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

ORIGINAL

PRINTED: 06/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435102		06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/10/14 through 6/12/14. Sturgis Regional Senior Care was found not in compliance with the following requirements: F225, F253, F280, F281, F323, F371, and F441.	F 000	Addendums noted with an asterisk per 7/8/14 telephone to facility DON. NS/SDDOH/MF	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7/8/14

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 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to report three of three reviewed elopements (left the facility unattended) for one randomly reviewed resident (17) to the state reporting agency. Findings include: 1. Review of the provider's April 2014 through June 2014 investigative reports revealed resident 17 had eloped from the facility three times 4/23/14, 5/12/14, and 5/17/14. Those elopements had not been reported to the state agency. Interview on 6/11/14 at 4:14 p.m. with the director of nursing confirmed she was not aware elopements were to have been reported to the state agency. The following provider's policies were reviewed and had not indicated elopements were to have been reported to the state agency: *The initiated 7/20/11 Reporting of Suspected Abuse or Neglect of Elderly or Disabled Adults. *The reviewed 7/20/11 Suspected Abuse or Neglect of Elderly or Disabled Adults. *The reviewed April 2009 Protection of Resident	F 225	**F225** 1. Director of Nursing or designee will report all elopements to the state agency and perform monitoring of all elopements to assure adequate documentation as well as reporting. Monitoring will be weekly for one month; if adequate documentation is seen monitoring will go to monthly for three months, then quarterly until 6/30/15. Monitoring will include all residents; resident 17 has been discharged from the facility. DON or designee will report monitoring results to the PI Committee monthly.	7/10/14 [redacted] NS/SDDCH/MF

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F 225	Continued From page 2 during Abuse Investigations. *The reviewed April 2009 Recognizing Signs and Symptoms of Abuse/Neglect.	F 225		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation and interview, the provider failed to maintain wooden surfaces in a cleanable manner for: *Random resident room doors throughout two of two units (Massa and Berry). *Handrails in one of two units (Berry). Findings include: 1. Observation from 6/10/14 to 6/11/14 revealed: *The handrails in the Berry unit had multiple gouges along the edges and corners with rough, exposed, raw wood (photo 1). *The handrails in the Berry unit had worn finish that exposed raw wood, making them an uncleanable surface (photo 2). *Multiple resident room doors throughout the facility had chipped edges with exposed, raw wood, making them an uncleanable surface (photo 3). Interview on 6/11/14 at 8:15 a.m. with the maintenance supervisor revealed the handrails and doors had not yet been scheduled to be fixed. He confirmed the surfaces had been	F 253	**F253 – Housekeeping and Maintenance Services** 1. Plant Operations will repair the doors and handrails by 7/31/14. 2. The director of Plant Operations has added doors and hand railing to the monthly preventative maintenance for LTC. 3. The director of Plant Operations has developed a weekly PI monitor for the condition of the handrails and doors. 4. The director of Plant Operations or designee will monitor weekly for six weeks or until substantial compliance is met; then monthly monitors will be performed. The director of Plant Operations will report on the PI monitor at the monthly LTC PI Committee meetings.	7/31/14

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F 253	Continued From page 3 uncleanable and should probably be refinished.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure care plans were reviewed and revised to reflect the current status or change in condition for 3 of 13 sampled residents (5, 9, and 10). Findings include: 1. Review of resident 5's physician's orders revealed she had multiple adjustments to her anti-psychotic (used to treat mental disorders)	F 280	**F280** 1. Director of Nursing or designee will audit five Care Plans per Unit per month to include Resident 5 and all other residents for accuracy to include the use of Antipsychotic medications, correlating behaviors, with redirection of those behaviors. Use of injections or PRN's and signs or symptoms of medication interactions. If compliance and accuracy, of 95% or greater, is noted for 3 consecutive months audits will be quarterly until 6/30/15. All results will be reported to the PI Committee monthly by DON or designee. 2. Director of Nursing or designee will audit five Care Plans per Unit per month to include Resident 9 and all other residents. These audits will be completed monthly until a 95% or greater accuracy rate is maintained for 3 consecutive months. Audits will then go to quarterly until 6/30/15. Audits will include review of Care Plans as well as physician progress notes and accumulative monthly order sheets to assure accuracy. Results will be reported monthly to the PI Committee by the DON or designee. 3. Director of Nursing or designee will audit five Care Plans per Unit per month to include Resident 10 and all other residents. These audits will include comparision of Care Plan to skin assessment records to insure accuracy. Continued on next page.	*07/10/14 [redacted] NS/SDDCH/MF *NS/SDDCH/MF [redacted] *NS/SDDCH/MF [redacted]

