

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>435125</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>STRAND-KJORSVIG COMMUNITY REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261</b>
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F 000	INITIAL COMMENTS  Surveyor: 12218 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/11/14 through 3/12/14. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F272, F281, F371, and F431.	F 000	Addendums noted with an asterisk per 4/30/14 telephone to facility administrator. MJH/SDDOH/ME	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	F272 The temporary care plan for resident 7 was completed on 3/13/14. The current nursing admission checklist was modified on 3/13/14 to include the item of "complete temporary care plan on the day of admission". DON will review the admission checklists each month for six months and report to QAPI committee on compliance. After six months, QAPI committee will then determine if further review is necessary. This was also addressed in the staff inservice held on 4/7/14.  * Staff were educated on their responsibility for the temporary care plan. MJH/SDDOH/ME * The DON reviews all admissions and reports to the QA committee quarterly. MJH/SDDOH/ME	4/7/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Channay Schmidt</i>	TITLE <i>Administrator</i> <b>4-8-14</b>
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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 114 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.

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F 272	<p>Continued From page 1</p> <p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265</p> <p>Based on interview and record review, the provider failed to ensure an initial temporary care plan was completed for one of one new resident (7). Finding include:</p> <p>1. Interview on 3/12/14 at 4:30 p.m. with the director of nursing revealed: *There was no care plan for resident 7. *There had been no care conference yet so there was no care plan.</p> <p>Review of the entire medical record for resident 7 revealed: *Resident 7 was admitted on 3/4/14. *No care plan was located in the care plan notebook for resident 7. *A blank "temporary care plan" was located in the front pocket of the care plan notebook.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, revealed: *Page 243 - 244: "In any setting a nurse is responsible for providing a nursing plan of care</p>	F 272		
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F 272	Continued From page 2 for all patients. A nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later in evaluation. The plan of care communicates nursing care priorities to nurses and other health care professionals. It also identifies and coordinates resources for delivering nursing care. The nursing care plan enhances the continuity of nursing care by listing specific nursing interventions needed to achieve the goals of care." *Page 356: "After completing a nursing assessment, the nurse identifies standard care plans that are appropriate for the patient and places the plans in his or her medical record. The nurse modifies the plans to individualize the therapies."	F 272		
F 281 SS=E	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: 33265 Based on interview, record review, and policy review, the provider failed to: Ensure interagency summary forms and physicians' orders were consistent concerning medication administration instructions for two of 10 sampled residents. Finding include:  1. Review of resident 1's physician's order sheets	F 281	F281 On 3/11/14 , resident 1 medications, routes and dosages recorded on the MAR were reconciled with the most recent medication list provided by the physician and reviewed by her primary physician. The MAR is current and correct. A policy and procedure for reconciliation of medications on admission and readmission was created on 4/4/14 and was incorporated on 4/7/14, being addressed at the in-	4/7/2014

