-style-type: none"> <li>*Medication effectiveness to have been documented in the medical record.</li> <li>*Further documentation if only half of a dose of medication had been given.</li> </ul> <p>Surveyor: 32572</p> <p>4. Review of resident 2's 10/10/13 physician's order revealed "Sodium chloride 45 ml (milliliters) I (inhale) PRN." There was no indication as to how that should have been inhaled; it could have been by the nasal (nose) route or as a nebulizer (breathing) treatment. There had been no frequency for the above medication.</p> <p>Resident 2 also had a 12/26/13 physician's order for "Tramadol (pain medication) 50 mg PO (by mouth) PRN. There had been no frequency for that medication.</p> <p>-The assistant director of nursing (ADON) presented the medication card to this surveyor.</p>	F 281	<p>Cont'd...</p> <p>The Director of Nursing, along with other nursing staff will conduct an ongoing audit and share the information with the Quality Assurance Committee for their review and instruction on further follow up.</p> <p><i>* Resident 0's orders for sodium chloride and tramadol were reviewed and a physician's order was obtained to discontinue medications due to non-usage. MAR updated accordingly. KW/SDDOH/MF</i></p> <p><i>* Resident 7's physicians order for saline mist and Nystatin reviewed with physician. Physicians order obtained to discontinue nasal spray and Nystatin frequency clarified for twice a day dosing - MAR updated accordingly. KW/SDDOH/MF</i></p>	4/09/14
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F 281	<p>Continued From page 2</p> <p>The card read to take the medications four times a day. There was a sticker on the card that stated the order had changed refer to the physician's order.</p> <p>5. Review of resident 7's 11/21/13 physician's order revealed "Saline Mist 0.65% (percent) Nasal Spray Aerosol [Sodium chloride] 1 spray PRN." There had been no frequency for the above medication. *He also had a 12/16/13 physician's order "Nystatin (fungal infection medication) 100,000 units/gram (units of measurement) Topical Powder, apply to groin PRN." -There had been no frequency for the above medication.</p> <p>6. Review of resident 10's 3/6/14 physician's order revealed "Senna with Docusate Sodium (bowel medication) 8.6 mg (milligrams)-50 mg tablet 1-3 tablets PO PRN." *There had been no frequency for the above medication. -That physician's order did not indicate the maximum number of tablets that could have been given in a day.</p> <p>Interview on 3/12/14 at 1:10 p.m. with the DON and the ADON confirmed they would have expected those physician's orders to have been clarified with the ordering physician.</p> <p>7. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing 6th Ed., St. Louis, MO., 2005, p.847, revealed "The components of a medication order are, resident's name, date the order is written, the medication name, dose, route of administration, along with the time and frequency of administration and the</p>	F 281	<p>* Resident 10's physicians order clarified for frequency and dosage. MAR updated accordingly. KW/SDDOH/MF</p> <p>* Resident 05 PRN medication effectiveness is being documented. KW/SDDOH/MF</p> <p>* Resident 10's MAR will note the amount of the dose resident consumed if different than dosage on MAR. KW/SDDOH/MF</p> <p>* DON or designee will audit PRN effectiveness and new physician orders weekly. Nursing staff passing medications are running PRN effectiveness report before end of shift to ensure documentation noted. KW/SDDOH/MF</p> <p>* DON or designee will report audit results quarterly to the Quality Assurance committee and until such time as the committee advises the audit reports can be discontinued. KW/SDDOH/MF</p>		

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F 281	Continued From page 3 signature."	F 281		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	<p>The policy and process for the storage of schedule 2 drugs has been changed to a new location in the Medication Room. Storage of these medications in the Medication Room does meet the requirements. This was reviewed and covered by the Director of Nursing, Assistant Director of Nursing and pharmacy consultant with nursing staff and implemented.</p> <p style="text-align: right;">4/09/14</p> <p><i>*The administrator will conduct bi-monthly audits to ensure cabinet is locked, and narcotics to be disposed have proper paper work attached. The administrator or designee will report audit results quarterly to the quality assurance committee and until such time as the committee advises the audit reports can be discontinued. KWK/DDH/jmf</i></p>	
	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>			
	<p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>			
	<p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>			
	<p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>			

