

ORIGINAL

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

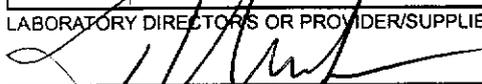
PRINTED: 03/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435121	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER ROSHOLT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260
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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
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F 000	INITIAL COMMENTS Surveyor: 18560 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. Rosholt Care Center was found not in compliance with the following requirements: F281, F323, and F441.	F 000	<i>Addendums noted with an asterisk per 4/2/14 telephone to facility administrator. PE/SDDH/ME</i>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, product information, and policy review, the provider failed to ensure liquids were of the appropriate consistency for two of two sampled residents (8 and 11) who were on thickened liquids. Findings include: 1a. Observation on 2/25/14 at 6:00 p.m. in the dining room of certified nursing assistant (CNA) B with resident 8 revealed: *She assisted resident 8 with her food and fluids. *She spoon fed resident 8 a red liquid. *There was an opened, small plastic cup containing a white powdered-type product on her tray. Interview and observation on 2/25/14 at the same time in the dining room with licensed practical nurse (LPN) A at the medication cart regarding resident 8 revealed:	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>3-24-14</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 30 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 45 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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If continuation sheet Page 1 of 17
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F 281	<p>Continued From page 1</p> <p>*Resident 8 had been on nectar thickened liquids. *The white powder-type product on her tray was Thick-It (a food and beverage thickener). *The thickener was also used when she had provided liquids with her medications. *There was a four ounce (oz) clear container with a gray lid in the medication cart that contained the thickener with no label or instructions on it. *There were no specific measurements used for the thickener, and "it was eyeballed" as to how thick it should have been.</p> <p>b. Observation on 2/26/14 at 11:30 a.m. of resident 8's room revealed an 8 oz glass of water sitting on her bedside table. The water was cloudy and easily poured out of the glass.</p> <p>Interview on 2/25/14 at 1:25 p.m. with certified nursing assistant C revealed she had not been sure if the water had been thick enough. She was not sure how thick the water should have been. The dietary staff had been responsible for the thickening of the resident's water, and she would have to check with them.</p> <p>Surveyor: 32355 2. Observation on 2/25/14 at 12:05 p.m. of LPN A during medication administration revealed she: *Prepared medications to be administered to resident 11. *Had taken a four oz cup and filled it with water. *Opened a small four oz clear container containing a white powder-type substance. *Retrieved a spoon and scooped an unmeasured amount of the white powder-type substance, poured it into the cup of water, and mixed it together. *Assisted the resident with his medications. *Administered his medications and gave him a</p>	F 281	<p>The Director of Nursing, Administrator and Food Services Supervisor reviewed and revised the policy and procedure regarding thickened liquids. All residents that require thickened liquids will have the liquids prepared by the dietary department only, until nursing to staff can be appropriately trained. This includes resident number 8 and resident number 11. Pre-made thickened liquids will be purchased and available to nursing staff at all times to be used for medication administration and use in resident rooms for times when the dietary staff is not available to thicken the liquids, as of 3/28/14. All dietary staff will be provided training by 3/24/14 as to the appropriate way to thicken liquids.</p> <p>Product information on the Thick-it Instant food and Beverage Thickener recommended the following: (continued)</p>	

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F 281	<p>Continued From page 2</p> <p>drink of the water she had mixed with the white powder-type substance.</p> <p>Interview during the above observation with LPN A revealed:</p> <ul style="list-style-type: none"> *The white powder-type substance in the container had been Thick-it. *The container had no label or mixing instructions on it. *The thickener was for her to use when she had provided liquids with resident's medications. *She had not been provided with measuring guidelines for the Thick-it. *She had been informed nursing was not to measure the Thick-it for any liquids and to "eye-ball it." *Dietary had done all the measuring and mixing of the Thick-it. *She was not sure but thought resident 11 had required nectar thickened liquids. *She could not ensure the thickened water she had given to resident 11 had been the right consistency. *She agreed resident 11 had been placed at risk for medical complications by not ensuring the liquid had been the right consistency. <p>3. Interview on 2/26/14 at 11:25 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *The dietary department had been responsible for thickening the residents' liquids. *She could not ensure dietary had provided the necessary thickened liquids for the staff to use. *The nursing staff had not been instructed on the proper measuring and use of the Thick-it. *She agreed that had placed any resident requiring thickened liquids at risk for medical complications. 	F 281	<p>"The amount of thickener may need to be adjusted to facility requirements and type of liquid or mixing temperature."</p> <p>* Weekly x 1 month and as needed thereafter Proper thickening of liquids will be monitored by visual inspection by the Administrator, Director of Nursing, Dietary Manager, Charge Nurse and Cook. Any adverse findings will be corrected and documented on a flow sheet and any adverse finding will be presented to the QA Committee on a quarterly basis for one year or until resolved.</p> <p>* by the dietary manager</p>	<p>PE/SDDH/IMF</p> <p>3/28/14 JM</p>