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F 281	<p>Continued From page 3 dated 2/28/14 and documented as to have begun on 3/1/14 revealed:</p> <ul style="list-style-type: none"> <li>*Zoloft 50 milligrams (mg) was to be administered every day.</li> <li>*Carafate was to be given three times a day at 8 a.m., 2 p.m. and at bedtime.</li> <li>*Albuterol was to be given two scheduled times a day and as needed (prn). There were two prn orders for the albuterol:             <ul style="list-style-type: none"> <li>-Albuterol every 6 hours prn without a specified dose.</li> <li>-Albuterol every 2 hours prn with a specified dose.</li> </ul> </li> <li>*Xopenex was not ordered.</li> </ul> <p>Review of resident 1's medication administration record (MAR) for March 2014 revealed:</p> <ul style="list-style-type: none"> <li>*Zoloft 50 mg was discontinued on 2/27/14. Zoloft 75 mg was to be given.</li> <li>*Carafate was to be given three times a day at 8 a.m., 2 p.m., and at bedtime.</li> <li>*Albuterol was to be given two scheduled times a day and as needed (prn). There were two prn orders for the albuterol:             <ul style="list-style-type: none"> <li>-Albuterol every 6 hours prn without a specified dose.</li> <li>-Albuterol every 2 hours prn with a specified dose.</li> </ul> </li> <li>*Xopenex was not ordered.</li> </ul> <p>Review of resident 1's after office visit summary form dated 3/3/14 revealed:</p> <ul style="list-style-type: none"> <li>*Zoloft 50 mg tablet was listed as a current medication. The instructions stated to take 75 mg daily.</li> <li>*Carafate was to be given before meals, not at 8 a.m., 2 p.m., and bedtime.</li> <li>*Albuterol was to be given twice a day. There was one prn order for the use of the albuterol:</li> </ul>	F 281	<p>service held that day. The nurse is to reconcile the transfer orders provided by the discharging facility against the current facility MAR, closely comparing all medications. If there are discrepancies, the nurse will contact the discharging physician for clarification orders. The DON or MDS Coordinator will review all hospital returns and new admissions for compliance and report to the QAPI committee with any problems. QAPI will address any changes to the monitoring as indicated.</p>	
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F 281	<p>Continued From page 4</p> <p>-Albuterol was to be given prn every 6 hours until xopenex was all used, then every 2 hours prn.</p> <p>Single physician's order sheet revealed a physician's order to discontinue prn xopenex on 2/20/14. The albuterol prn order for every 6 hours use should have been deleted when the xopenex was no longer available.</p> <p>2. Review of resident 10's physician's order sheets dated 2/28/14 and documented as to have begun on 3/1/14, and the March 2014 MAR revealed 60 mg of the medication lasix was ordered with the instructions to take one and one half tablets by mouth daily.</p> <p>Review of resident 10's interagency transfer orders form dated 6/1/13 revealed an order for the medication furosemide (lasix) 40 mg tablet, with the dose identified as 60 mg, and instructions to take one and a half tablets by mouth daily.</p> <p>3. Interview on 3/12/14 at 8:35 a.m. with the director of nursing revealed: *She was aware the facility MARs and the physicians' orders did not always match summary sheet information received from the clinic or the acute care facility. *She stated they caught most of the discrepancies. *She had tried in the past to reconcile that issue without success. *She stated she should just get rid of the summary form they received from the clinic and the acute care facility.</p> <p>Review of undated Physician Orders/Transcribing for New and Re-admitted Residents policy</p>	F 281		
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F 281	Continued From page 5 revealed: *Special Considerations: -If any information was incomplete, the deficiency should have been corrected by a call to the physician before medications/treatments were administered.	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: 12218 Based on menu review, observation, food temperature testing, and interview, the provider failed to ensure proper food temperatures of all food on the steamtable were maintained during two of three food services. Findings include:  1. Review of the supper menu for 3/11/14 revealed: *The regular diet had hamburger/bun, fried potatoes, vegetable, and Mandarin oranges planned. *Mechanical soft/pureed diets had ground/pureed hamburger, baked potato, pureed vegetables, and regular/pureed Mandarin oranges.	F 371	F371 The policy and procedure for "Food Temperatures" was revised on 4/2/14. The mechanically altered foods will be prepared and the hot foods will be placed in a steam table pan in the steam table to ensure the foods maintain proper temperature of at least 135 degrees F. CDM will spot check temperatures of the mechanically altered foods one time per week for three months and record results on "Mechanically Altered Foods Temperatures" record sheet, which was created on 4/4/14. CDM will report results at QAPI committee meetings. QAPI committee will then determine if spot checks and monitoring need to continue. This was also addressed in the staff inservice held on 4/7/14.	4/7/2014  <i>*QUALITY MHS/DMH/ME</i>

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F 371	<p>Continued From page 6</p> <p>Observation on 3/11/14 at 5:55 p.m. of the supper meal foods on the steamtable revealed:</p> <ul style="list-style-type: none"> <li>*One small China serving bowl and four small individual China serving dishes had been set on top of a lid covering an empty pan in the steamtable.</li> <li>*All of those China dishes were covered with aluminum foil.</li> <li>*The small serving bowl was labled "grd" (ground), and the four small individual dishes were labled "pur" (pureed) each with a resident's name.</li> </ul> <p>Food temperature testing at the above time with a food thermometer of those five dishes revealed:</p> <ul style="list-style-type: none"> <li>*The small serving bowl of ground hamburger had a temperature of 120 degrees Fahrenheit (F).</li> <li>*Two small dishes of pureed hamburger had food temperatures of 89 and 109 degrees F.</li> <li>*Two small dishes of pureed corn had food temperatures of 126 degrees F.</li> </ul> <p>Review of the lunch menu for 3/12/14 revealed:</p> <ul style="list-style-type: none"> <li>*The regular diet had Turkey ala King over biscuit, Prince Edward vegetables (green and wax string beans and carrots), and angel food cake planned.</li> <li>*The mechanical soft/pureed diet menu had regular and pureed Turkey ala King, pureed biscuit, regular and pureed vegetable, regular and pureed dessert.</li> </ul> <p>Observation on 3/12/14 at 11:45 a.m. of the lunch meal foods on the steamtable revealed:</p> <ul style="list-style-type: none"> <li>*One small serving China dish and four small individual serving dishes that had been set on top of a lid on an empty pan in the steamtable.</li> <li>*All of the dishes had been covered with</li> </ul>	F 371		