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F 431	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333</p> <p>Based on observation, interview, testing, and policy review, the provider failed to ensure schedule II narcotics awaiting destruction had been stored in a permanently affixed, separately locked compartment with limited access from unauthorized personnel. Findings include:</p> <p>1. Observation and interview on 3/12/14 at 9:25 a.m. in the director of nursing's (DON) office revealed:</p> <ul style="list-style-type: none"> <li>*A locked three drawer cabinet.</li> <li>*The bottom drawer of the cabinet contained multiple bubble packs of schedule II narcotics awaiting destruction.</li> <li>*The cabinet was not permanently affixed inside of the office.</li> <li>*The key to the cabinet was stored in that office.</li> <li>*Several staff members had a key to her office including the front office person, administrator, and maintenance supervisor.</li> <li>*The DON had no log of the schedule II narcotics in the drawer. She did not know what was in the drawer without looking.</li> <li>*The DON had not locked her office door when she was not in the office. She only locked her office door when she had left the facility.</li> </ul> <p>Random observations on 3/12/14 between 10:25 a.m. and 10:45 a.m. of the DON's office revealed the DON had not been in her office. The door had been left open during that time frame.</p> <p>Review of the provider's 10/1/13 Medication Storage in the Facility Controlled Substance policy revealed "Schedule II-V medications and other medications subject to abuse or diversion</p>	F 431		
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F 431	Continued From page 5 are stored in a permanently affixed, double-locked compartment separate from all other medications or per state regulation."	F 431			
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	F 441	1. The wooden edges of the laminate countertops identified in the Dining Room/Kitchenette area will be addressed by the Plant Operations Supervisor with the work completed either by his staff or contractor.  2. The caulking by the sinks has been addressed by the Plant Operations Supervisor. On our preventative maintenance program, ongoing review will be provided for these areas by Plant Operations Supervisor, Dining Services Supervisor and Housekeeping Supervisor or their designee. These areas will also be reviewed and discussed at each of the upcoming staff meetings for each department as well.  3. Housekeeping/Laundry Supervisor has informed Laundry staff on the appropriate methods to store and deliver linen. The Housekeeping/Laundry Supervisor will conduct an in-service with Laundry personnel to ensure all policies and protocols are followed that will include cleaning, storing, delivering, covering and hanging linen in an appropriate method. Cont'd...		

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F 441	<p>Continued From page 6 transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and policy review, the provider failed to ensure: *The wooden edges of the laminate counter-top in the dining room/kitchenette area were maintained with a cleanable surface in front of two of two handwashing sinks, one of one ice machine, and one of one sinks with two compartments. *The caulking by the two compartment sink and one of two handwashing sinks had been maintained. *Residents' clean clothing was delivered in a covered cart to avoid contamination. *Sharps containers were sanitized or a barrier was placed between the container and the resting surface for two of two residents' (8 and 13) glucose checks performed by one of one registered nurse (B) and one of one unlicensed assistive personnel (A). *Handwashing or hand sanitizing had been completed by one of one licensed practical nurse (LPN) C before donning gloves. Findings include:</p> <p>1. Observation on 3/11/14 at 10:05 a.m. in the dining room revealed: *The edge of the laminate counter-tops were wood. Those wooden edges were worn through the varnish to the bare wood making them uncleanable surfaces. Those wooden edges were in front of :</p>	F 441	<p>Cont'd.../</p> <p>4. Director of Nursing and Assistant Director of Nursing have in-serviced and will review the practice of ensuring sharps containers have a barrier when removed from the Medication Cart to ensure compliance with infection control policies. Protective barrier has been ordered from supply vendor for use with sharps container. This was also reviewed at the in-service provided to all nursing personnel.</p> <p>5. Director of Nursing and Assistant Director of Nursing conducted an in-service to all nursing personnel on proper glove use and hand-washing techniques while providing services to residents.</p> <p>All above items will be reported to and reviewed with the Quality Assurance Committee by the respective personnel that will include Plant Operations Supervisor, Director of Nursing/Assistant Director of Nursing, Housekeeping/Laundry Supervisor for committee's input and follow up recommendations.</p> <p style="text-align: right;">4/09/14</p>