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F 281	Continued From page 3 Product information on the Thick-it Instant Food and Beverage Thickener revealed: *The thickener should have been scooped and leveled off with the recommended amount of Thick-it using a measuring spoon. *The thickener should have been added slowly to the liquid while stirring briskly with a spoon, fork, or whisk until the thickener had dissolved. *The thickened liquid should have been left to sit for thirty seconds to one minute to achieve the desired consistency and then served. Review of the provider's 2006 Thickened Liquids policy revealed: **Thin liquids tend to be more difficult to swallow and can cause choking." **Thickening liquids helps make them easier and safer to swallow." **The facility will determine whether nursing or dietary will thicken the liquids or if already thickened products will be used." **Manufacturer's instructions are to be followed when using thickening agents." **Thicken all liquids to the proper consistency."	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by:	F 323		

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F 323	<p>Continued From page 4</p> <p>Surveyor: 32331</p> <p>Based on observation, interview, product label information, and policy review, the provider failed to maintain proper labeling and storage of chemicals in one of one beauty shop and in one of two bathing rooms (South hall). Findings include:</p> <p>1. Observation on 2/25/14 at 8:35 a.m. in the unlocked beauty shop on the East hall on top of the counter in front of the mirror revealed: *Two twelve ounce (oz) spray containers of Clippercide germicidal (kills germs). *One four oz opened bottle of Wahl Clipper oil (photo 1).</p> <p>Review of the product label information of the above chemicals revealed: *The Clippercide spray had the following warnings: -Keep out of reach of children. -Hazardous to humans and domestic pets. -Causes skin irritation. -Harmful if inhaled. -Causes moderate eye irritation. -Do not get on skin and clothing. -Avoid breathing spray mist. -Wash hands before eating, drinking, or using the toilet. *The Wahl Clipper oil had the following warning: -Harmful or fatal if swallowed.</p> <p>Interview on 2/25/14 at 2:00 p.m. with the administrator and the maintenance supervisor in the unlocked beauty shop revealed: *They agreed the Clippercide spray and the Wahl Clipper oil needed to be locked up when not in use by the beautician. *There was not a written agreement or contract</p>	F 323			

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F 323	<p>Continued From page 5 with the beautician regarding proper storage of chemicals used in the beauty shop.</p> <p>Surveyor: 33488 Preceptor: 32331</p> <p>2. Observation and interview on 2/25/14 at 10:30 a.m. with certified nursing assistant (CNA) C in the South hall whirlpool tub bathing room revealed: *An unmarked squirt bottle filled with a yellow liquid (photo 2). *The unmarked bottle with the yellow liquid was the Penner classic whirlpool disinfectant cleaner. *The unlabeled bottle would be unsafe if used accidentally on a resident and should have been labeled properly.</p> <p>Review of the material safety data (MSD) sheet for the Penner classic whirlpool disinfectant cleaner revealed: **Eye irritation: will cause redness, burning sensation and watering." **Skin irritation: redness, irritation and burning sensation." **Inhalation: burning sensation, dizziness, and headache." **Ingestion (swallowing): stomach irritation, disturbance or pain."</p> <p>Observation and interview on 2/25/14 at 2:20 p.m. with the maintenance supervisor and the administrator in the South hall whirlpool tub bathing room revealed: *The above unmarked bottle had been placed in the cupboard beside resident care items. *They agreed that was a hazard to residents and under no circumstances should it have been unlabeled or stored next to resident items.</p>	F 323	<p>1) On 2/25/14 the two twelve ounce containers of Clippercide and the four oz. opened bottle of Wahl Clipper oil that were in the beauty shop were disposed of. A written agreement was implemented between the facility and the beautician regarding the proper storage of chemicals on 3/20/14. * Weekly x 1 month and as needed thereafter 2) The unmarked bottle of Penner classic whirlpool disinfectant cleaner was removed on 2/25/14 and disposed of. All bottles will be labeled as to contents and if hazardous will be marked as such. Proper labeling of bottles will be monitored by Administrator, Director of Nursing, Maintenance Supervisor, Charge Nurse and all other staff by visual observation. Any adverse findings will be corrected and documented in written form though a flow sheet and will be presented to the QA Committee and the Safety Committee on a quarterly basis or until resolved.</p>	PE/SDD/H/MF by the DON PE/SDD/H/MF