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F 371	Continued From page 7 aluminum foil. *The small serving dish was labled "grd," and the four individual dishes were labled "pur."  Food temperature testing of those five dishes at the above time with a food thermometer revealed: *The small serving bowl of ground Turkey ala King had a temperature of 150 degrees F. *Two small dishes of pureed Turkey ala King had temperatures of 121 and 122 degrees F. *Two small dishes of pureed carrots had temperatures of 127 and 128 degrees F.  Interview with the certified dietary manager (CDM) at 11:45 a.m. on 3/12/14 revealed: *She was unaware that the small dishes had not maintained proper food temperatures for serving. *She confirmed the temperatures were too low for all of the food in the small dishes for the supper meal on 3/11/14 as they needed to be at least 135 degrees F or hotter. *She confirmed all the pureed food temperatures were too low for the lunch meal on 3/12/14. *She stated they could put them into small steamtable pans into the steamtable to keep them at the proper temperatures.  According to the United States Department of Health and Human Services, Food and Drug Administration's Food Code regulation 3-501.16 for "Potentially hazardous food (time/temperature control for food safety), Hot and Cold Holding," food shall be maintained: *At 57 degrees centigrade (C) or 135 degrees Fahrenheit (F) for hot foods. *At 7 degrees C or 41 degrees F or less for cold foods.	F 371			
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431			

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F 431 SS=E	<p>Continued From page 8</p> <p><b>LABEL/STORE DRUGS &amp; BIOLOGICALS</b></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> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265</p>	F 431	<p><i>* All medication carts were checked on 3/12/14 and no cards were found to be expired.</i> MWH/SDDH/IMF</p> <p>F431 DON spoke with the pharmacist of the deficient pharmacy on 4-4-14 regarding Board of Pharmacy recommendation to provide medications using expiration date for repackaged medications of no greater than one year from the time of repackaging date. He is working with his label makers. All medications received from this pharmacy will have labels attached that read 'Med expires 11 months from dispensed date' attached to the punch cards until he can correct his labels. Consulting pharmacist will review labels for compliance during his monthly visit and report to DON any non-compliance. This will be reviewed at QAPI committee meetings quarterly until decided it is no-longer needed. This was also addressed at the inservice held on 4/7/14</p>	4/7/2014	

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F 431	<p>Continued From page 9</p> <p>Based on observation and interview, the provider failed to ensure one of two pharmacies providing medication to the provider used the expiration date for repackaged medications recommended by the Board of Pharmacy. Findings include:</p> <p>1. Observation of medication punch cards on 3/12/14 between 9:30 a.m. and 9:50 a.m. and 11:15 a.m. to 11:35 a.m. in the nurses station in two of two medication carts revealed: Both repackaged scheduled and as needed (prn) medications from the pharmacy had expiration dates exceeding one year from the repackaging date.</p> <p>Interview on 3/12/14 at 3:10 p.m. with the pharmacist from the pharmacy which had expiration dates on repackaged medications exceeding the recommended one year date revealed:</p> <p>*He used the expiration date on the medication bottle as the expiration date for all scheduled and all prn medications he repackaged for the facility.</p> <p>*He was unaware repackaged medications were to have the expiration date of no later than one year from the repackaging date.</p>	F 431			

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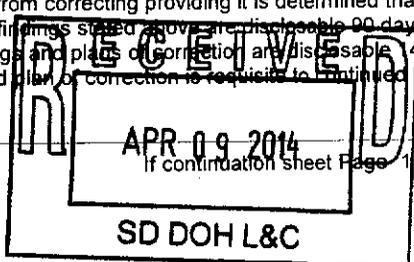
NAME OF PROVIDER OR SUPPLIER  <b>STRAND-KJORSVIG COMMUNITY REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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) COMPLETION DATE
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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/12/14. Strand-Kjorsvig Community Rest Home 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 and the Fire Safety Evaluation System (FSES) dated 3/12/14.  Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches in the cross-corridor smoke barriers in both the east and west corridors. Findings include:	K 028		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shannon Schmidt</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4-8-14</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 45 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to maintain program participation.



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435125</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>STRAND-KJORSVIG COMMUNITY REST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261</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 028	Continued From page 1 1. Observation at 10:00 a.m. on 3/12/14 revealed the cross-corridor doors in the east and west wing corridors were only 32 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report revealed those doors were the original doors.  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028			

ORIGINAL

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FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10673</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2014</b>
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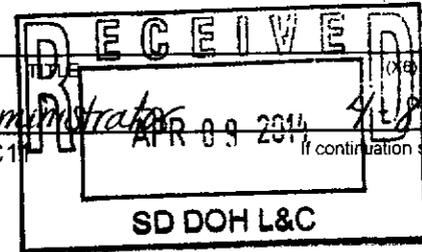
NAME OF PROVIDER OR SUPPLIER  <b>STRAND-KJORSVIG COMMUNITY REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	<p>Initial Comments</p> <p>Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/11/14 through 3/12/14. Strand-Kjorsvig Community Rest Home was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Shannon Schmidt*



(X6) DATE

*Administrators*  
APR 09 2014  
*4-9-14*