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F 280	Continued From page 4 medications since her admission on 2/13/14. She had been showing behaviors that had been a danger to herself and others. Those behaviors were not able to be re-directed with non-drug therapies. Review of her 5/27/14 physician's orders revealed orders for the following anti-psychotics: *Seroquel changed to 25 milligrams (mg) at noon each day. *Haldol increased to 4 mg twice each day. *Thorazine 50 mg IM (injected into the muscle) every six hours as needed for extreme agitation. Review of resident 5's revised 5/30/14 care plan revealed there had been no mention of: *Anti-psychotic medication usage. *What behaviors would indicate extreme agitation and the need for the IM medication. *Signs and symptoms to watch for a potential drug interaction between the Seroquel and Haldol. *Interventions for redirecting her behavior before it resulted in extreme agitation. Interview on 6/11/14 at 9:30 a.m. with Minimum Data Set (MDS) coordinator A revealed care plans should have been updated when new orders were received or there had been a change in the resident's condition. She confirmed there was nothing on resident 5's care plan regarding her psychoactive medications. She stated the MDS coordinators were primarily responsible for updating the care plans, but any nurse was able to add to them as needed. Surveyor: 32572 2. Review of resident 9's medical record revealed: *She had been admitted on 8/8/13.	F 280	Audits will be completed monthly until 95% or greater accuracy is maintained for 3 consecutive months. Audits will then go to quarterly until 6/30/15. Results will be reported monthly to the PI Committee by the DON or designee. 4. Audits of five Care Plans per Unit will be done monthly to assure accuracy for all residents. These audits will be completed monthly until 3 consecutive months of 95% or greater is maintained and then audits will go quarterly until 6/30/15. Results of these audits will be reported to the PI Committee monthly by the DON or designee.	xNS/SDDOH/MF [redacted]

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F 280	Continued From page 5 *The Patient Transfer (Nursing) record indicated resident 9 had "no known allergies (NKA)." *The Admission Record indicated "No Known Allergies." *The 8/8/13 Admission Summary indicated "NKA." *The certified resident assistant (CRA) Care Plan indicated "NKA." *The June 2014 medication administration record (MAR) indicated "NKA." *The physician progress notes from visits on 3/13/14 and 5/12/14 indicated she had been allergic to "alendronate sodium" which had been "last reviewed [by the physician] on 7/3/13." Interview on 6/11/14 at 8:50 a.m. with registered nurse D confirmed she had not been aware of the allergy. She stated the process should have been to clarify the allergy with the physician upon notification. She confirmed the care plan should have been updated to indicate the correct information. Surveyor: 32333 3. Review of resident 10's pressure and stasis ulcer monitoring (skin breakdown) report revealed: *She had a stage II pressure ulcer on her coccyx (tailbone). *That pressure ulcer had been documented as resolved on 5/15/14. Review of resident 10's current care plan revised on 5/5/14 revealed: *She was at risk for impaired skin integrity. *"I currently have an open area to my coccyx..." *Her care plan had not been updated to reflect the pressure ulcer on her coccyx had been	F 280		