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F 441 F 441 SS=E	Continued From page 6 483.65 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 infection.	F 441 F 441 F323	All staff will be inserviced by 3/26/14 as to Accident and Hazard Identification. This will be monitored by the Administrator through visual observation and completion of sign in sheet at inservice. . Any adverse findings will be corrected and documented in written form though a flow sheet and will be presented to the QA Committee and the Safety Committee on a quarterly basis or until resolved. X by the DON PERIODH/MF	3/26/14 ym

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F 441	Continued From page 7 This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 32331 A. Based on observation, interview, and policy review, the provider failed to: *Properly disinfect one of one whirlpool tub between each residents use. *Ensure three of three hooded hair dryer filters were maintained and cleaned in the beauty shop. *Ensure proper cleaning of the beauty shop and items used in the beauty shop. *Properly clean three randomly observed stand lifts (mechanical equipment used to transfer a resident from one surface to another). *Properly clean and sanitize the floor for one of two bathing rooms (South hall). Findings include: 1. Observation and interview on 2/25/14 at 10:30 a.m. with certified nursing assistant (CNA) C in the whirlpool tub bathing room revealed she: *Had finished giving her last resident a bath for the day and was preparing to disinfect the whirlpool tub. *Had not disinfected the whirlpool tub jets between resident baths. *Only ran the disinfectant through the whirlpool tub jets at the end of the bathing day. *Would pour the disinfectant on a cloth, wipe the whirlpool tub down, and then rinse the whirlpool tub between residents. *Averaged five to six residents baths per day. *Shared the residents' bathing task with one other CNA. *Had no formal training on disinfecting the whirlpool tub with this provider, but she had	F 441	A 1. Review of formal training provided to certified nursing assistant C in the whirlpool tub bathing reveals formal training occurred on 8/30/2014. 2013 <i>ym</i> On 2/26/14 all certified nursing assistants who assist with the whirlpool tub bathing were instructed/trained as to the need to disinfectant all components of the whirlpool between each resident including the jets. The policy for disinfecting/cleaning of the Penner whirlpools system was reviewed and updated on 3/19/14. This will be monitored by the Director of Nursing, Charge Nurse and Administrator through visual observation. Any adverse findings will be corrected and documented on a flow sheet and will be presented to the QA Committee on a quarterly basis or until resolved. <i>* weekly x 1 month and as needed thereafter PE/SDDH/ME</i>	

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F 441	<p>Continued From page 8 previous training at another facility.</p> <p>Observation and interview on 2/25/14 at 2:20 p.m. with the maintenance supervisor and the administrator in the whirlpool tub bathing room revealed they: *Were unaware the whirlpool tub jets were not being disinfected between residents' baths given by CNA C. *Agreed the whirlpool tub jets were not properly being disinfected. *Agreed that should have been done between every resident bath and at the end of the day.</p> <p>Review of the 8/1/06 Tub Disinfection/Cleaning Procedure policy revealed the whirlpool tub was to have been thoroughly cleaned and disinfected (including injectors [jets]) between baths and at the start of the day.</p> <p>2. Observation on 2/25/14 at 1:00 p.m. of the beauty shop revealed: *The door had been left open, and the room had been left unoccupied. *Three hooded hair dryer filters were full of hair, lint, and a white powdery substance (photos 3 and 4). *There had been nail clippings lying on one of the two beauty shop chairs (photo 5). *The floor had been visibly dirty with hair and other debris.</p> <p>Observation and interview on 2/25/14 at 1:55 p.m. with the maintenance supervisor and the administrator in the beauty shop revealed: *The beautician had not been at the facility since last week, and to their knowledge no one else had used the beauty shop since that time. *Housekeeping staff were responsible for</p>	F 441	<p>thoroughly cleaned the beauty shop including sweeping and mopping of the shop floor, cleaning of the hair dryer filters which did not require tools to remove and all curlers were cleaned prior to use on individual residents and will be maintained and cleaned/disinfected between each resident use. A policy was developed and implemented on 3/19/14 that addressed each of these items. This will be monitored by the Administrator through visual observation. Any adverse findings will be corrected and documented on a flow sheet and will be presented to the QA Committee on a quarterly basis or until resolved.</p> <p>* by the Administrator PEJSDOH/MF</p> <p>* 2. On 2/26/14 the beautician PEJSDOH/MF * weekly x 1 month PEJSDOH/MF and as needed thereafter PEJSDOH/MF</p>	PEJSDOH/MF