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F 441	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>-The two handwashing sinks (photos 6 and 7).</li> <li>-The ice machine (photo 5).</li> <li>-The two compartment sink (photos 1 and 2).</li> <li>*The caulking behind the two compartment sink and one handwashing sink was cracked making those uncleanable surfaces (photos 3 and 4).</li> </ul> <p>Interview on 3/11/14 at 3:30 p.m. with the maintenance supervisor revealed:</p> <ul style="list-style-type: none"> <li>*He was not aware the finish of the wooden edges on the counter-tops was worn.</li> <li>*He agreed the caulking needed to be redone.</li> <li>*He had not included those areas in his monthly preventative maintenance program.</li> </ul> <p>2. Observation on 3/11/14 from 11:15 a.m. through 11:30 a.m. revealed:</p> <ul style="list-style-type: none"> <li>*A linen cart being unloaded down Nature Lane.</li> <li>*The linen cart had clothes hanging on the front top frame.</li> <li>*There were also folded clothes lying on the shelves.</li> <li>*Laundry assistant E moved the cart from room-to- room and then up in front of the nurse's station.</li> <li>*When she took hanging clothes off the cart and bent down to retrieve folded clothes from the bottom shelf the hanging clothes touched the floor.</li> <li>*She then covered the hanging clothes partially with a cloth sheet.</li> </ul> <p>Interview on 3/12/14 at 11:00 a.m. with laundry assistant E revealed:</p> <ul style="list-style-type: none"> <li>*She used the laundry cart with shelves to deliver all the clean clothing.</li> <li>*She covered the clothes with a cloth sheet.</li> <li>*There was a cart specifically for hanging clothes that had a plastic cover, but she did not use it.</li> </ul>	F 441	<p>*The DON or designee will conduct weekly audits for usage of a barrier for the sharps container and for hand hygiene. Laundry coordinator or designee will conduct weekly audits for proper linen cart covers. DON or designee will report audit results quarterly to the Quality Assurance Committee and until such time as the committee advises the audit reports can be discontinued. The administrator or designee will present linen audit results quarterly to the Quality Assurance Committee and until such time as the committee advises the audit reports can be discontinued.</p> <p>KW/SDDCH/MF</p>	

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F 441	<p>Continued From page 8</p> <p>Interview on 3/12/14 at 1:40 p.m. with the housekeeping/laundry manager revealed: *She was not aware the correct laundry cart was not being used to deliver hanging clothes. *She agreed a cloth sheet could not prevent contamination during the delivery of clean clothes.</p> <p>Review of the provider's 3/12/14 Laundry Department Guidelines Policy revealed: *Resident's personal clothing would be delivered in a covered container or cart to their rooms.</p> <p>Surveyor: 32333</p> <p>3. Observation on 3/11/14 at 10:50 a.m. of unlicensed assistive personnel (A) while checking resident 13's blood sugar revealed she had: *Taken the sharps container out of the medication cart and carried it into the resident's room. *Set the sharps container on top of the residents bedside table. There had been several resident's use items (papers) on the bedside table. *Obtained the resident's blood sugar and disposed of her blood sugar test strip in the sharps container. *Returned the sharps container to the medication cart. *Not disinfected the sharps container or used a barrier when she had transported it to the resident's room or back to the medication cart.</p> <p>4. Observation on 3/11/14 at 11:00 a.m. of registered nurse (RN) B while checking resident 8's blood sugar revealed: *She had taken the sharps container out of the medication cart and carried it into the dining room. *The resident had been seated at a table with her</p>	F 441			

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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 441	<p>Continued From page 9</p> <p>husband and approximately four other residents. *The nurse set the sharps container onto the dining room table. *She then checked the resident's blood sugar. *She disposed of her blood sugar test strip in the sharps container and returned it to the medication cart. *She had not used a barrier or disinfected the sharps container when she had transported it to the dining room table or back to the medication cart.</p> <p>5. Observation on 3/11/14 at 4:20 p.m. of LPN C while she administered an insulin injection to resident 7 revealed she had not washed or sanitized her hands before she put on her gloves. Then she administered the insulin injection.</p> <p>Interview on 3/12/14 at 1:40 p.m. with the director of nursing revealed she: *Agreed the sharps container could have been a potential infection control risk and a safety hazard. *Would have expected staff to follow the facility policy on handwashing and glove use.</p> <p>Review of the provider's Hand Hygiene policy revealed hand hygiene should have been done before performing invasive procedures and handling devices.</p>	F 441		