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F 280	Continued From page 6 resolved. Interview on 6/11/14 at 4:30 p.m. with the director of nursing revealed resident 10's care plan should have been updated to reflect her pressure ulcer had been resolved. 4. Review of the provider's revised 2/4/04 Care Plans-Comprehensive policy revealed: *An interdisciplinary team, in coordination with the resident and family/representative, was responsible for maintaining a comprehensive care plan for each resident. *The care plan was to have included: -Identified actual/potential problem areas. -Goal statements that were obtainable and measurable. -Approaches/interventions that were specific to the resident. *Care plans were to have been revised as changes to the resident's condition dictated. *It was the responsibility of all staff involved in the resident's care to review and update the care plans on an ongoing basis.	F 280		
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: 23059 Based on record review and interview, the provider failed to ensure physician's orders had been followed for 2 of 13 sampled residents (3 and 5). Findings include:	F 281		

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F 281	Continued From page 7 1. Review of resident 5's 5/27/14 physician's order revealed an order for a psychiatric/behavior management consultation. Review of her nurses notes from 5/27/14 through 6/10/14 revealed there had been no mention of an appointment made for that consultation. Review of the provider's calendar schedule book through July 2014 revealed there was no appointment for resident 5 in that book. Interview on 6/10/14 at 5:00 p.m. with registered nurse G revealed if an appointment had been made it would have been documented in the calendar schedule book. She stated the facility's bus driver made all of the appointments. She confirmed no appointment had been made for resident 5. Interview on 6/11/14 at 9:30 a.m. with Minimum Data Set (MDS) coordinator A revealed the provider's bus driver was responsible for making any outside appointments. She stated it was the nurse's responsibility to make a copy of the physician's order and to notify the bus driver if an appointment was needed. She stated she talked with the activity director since the bus driver was not available at that time. She confirmed no notification had been found for the bus driver. The MDS coordinator stated they had no process in place to check to ensure all physician's orders had been followed. She stated there had been a breakdown in communication between the nurses and the bus driver. She further stated that order for the consultation probably would not have been found until she had done her next MDS review that was not scheduled until August 2014. Interview on 6/11/14 at 2:30 p.m. with the director	F 281	**F281** 1. Director of Nursing or designee will audit five appointments per Unit weekly to assure all residents, including Resident 5, with returning order are complete and accurate. These audits will continue weekly for one month with an accuracy rate of 95% or greater; then will be completed monthly for 3 months and then quarterly until 6/30/15. Results will be reported to the PI Committee monthly by DON or designee. Training will be provided to all nurses about follow up of orders when resident returns from appointment and assuring completion of orders upon returning to the facility from the outside physician. 2. All residents are to be offered a supplement when eating 50% or less of their meal. Director of Nursing or designee will be reeducating all staff regarding the policy to include nurses as well as CNAs to assure adequate oversight of this policy. DON or designee will be monitoring dietary documentation of all residents, to include Resident 3, daily for one month; then weekly for one month; then monthly for three months; and then quarterly thereafter to assure 95% or greater accuracy and compliance of the policy. Results will be reported to the PI Committee monthly by DON or designee.	x 7/10/14 [redacted] NS/SDDOH/MF x NS/SDDOH/MF [redacted]

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F 281	Continued From page 8 of nursing (DON) confirmed they had no process in place that would have found that missed order in a timely manner. She also stated they did not have a policy in place for ensuring physician's orders were followed. Surveyor: 32573 2. Review of resident 3's medical record revealed a 4/30/13 physician's order for nutritional supplements to have been offered if the resident had consumed less than 50 percent of her meals. Her care plan dated 4/15/14 had a goal of maintaining an adequate nutritional status by maintaining weight and consuming 50 percent of at least three meals with daily current interventions. One of the interventions listed had been to offer a supplement if she ate less than 50 percent of a meal. Review of resident 3's food intake forms from February 2014 through May 2014 revealed: *A note at the bottom stating, "Remember it is a requirement to offer supplement if intake is less than 50% for a meal- Document how much resident consumed of supplement in ml (milliliters) or if they refused supplement." *February 2014- supplements had not been documented sixteen times when the resident had eaten less than 50 percent of a meal. *March 2014- supplements had not been documented seventeen times when the resident had eaten less than 50 percent of a meal. *April 2014- supplements had not been documented twenty times when the resident had eaten less than 50 percent of a meal. *May 2014- supplements had not been documented seventeen times when the resident had eaten less than 50 percent of a meal.	F 281		