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F 441	<p>Continued From page 9</p> <p>sweeping and mopping the beauty shop floor. *They thought the beautician should have been responsible to clean items used during her provided services. *Curlers were observed unclean and lying on the counter full of hair. *They had no policy on beauty shop cleaning or responsibilities. *They agreed they needed to do training for staff and the beautician on cleaning the beauty shop.</p> <p>Observation and interview on 2/26/14 at 9:00 a.m. with the beautician revealed: *She had no tools to remove the hooded dryer filters, so she "had never attempted to clean them" and assumed it had been the responsibility of maintenance. *She did not have enough curlers for individual resident's use per day. *She reused the hair curlers without disinfecting or removing the trapped hair. *Stated activities staff used the room occasionally for nail care. *There had been nail clippings left on the chair. *There needed to be consistent disinfecting of beauty items used daily and cleaning of the beauty shop by all staff. *There had been no policy or instructions on who had been responsible to clean items used in the beauty shop.</p> <p>3. Random observations on 2/25/14 between 8:30 a.m. and 5:30 p.m. in the bathing room on the West hall revealed: *Stand lifts were stored in the bathing room when not in use. *The stand lifts observed were visibly dirty and had unknown debris on the foot pedals (photos 6 and 7).</p>	F 441	<p>3.All mechanical lifts were thoroughly cleaned and disinfected on 2/25/14. Beginning on 2/25/14 all mechanical lifts were disinfected after each resident use. On 3/19/14 a policy was developed and implemented in regards to proper cleaning and disinfecting of all mechanical (continued)</p>	

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F 441	Continued From page 10 Observation and interview on 2/25/14 at 4:40 p.m. with CNA F in the West hall bathing room regarding the stand lifts revealed: *They were to be cleaned after each use and every shift. *She cleaned the handles used by the residents with personal care wipes if dirty but had not cleaned the foot pedal areas. *The personal care wipes used had not contained a disinfectant, therefore the above was not an appropriate cleaning method. *She agreed the foot pedal areas had not been cleaned, were full of debris, and were visibly soiled. *At night residents would be barefoot or in socks when staff had assisted them during toileting and placed their feet on the foot pedal areas. *They had no log of cleaning the stand lifts, and she was unsure who cleaned them. Observation and interview on 2/25/14 at 5:00 p.m. with the administrator in the bathing room regarding the stand lifts on the West hall revealed: *They had no policy on cleaning the stand lifts. *They had no way of showing when the stand lifts had last been cleaned. *She agreed the foot pedals were full of debris, were visibly soiled, and needed to be cleaned immediately. *She agreed personal care wipes were not appropriate for disinfecting the stand lifts. 4. Observation and interview on 2/25/14 at 10:30 a.m. with CNA C in the South hall whirlpool tub bathing room revealed: *There were two bath mats, one on top of the other, lying beside the whirlpool tub used for staff	F 441	lifts, which includes using the product Medline Micro-Kill (with the Label indicating the Active Ingredients to be: Alkyl (60% C14, 30% C16, 5% C18); Dimethyl benzyl ammonium chlorides 0.105%; Alkyl (68% C12, 32% C14 dimethyl); Ethyl benzyl ammonium chlorides 0.105%; And the Inert Ingredients to be 99.790% which combined totals 100.00%) to be completed after each resident use and a weekly cleaning and disinfecting with DMQ diluted according to manufacturers' recommendations. The cleaning will be monitored through the use of a checklist completed by the individual cleaning weekly and monitored through visual observation by the Administrator, Director of Nursing, Charge Nurse and Nursing Assistants. Any adverse findings will be corrected and documented on a flow sheet and will be presented to the QA Committee on a quarterly basis or until resolved. x by the DON PE/SDDH/MF	