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

ORIGINAL

PRINTED: 03/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WESTHILLS VILLAGE HEALTH CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 TEXAS ST RAPID CITY, SD 57701</b>
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K 000

INITIAL COMMENTS

Surveyor: 18087  
A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 3/11/14 through 3/12/14. Westhills Village Health Care Facility 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 the deficiency identified at K050 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 050  
SS=D

NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:  
Surveyor: 18087

Based on observation, record review, and interview, the provider failed to ensure a staff member was familiar with fire drill procedures. Findings include:

1. Observation at 4:00 p.m. on 3/11/14 revealed

K 000

Addendums noted with an asterisk per 4/14/14 telephone to facility CEO. CH/SDDOH/MF

K 050

Departments that include Housekeeping, Laundry, Therapy, Plant Operations, Nursing, Office and Dining Services will review at the next scheduled in-service the appropriate steps and follow up regarding a fire drill.\*

Results will be shared at the next Quality Assurance Committee meeting for any follow up directed.

\*The plant operations director will monitor the fire drills and the  
CH/SDDOH/MF

4/30/14

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

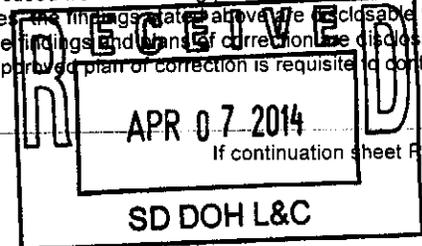
TITLE

CEO

(X6) DATE

4-4-14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>WESTHILLS VILLAGE HEALTH CARE FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 TEXAS ST RAPID CITY, SD 57701</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 050	Continued From page 1 the charge nurse responding to the simulated fire resident room 17 asked what procedure to follow after the initial discovery of the simulated fire. Resident room 17 was unoccupied at that time. She was told to use her walkie-talkie to call for the fire discovery announcement. She then obtained a fire extinguisher from a corridor wall cabinet and re-entered room 17 (to simulate extinguishing the fire). She did not check the door or the door handle for heat and was not accompanied by another staff person. The adjacent resident rooms 18 and 23 (across the corridor) doors had not yet been closed to minimize the effects of smoke from a fire. After leaving the room, she then closed the doors to resident rooms 18 and 23.  Interview with the plant operations supervisor at the time of the above observation confirmed that finding. He stated the respondent to the simulated fire was a new employee in the past six months. He added that this was her first response to a simulated fire for a fire drill.	K 050		

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10721</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2014</b>
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NAME OF PROVIDER OR SUPPLIER <b>WESTHILLS VILLAGE HEALTH CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 TEXAS ST RAPID CITY, SD 57701</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments  Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/10/14 through 3/12/14. Westhills Village Health Care Facility was found not in compliance with the following requirement: S206.	S 000	Addendums noted with an asterisk per 4/21/14 email from facility administrator. KM/SDDOH/MF	
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.	S 206	The formal Orientation Program has been updated to include the 10 areas identified required for the Orientation/Education Program for appropriate personnel. Human Resource Manager or designee will conduct audits and report findings to the Quality Assurance Committee for any further follow up and/or recommendation.  *Staff will have training completed by April 22, 2014. Audit will be conducted once a month for one quarter. KM/SDDOH/MF	4/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE SRFT1	(X6) DATE
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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10721</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>WESTHILLS VILLAGE HEALTH CARE FACILITY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>255 TEXAS ST RAPID CITY, SD 57701</b>		
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S 206	Continued From Page 1  This Rule is not met as evidenced by: Surveyor: 32333 Based on record review and interview, the provider failed to ensure mandatory education for five of five sampled staff members (A, B, C, D, and E) had been completed and documented. Findings include:  1. Interview and record review on 3/12/14 at 10:30 a.m. with the human resources manager of employee files (A, B, C, D, and E) hired between December 2013 and February 2014 revealed no formal orientation had been completed to include the following mandatory education: *Accident prevention and safety procedures. *Dining assistance, nutritional risks, and hydration needs of residents. *Proper use of restraints.	S 206	*The administrator or designee will conduct an audit of new employee formal orientation program. Results of the audit will be reported quarterly to the Quality Assurance Committee and until such time as the committee advises the audit reports can be discontinued.  KW/SDDH/MF	