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F 281	Continued From page 9 Interview on 6/11/14 at 3:50 p.m. with the DON confirmed she would have expected staff to offer a supplement and document intake amount or refusal on the food intake forms.	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: Surveyor: 32333 Based on observation and interview, the provider failed to ensure chemicals had remained locked in four of four tub/shower rooms in two of two units (Massa and Berry). Findings include: 1. Random observations from 6/10/14 through 6/11/14 in all four tub/shower rooms revealed: *The doors to the rooms had been unlocked at all times. *A bottle of Quat 5 disinfectant had been left unlocked in each room. *Residents including cognitively impaired (impaired thinking abilities) had been in those areas. Interview and walk-through on 6/11/14 at 4:30 p.m. with the director of nursing (DON) revealed the Quat 5 disinfectant should have been locked	F 323	**F323** 1. Director of Nursing or designee will be performing random checks of all tub/shower rooms to assure Quat 5 cleaner containers are stored in a locked area out of the reach of cognitive and cognitively impaired residents. Training was provided to all staff regarding these practices. Random checks of all Tub/Shower rooms will be completed twice daily for one week; then weekly for one month; then monthly thereafter until 6/30/15 to assure compliance is maintained. All results will be reported to the PI Committee monthly by the DON or designee. 2. Elopements will be monitored by the Director of Nursing or designee to assure adequate measures are taken to ensure safety of all residents; Resident 17 has been discharged from the facility. Upon an elopement the resident will be placed on checks every half hour for a period of 3 days, if compliance is noted the resident will be on hourly checks for 3 days; then return to every checks every 2 hours if no further elopements are noted. If elopement attempts continue, residents will be left on the more frequent monitoring and placement in a locked facility is pursued.	x 7/10/14 [redacted] NS/SDDOH/MF x NS/SDDOH/MF [redacted]

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F 323	Continued From page 10 in the housekeeping closet. It should not have been left in the rooms unattended. Surveyor: 32572 Based on record review and interview, the provider failed to ensure adequate supervision for one of one randomly selected resident (17) who had multiple elopements (left the facility unattended). Findings include: 1. Review of the provider's investigative reports revealed: *Resident 17 had eloped from the facility three times from 4/23/14 through 5/17/14. *He had obtained injuries two of those times. -On 4/23/14 he had eloped from the facility and had been found knocking on the locked door to get in. He had blood on his face and an injury on his nose. -On 5/12/14 he had eloped from the facility and had been found with an abrasion on his right knee and the palm of his right hand. -On 5/17/14 he had eloped from the facility and been found outside the facility. Interview on 6/11/14 with the DON confirmed the resident's plan of care had not been modified until the 5/12/14 elopement. At that time he had been placed on every half-hour checks. Refer to F225.	F 323		
F 371 SS=D	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	F 371		

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F 371	Continued From page 11 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure: *One randomly observed dietary aide (C) had his hair restrained while serving food during a meal service. *Appropriate handwashing and glove use by one of two observed cooks (B). *Three of three ice machines (kitchen, Massa unit, and Berry unit) had been maintained in a sanitary manner. Findings include: 1. Observation on 6/10/14 of dietary aide C while plating the noon meal in the Massa unit revealed he had not been wearing a hair net throughout the entire meal service. 2. Observation on 6/10/14 from 4:05 p.m. through 5:25 p.m. of cook B while preparing the supper meal service revealed she: *Took a pan of hashbrown sticks out of the oven. *Put gloves on. *Touched the hashbrown sticks with her gloved hands. *Removed her gloves. *Took another pan of hashbrown sticks out of the oven. *Put on gloves without washing her hands.	F 371	**F371** Dietary Aide C was counseled on the importance of wearing a hair net throughout the entire meal service. All other dietary staff was counseled regarding this importance. Additional hairnet dispensers have arrived and are located throughout department. Dietary director or designee will do monitoring of staff to ensure proper hair net use. Each staffed shift will be randomly checked once per week for a period of one month. The, hair net checks will be done monthly for a period of 11 months, ending on 6/30/15. Results of the staff hair net checks will be reported at the monthly Performance Improvement (QA) meetings by the Dietary Director or designee. Cook B was counseled on the importance of proper hand washing technique during the meal service time. All other dietary stass was also counseled regarding this importance through policy distribution. Hand washing compliance kits have been ordered and will be used to further instruct staff on proper technique and importance of hand washing. Dietary director or designee will do monitoring of staff to ensure proper hand washing practices. Each staffed shift will be randomly checked once per week for a period of one month. Then, proper hand washing practices will be monitored monthly for a period of 11 months, ending on 6/30/15. Results of the staff hand washing checks will be reported during the monthly Performance Improvement (QA) meetings by the Dietary Director or designee.	7/9/14 xNS/SDDDH/MF [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435102		06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