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

PRINTED: 03/10/2014
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER ROSHOLT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260	
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F 441	<p>Continued From page 11</p> <p>to stand on while residents were bathed. *The floor was visibly dirty between the mats and the whirlpool tub (photos 8 and 9). *She had no idea if the mats were ever moved to clean the floor.</p> <p>Observation and interview on 2/25/14 at 2:20 p.m. with the maintenance supervisor and the administrator in the whirlpool tub bathing room revealed they agreed: *The floor between the whirlpool tub and the mats was visibly dirty and needed to have been cleaned. *The mats were large and heavy and were "probably" not moved when the floor was cleaned. *The floor should have been thoroughly cleaned after use including the removal of floor mats.</p> <p>Surveyor: 32355 B. Based on observation, interview, and policy review, the provider failed to ensure appropriate infection control practices were maintained for : *One of one sampled resident (7) who received medications and nutrition through a gastronomy-tube (g-tube) (tube inserted directly into the stomach for feeding and nutritional purposes). *Two of four observed residents (12 and 13) with insulin administration. *Multiple residents' medications in one of one treatment cart and one of one medication cart. Findings include:</p> <p>1a. Observation on 2/25/14 at 11:45 a.m. of registered nurse (RN) D revealed: *She prepared to administer a feeding through the g-tube for resident 7. *She had washed her hands and applied gloves.</p>	F 441	<p>4.Beginning on 2/26/14 the mats in the South Hall whirlpool tub bathing room are removed after the bathing for the day is completed. The floor is cleaned and dried, mats are washed off and replaced when dry. The cleaning will be monitored through visual observation by the Administrator, Director of Nursing, Housekeepers, Charge Nurse and Nursing Assistants responsible for bathing residents. Any adverse findings will be corrected and documented on a flow sheet and will be presented to the QA Committee and Infection Control Committee on a quarterly basis or until resolved.</p> <p>B 1a. The policy for handwashing/infection control in regards to medications and nutrition through a gastronomy-tube was reviewed with (RN) D on 2/26/14.</p> <p>1b. The policy for handwashing/infection control in regards to medications and nutrition through a gastronomy-tube was reviewed with (RN) E on 3/3/14,</p>	<p>* Weekly x 1 month and as needed thereafter PEJ/SDDH/MF</p> <p>* by the Administrator PEJ/SDDH/MF</p>

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F 441	<p>Continued From page 12</p> <p>*With those gloved hands she:</p> <ul style="list-style-type: none"> -Retrieved a tray from a shelf above the sink in the resident's room. The tray contained supplies necessary to administer the resident her feeding. -Hung a feeding bag on a hook by the sink. -Opened two cans of Jevity (nutritional supplement) and poured the liquid into the feeding bag. -Took the feeding bag to the resident and hung it on a pole attached to the resident's wheelchair (w/c). -Closed the resident's divider curtain to provide privacy from the entrance door. -Adjusted the resident's lap tray attached to her w/c and adjusted the resident's blouse to expose the g-tube. -Took a clear plastic container from the supplies and returned to the sink. -Touched the handle on the sink and turned on the water. -Filled the clear plastic container with water. -Returned to the resident and opened up the site of the g-tube. -Checked for placement of the g-tube with a 60 milliliter (ml) syringe. -Flushed the g-tube with water and attached the feeding bag. -Gathered all the supplies and returned to the sink. <p>*She removed her gloves and washed her hands.</p> <p>*With her ungloved hands she:</p> <ul style="list-style-type: none"> -Retrieved a plastic cap that had fallen into the sink. -Touched the handle on the sink, turned on the water, and rinsed the cap. -Placed the cap on the 60 ml syringe that had been used to check for placement of the g-tube. -Placed the syringe on the tray with the rest of the g-tube supplies. 	F 441	<p>handwashing and nutrition through a gastronomy-tube will be monitored through visual observation by the Director of Nursing and/or Infection Control Coordinator. Any adverse findings will be corrected and documented on a flow sheet and will be presented to the QA Committee and reviewed at the Infection Control Meeting on a quarterly basis or until resolved.</p> <p>* by the DON PE/SDDH/MF</p> <p>2. The policy for handwashing and infection control in regards to medication administration was reviewed with (RN) E on 3/3/14.</p> <p>* Weekly x 1 month and as needed thereafter PE/SDDH/MF</p> <p>Continued handwashing and infection control regarding medications and nutrition through a gastronomy-tube will monitored through visual observation by the Director of Nursing and/or Infection Control Coordinator. Any adverse findings will be corrected and documented on a flow sheet and will be presented to the QA Committee and reviewed at the Infection Control Meeting on a quarterly basis or until resolved.</p> <p>* by the DON PE/SDDH/MF</p>	

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F 441	Continued From page 13 Interview on 2/26/14 at 10:50 a.m. with RN D regarding the above observation confirmed infection control practices and sanitary conditions had not been maintained. b. Observation on 2/25/14 at 5:15 p.m. of RN E revealed she prepared to administer medication through a g-tube for resident 7. RN E applied gloves without washing her hands or performing hand hygiene. With those gloved hands she: *Retrieved the supplies from the tray located above the sink in the resident's room and sat it on her bedside table. *Closed the resident's door and pulled the privacy curtain. *Assisted the resident to lay back down on the bed and covered her with a blanket that had been on her bed. *Took a clear plastic container from the supplies and returned to the sink. *Touched the handle on the sink and turned on the water. *Filled the container with water and turned off the water. *Adjusted the resident's shirt to expose the g-tube and opened the cap to the g-tube. *Attached the 60 ml syringe to the opening and checked for placement of the g-tube. *Administered the medication through the g-tube. *Closed the g-tube and returned to the sink. *Placed the tray with the supplies on the shelf above the sink. *Removed her gloves. After she removed her gloves she did not wash or sanitize her hands. Interview on 2/26/14 at 11:15 a.m. with the director of nurses (DON) revealed:	F 441	3a. On 2/26/14 individual resident's creams and ointments were placed in individual containers. 3b. On 2/26/14 individual resident's eye medications were placed in individual containers and will not be stored together. <i>* weekly x 1 month and as needed thereafter PE/SDDOH/MF</i> A policy was developed on 3/31/14 regarding proper storage of resident's medications. This will be monitored by the Director of Nursing and/or the Infection Control Coordinator through visual observation. Any adverse findings will be corrected and documented on a flow sheet and will be presented to the QA Committee and reviewed at the Infection Control Meeting on a quarterly basis or until resolved. <i>* by the DON PE/SDDOH/MF</i> All staff will be provided an inservice training by 3/26/14 as to Infection Control and Prevention. This will be monitored by the Administrator through visual observation and	

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F 441	<p>Continued From page 14</p> <p>*The above observations had not been good infection control practices.</p> <p>*She would have expected the nurses to remove their gloves and wash their hands after touching dirty surfaces.</p> <p>*There had been potential for cross-contamination and the risk of infection.</p> <p>2. Observation on 2/25/14 from 5:30 p.m. to 5:40 p.m. revealed RN E was prepared to administer an insulin (medication to control blood sugar levels) injection to residents 12 and 13.</p> <p>*Without performing hand hygiene RN E had applied a pair of gloves. With those gloved hands she:</p> <ul style="list-style-type: none"> -Gathered all the necessary supplies to administer an insulin injection for resident 12. -Drew up the correct dose of insulin. -Closed the medication room door. -Went into the dining room to have licensed practical nurse (LPN) A check the insulin dose. -Opened a tray on the side of the medication cart and set the supplies on the tray. -Moved the medication cart to the side. -Retrieved a pen and charted. -Gave the insulin injection to resident 12. -Retrieved the medication room keys from her pocket. -Returned to the medication room and opened the door. -Properly disposed of the syringe and put the insulin vial back in its original container. -Removed her gloves and had not washed or sanitized her hands. <p>*Applied another pair of gloves.</p> <p>*Gathered all the necessary supplies to administer an insulin injection for resident 13.</p> <p>*Repeated the same above process with her gloved hands for resident 13.</p>	F 441	<p>completion of sign in sheet at inservice. Any adverse findings will be corrected and documented in written form though a flow sheet and will be presented to the QA Committee Safety Committee and Infection Control Committee ^{* by the Administrator} on a ^{per RDDH/INF} quarterly basis or until resolved.</p> <p><i>3/26/14</i> <i>JNY</i></p>	