(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 371	Continued From page 12 *Touched those hashbrown sticks with her gloved hands. *Removed her gloves and had not washed her hands. *Continued preparing the supper meal. Review of the provider's 6/11/13 Proper Handwashing policy revealed hands should have been washed before putting on gloves and after removing soiled gloves. 3. Random observations on 6/10/14 and 6/11/14 of all three ice machines in the kitchen, Massa unit, and Berry unit revealed they had lime build-up on the front and dispensing parts of the machines (photo 4). 4. Interview on 6/11//14 at 9:40 a.m. with the dietary manager revealed: *Employees were responsible for providing their own hair restraints. *She had noticed dietary aide C had not been wearing a hair restraint. *She would have expected employees to wear hair restraints. *Employees should have washed their hands for twenty seconds before putting on gloves and after glove removal. *She agreed the ice machines had been soiled. Interview on 6/11/14 at 4:30 p.m. with the director of nursing who also supervised the kitchen staff revealed she: *Was unaware staff had to provide their own hair restraints. *Expected appropriate handwashing before putting gloves on and after glove removal. *Agreed the ice machine should have been maintained in a sanitary manner.	F 371	Dietary Director has been made aware of lime buildup issue on the three ice machines. Machines were cleaned and lime removed on 6/13/14. All machines throughout the facility were also inspected and appropriately cleaned by Dietary department. Dietary Director or designee will do visual inspections for cleanliness each week starting on 7/1/14 of all ice machines in the facility for a period of one month. Inspections will continue on a monthly basis for 11 months, ending on 6/30/15. Results of these inspections will be reported during the monthly Performance Improvement (QA) meetings by the Dietary Director or designee.	*NS/SDDH/MF [redacted]

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F 371	Continued From page 13	F 371		
	Review of the provider's undated Employee Sanitary Practices policy revealed "All employees shall wear hair restraints (hairnet, hat, and/or beard restraint) to prevent hair from contacting exposed food."		F441 1. Training has been provided to all staff including CNAs regarding the cleaning of the tubs/showers. New cleaning posters have been posted in the tub/shower rooms to provide step-by-step instructions for cleaning between showers and bathers, as well as end of the day cleaning instructions. The Director of Nursing or designee will be conducting random testing of bathing staff weekly for one month; then monthly for 3 months; then quarterly thereafter to assure compliance of cleaning processes. Checks will continue until 6/30/15. Results of checks will be reported to the Performance Improvement Committee monthly by the DON or designee.	*7/10/14 [redacted] NS/SDDCH/MF
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.	F 441	2. Steriplex wipes have been implemented for all staff to use on the kiosks in the hallways. This task is completed on a daily basis by the PM shift and is on a cleaning schedule. The Director of Nursing or designee will be performing random checks of all kiosks weekly for one month; then monthly for 3 months; then quarterly thereafter until 6/30/15. 3. Steriplex wipes have replaced the alcohol for cleaning of nail clippers. Continued on next page	*NS/SDDCH/MF [redacted] *NS/SDDCH/MF [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435102	A. BUILDING _____ B. WING _____	06/12/2014

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F 441	Continued From page 14 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure: *One of four whirlpool tub (Masa unit) and one of four showers (Berry unit) had been properly disinfected by two of two observed certified nursing assistants (CNA) (E and F). *Six of six CNA computer charting stations had been maintained in a sanitary manner in two of two units (Massa and Berry). *Multiple resident use nail clippers had been maintained in a sanitary manner in four of four tub/shower rooms. *Personal care items had been stored in a sanitary manner in two of two tub/shower rooms on the Berry unit. Findings include: 1. Observation and interview on 6/10/14 at 11:05 a.m. with CNA E while she verbalized how to clean the whirlpool tub and shower in the Massa unit revealed she would have done the following: *Whirlpool tub: -Filled the tub half full of water. -Put an unmeasured amount of Mastercare disinfectant into the tub. -Then ran the jets for ten minutes. *Shower: -Used the Mastercare disinfectant to clean the	F 441	**F441-continued** All staff have been trained on the cleaning of nail clippers. Nail clippers have been put on chains and removed from boxes to ensure sanitary storage. Director of Nursing or designee will be checking the process of cleaning nail clippers when doing random chekcs of the tub/shower rooms. These checks will be done weekly for 1 month; then monthly for 3 months; then quarterly thereafter until 6/30/15. Results will be reported to the Performance Improvement Committee monthly by the DON or designee. 4. Toilet paper has been removed from the handrails in both Tub/shower rooms on Berry Unit. Staff has been educated to keep toilet paper on higher shelf for sanitary reasons. Director of Nursing or designee will perform random checks daily for 1 week; then weekly for 1 month; then monthly for 3 months; then quarterly thereafter until 6/30/15 to assure process is followed. Results will be reported monthly to the Performance Improvement Committee by DON or designee.	*NS/SDDCH/MF [redacted]

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F 441	Continued From page 15 shower chair. -Did not disinfect the shower walls or floor. -Had been unsure if she was supposed to clean the shower walls and floor. There had been a sign on the wall next to the shower with the procedure to follow for the disinfection of the shower that included to disinfect all surfaces of the shower. Review of the Mastercare disinfectant label revealed the proper dilution of the chemical would have been two ounces of disinfectant to one gallon of water. Observation and interview on 6/10/14 at 11:30 a.m. of CNA F while she cleaned the shower in the Berry unit revealed she: *Put Quat 5 disinfectant onto the shower chair. *Put a small amount of Quat 5 disinfectant on the shower floor. *Would allow it sit on the surfaces for ten minutes and then rinse it off. *Had not disinfected the shower walls. Interview on 6/11/14 at 4:30 with the director of nursing revealed: *She would have expected the whirlpool tub to have been disinfected appropriately. *She would have expected all surfaces of the showers to have been disinfected. 2. Random observations on 6/10/14 and 6/11/14 revealed all six CNA charting stations on the Massa and Berry units had been visibly soiled with fingerprints. Interview with the DON on 6/11/14 at 4:30 p.m. revealed the CNA charting stations had not been	F 441		

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F 441	Continued From page 16 on a cleaning schedule. She agreed they had been soiled and needed to be on a cleaning schedule. 3. Random observations on 6/10/14 and 6/11/14 in all four tub/shower rooms revealed: *Plastic storage containers with nail clippers and nail care items. *The nail clippers were visibly soiled with nail debris. *The plastic storage containers were visibly soiled with nail clippings (photo 5). Interview and walk-through on 6/11/14 at 4:30 p.m. with the DON revealed she would have expected the nail clippers to have been cleaned after each use. Review of the provider's 9/15/10 Nail Care policy revealed "Clean and disinfect the nail clippers and file after each use." 4. Random observations on 6/10/14 and 6/11/14 in the tub/shower rooms in the Berry unit revealed the grab bars on the toilets had toilet paper rolls attached to them. That had created potentially unsanitary resident personal care items (photo 6). Interview and walk-through on 6/11/14 at 4:30 p.m. with the DON revealed she had been unaware of the toilet paper attached to the grab bars on the toilets. She agreed the toilet paper had been stored in an unsanitary manner.	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MASSA B. WING	(X3) DATE SURVEY COMPLETED
	435102		06/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	949 HARMON STREET STURGIS, SD 57785