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F 441	<p>Continued From page 15</p> <p>*Had not performed hand hygiene or sanitized her hands upon completion of administering the insulin injection to resident 13.</p> <p>Interview on 2/26/14 at 11:15 a.m. with the DON confirmed the above observation had not been a sanitary practice with the potential for cross-contamination.</p> <p>Review of the provider's undated Administration of Insulin policy and procedure revealed: **Nurse preparing the medication will wash their hands prior to handling the Insulin vial." *Gloves should have been removed after the administration of the medication and hands were to have been washed.</p> <p>Review of the provider's undated Methods of Compliance regarding Handwashing revealed: *Handwashing should occur: -"Immediately or as soon as possible after removal of gloves." -"Before and after caring for each resident." -"Before and after giving injections."</p> <p>3a. Observation on 2/26/14 at 1:40 p.m. with RN D of the treatment cart revealed: *Multiple residents' creams and ointments were co-mingled together. *They had not been placed in separate compartments or containers. *The creams and ointments consisted of: -Triamcinolone cream (corticosteroid). -Hydrocortisone cream and ointment. -Gentamycin cream (antibiotic cream). -Calamine lotion. -Clindamycin vaginal cream (antibiotic cream). -Debrox ear drops (loosens ear wax). -Nystatin cream (anti-fungal cream).</p>	F 441		

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F 441	Continued From page 16 Interview on 2/26/14 at the time of the above observation with RN D revealed: *The above creams and ointments had always been stored in that manner. *She had agreed that had not been a proper infection control technique. *There had been potential for cross-contamination. b. Observation and interview on 2/26/14 at 1:55 p.m. with the DON of the medication cart revealed multiple residents' eye medications co-mingled together in the same tray. The DON confirmed the eye medications should not have been stored together. The provider could not provide a policy and procedure for the proper storage of residents' medications.	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435121	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
NAME OF PROVIDER OR SUPPLIER ROSHOLT CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260	
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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 on 2/26/14. Rosholt Care Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K018, K046, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 2/17/14 telephone to facility administrator. (H)SDDH/ME	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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

TITLE

Administrator

(X6) DATE

3-24-14

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 34 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 continuation sheet Page 1 of 4

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain the smoke tight rating of corridor wall assemblies for one of one soiled utility rooms. The door would not latch into the frame. Findings include: 1. Observation and testing at 10:15 a.m. on 2/26/14 revealed the corridor door for the soiled utility room would not latch into the frame. The door would not resist the passage of smoke. Interview with the administrator at 11:45 a.m. on 2/26/14 confirmed that finding. She revealed staff had difficulty opening the door under certain conditions with the existing lever handle for the door latch. Ref: 2000 NFPA 101 Section 18.3.6.3.2 The deficiency affected one of numerous corridor doors in the building.	K 018	On 2/26/14 the latch was reset on the door to the soiled utility room to allow full closure and latching. This will be monitored by the Charge Nurse, Director of Nursing, and/or Maintenance Supervisor ^{* weekly check} through visual observation and actual opening and closing of the door. Any adverse findings will be corrected and documented in written form though a flow sheet and will be presented to the QA Committee and the Safety Committee on a quarterly basis or until resolved.	2/26/14 YM
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a remote stop button for the generator. Findings include: 1. Observation at 9:15 a.m. on 2/26/14 revealed	K 046		

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K 144	Continued From page 3 at 9:30 a.m. on 2/26/14 revealed the generator ran for twenty minutes under load and had a ten minute cool down for a total of thirty minutes. He added the run times were pre-programmed for the generator by the service company. Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3; 1999 NFPA 110 Section 6-4.2.2 The deficiency affected a single component of numerous generator operational requirements.	K 144	The service company is scheduling a time to re-program the run times for the following: The pre-programmed exerciser will be disconnected and a manual start will be done on the water heater transfer switch twice monthly, every other week, for 30 minutes plus a 10 minute cool down period. The alternate weeks there will be a test on the transfer switch for on the main disconnect for 30 minutes plus a 10 minute cool down period. The weeks will continuously be rotated throughout the year. This will comply with the generator company's maintenance recommendations of 60 minutes per month on each transfer switch with a cool down period of 10 minutes for each. This will be monitored by the Maintenance Supervisor and/or Administrator through visual observation. Any adverse findings will be corrected and documented in written form though a flow sheet and will be presented to the QA Committee and the Safety Committee on a quarterly basis or until resolved.	

* 04/17/14
CHISSON/ME

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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10672	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2014
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NAME OF PROVIDER OR SUPPLIER ROSHOLT CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 85 FIRST AVE E, POST OFFICE BOX 108 ROSHOLT, SD 57260
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S 000	<p>Initial Comments</p> <p>Surveyor: 18087 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. Rosholt Care Center was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

STATE FORM

021199

CLVD11

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	<small>If continuation sheet 1 of 1</small> MAR 27 2014 SD DOH L&C	

Administrator