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/11/14. Sturgis Regional Senior Care Building 1 (Massa) 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 K022 and K056 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 7/18/14 telephone to facility Director of Plant Operations and facility Safety Coordinator. LF/SDDOH/MF	
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure access to exits were marked by approved, readily visible exit signs in one randomly observed location (main entrance near nurse station). Findings include:	K 022	*cross corridor doors near the main entrance LF/SDDOH/MF **K022 – Access to Exits** 1. On 6/25/14 all exits were inspected by Plant Operations for compliance. 2. On 7/1/14 the exit sign at the [redacted] was moved to a readily visible exit sign at the main entrance near the nurse's station. 3. Preventative maintenance for exit inspections was added to the Plant Operations Preventive Maintenance schedule. 4. The Director of Plant Operations will report the corrective action to the Safety Committee meeting held bi-monthly.	7/1/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-8-14

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MASSA** B. WING _____	(X3) DATE SURVEY COMPLETED
	435102		**06/11/2014**

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STURGIS REGIONAL SENIOR CARE	**949 HARMON STREET** **STURGIS, SD 57785**

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K 022	Continued From page 1	K 022		
	1. Observation at 11:10 a.m. on 6/11/14 revealed an exit access door at the main entrance near the nurse's station. Further observation revealed that door was not provided with exit signage. It was a solid panel door with no vision panels and was not a readily apparent exit access door. Interview with the plant operations director at the time of the observation confirmed that condition.			
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		
	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5			
	This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview the provider failed to ensure the facility was protected throughout by an automatic sprinkler system installed in accordance with NFPA 13 in randomly observed locations (corridor alcove, janitor's closet, clean linen closet and kitchen freezer). Findings include:			

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	435102	A. BUILDING 01 - MASSA B. WING _____	06/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 056	Continued From page 2 1. Observation at 11:30 am on 6/11/14 revealed an alcove in the west Massa unit wing. That alcove was protected by a quick response sprinkler head. Further observation revealed the sprinkler head was an intermediate-temperature rated sprinkler head. Only ordinary-temperature rated sprinklers may be installed throughout a light hazard occupancy. Interview with the maintenance supervisor at the time of the observation confirmed that condition and was unaware of that requirement. Further observation revealed the same condition in a janitor's closet of that wing and in a clean linen closet of the north wing. 2. Observation at 1:20 p.m. on 6/11/14 revealed a freezer in the dietary area. That freezer was protected by an automatic sprinkler system. A single sidewall sprinkler was installed to protect the entire freezer area. Storage of boxed frozen goods in the middle of the freezer were stacked to within eight inches from the ceiling. That storage would impede development of the sprinkler discharge pattern and would not provide full coverage of that area. The stacked storage obstruction was more than thirty inches horizontal from the sprinkler and would require eighteen inches vertical distance below the deflector to top of the storage area.	K 056	**K056 – 1. Sprinkler Heads** 1. All intermediate sprinkler heads in a light hazard occupancy were inspected by Plant Operations and will be replaced by 7/31/14. The deficiency was brought to the attention of the sprinkler vendor on 6/25/14. 2. The Plant Operations Director will report the corrective action to the [redacted] at their bi-monthly meeting. L x long-term care performance improvement committee. LF/SDDOH/MF **K056 – 2. Freezer Sprinkler** 1. The boxes of frozen goods in the middle of the freezer stacked within 8 inches of the ceiling were removed on 6/12/14. 2. On 7/7/14 the level of permissible height of storage items was marked with a red line on an indicator stick and placed on the storage shelf. Additionally, a notification sign for incorrect storage was created and placed on the storage shelf in the freezer. 3. Dietary staff were provided an in-service on 7/6/14 and 7/7/14 on proper freezer storage. 4. The Dietary Director or designee will monitor appropriate freezer storage through a weekly PI monitor and will report monthly to the LTC PI Committee for three consecutive months or until substantial compliance is met.	7/31/14 x LF/SDDOH/MF [redacted]

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BERRY B. WING	(X3) DATE SURVEY COMPLETED
	435102		06/11/2014

NAME OF PROVIDER OR SUPPLIER
STURGIS REGIONAL SENIOR CARE

STREET ADDRESS, CITY, STATE, ZIP CODE
949 HARMON STREET
STURGIS, SD 57785

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/11/14. Sturgis Regional Senior Care 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 K62 and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition and inspected and tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports revealed no	K 062	**K062 – Sprinkler Internal Obstruction Inspection** 1. The Plant Operations Director has scheduled a sprinkler internal obstruction inspection with the sprinkler vendor to be completed by 7/31/14. 2. The five-year inspection requirement was added to the Preventative Maintenance schedule in the Life Safety Binder. 3. The Director of Plant Operations will report on the corrective action at the [redacted] meeting scheduled bi-monthly. L* Long Term Care Performance Improvement Committee LF/SDDOH/MF	7/31/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7-8-14

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.

JUL 11 2014

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	435102	A. BUILDING 02 - BERRY B. WING _____	06/11/2014

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K 062	Continued From page 1 documentation for when the last five year internal obstruction investigation had been conducted. Interview with the facility services supervisor at the time of the record review indicated he was unaware of the five year internal obstruction investigation testing requirements.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure electrical wiring was installed in accordance with the National Electrical Code in one randomly observed location (serving kitchen). Findings include: 1. Observation at 10:10 a.m. on 6/11/14 revealed a serving kitchen in the dining area. Further observation revealed an ice maker had been installed on a wall directly above a standard electrical outlet. That ice maker would be considered a wet location with direct water supply and waste plumbing. That electrical outlet should have been provided with ground fault circuit interruption protection in accordance with the National Electric Code. Interview with the maintenance supervisor at the time of observation confirmed that condition.	K 147	**K147 – Electrical wiring and equipment** 1. On 6/18/14 the outlet below the ice maker was changed by plant operations to provide protection. All other facility outlets located in wet locations were inspected for compliance by plant operations on 6/24/14 & 6/25/14. 2. The director of plant operations will report the corrective action to the [redacted] at their bi-monthly meeting. L x Long Term Care Performance Improvement Committee LF/SDDOH/MF	6/18/14

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STURGIS REGIONAL SENIOR CARE	**949 HARMON STREET** **STURGIS, SD 57785**

(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 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/11/14. Sturgis Regional Senior Care Building 3 (Administration) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7-8-14

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.

RECEIVED JUL 11 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	10693		06/12/2014

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S 000	Initial Comments	S 000		
	Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/10/14 through 6/12/14. Sturgis Regional Senior Care was found not in compliance with the following requirement: S322.			
S 322	44:04:08:04.01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS	S 322		
	Written authorization by the attending physician must be secured for the release of any medication to a...resident upon discharge or transfer. The release of medication must be documented in the...resident's record, indicating quantity, drug name, and strength.		S322 All nurses and med aides have been trained on the process of med distribution as well as medication documentation and handling of transfers. Resident 16 has transferred from our facility. Director of Nursing or designee will audit all discharges from the facility for 1 month to assure accuracy of charting until 3 consecutive months of 95% or greater is achieved; then quarterly monitoring will be done until 6/30/15. The results will be reported monthly to the Performance Improvement Committee by the DON or designee.	6/30/15
	This Rule is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the provider failed to ensure released medication name, strength, and quantity had been documented for one of three sampled resident's (16) closed records. Findings include:			
	1. Review of resident 16's medical record revealed she had transferred from the facility on 5/11/14 to another nursing home. There had been no documentation of the name, strength, and quantity of medications that had been sent with her to the receiving facility.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7-8-14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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S 322	Continued From Page 1 Interview on 6/12/14 at 7:30 a.m. with the director of nursing revealed she had gone through all of the resident's files and had not been able to find a medication discharge instruction sheet. She confirmed there should have been documentation of the name, strength, and quantity of medications that had been sent with resident 16.	S 322		