

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

ORIGINAL

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/4/14 through 11/5/14. Winner Regional Healthcare Center was found not in compliance with the following requirements: F156 and F441.</p> <p>F 156 SS=B 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p>	F 000	<p>F156</p> <ol style="list-style-type: none"> 1. Resident #16 has been given another written and verbal denial of services on Nov. 26th, 2014. The regulatory requirement was reviewed by the quality assurance team on November 26th, 2014. Winner Regional Long Term Care will continue to inform residents both verbally and in writing of the Medicare denial process. 2. All resident charts have been checked to ensure that a Medicare denial letter has been issued and verbal confirmation provided appropriately for those residents with Medicare benefits. 3. All incoming residents with Medicare benefits and residents who are coming off Medicare benefits will be reviewed for two months to verify that a Medicare denial has been issued timely and verbal confirmation documented. *See Page 3 of 8 - 3a. ✓ 4. To assure continued compliance, the following plan has been implemented: Auditing of charts for Medicare denials will occur with each admit/ readmit/ and those coming off of Medicare for two months and thereafter will be determined by the Quality Assurance team based on audit review. ✓ 5. The business office, social services, and MDS staff were educated on the F156 regulatory requirement on November 18th, 2014. The CEO or designee will be responsible to ensure ongoing compliance. This deficiency will be corrected by <u>November 30, 2014</u>. ✓ 	11.30.2014
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE CEO	(X6) DATE 11/19/14
-----------------------------------------------------------------------	---------------------	------------------------------

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.

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2014
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580		
(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 156	<p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the</p>	F 156	<p>F156</p> <p>*3a. The DON will validate results and report to QA-PI. </p> <p>*4a. The DON will conduct audits weekly times 3 months and then quarterly times one until the QA committee can validate compliance. The DON will be responsible to complete the audits and report to QA-PI. </p>	

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580	
(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 156	<p>Continued From page 2</p> <p>name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on record review and interview, the provider failed to ensure notification of the Medicare denial process information was documented for one of six random residents (16) reviewed. Findings include:</p> <p>1. Review of resident 16's medical record revealed she had been discharged from Medicare on 10/20/14.</p> <p>Interview on 11/5/14 at 2:30 p.m. with the licensed social worker (LSW), social service designee (SSD), and business office manager regarding resident 16 revealed: *No notification of the Medicare denial process information had been located. *The LSW and SSD thought resident 16's husband had received the information but had not returned the form to them. They were unsure if he had requested an appeal to the Quality Improvement Organization. *The business office manager stated she was unaware if resident 16's husband had requested</p>	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580	
(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 156	Continued From page 3 a demand bill. She had continued to bill him for the services provided to his wife.	F 156		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F 441 1. Resident's 8, 17, 18, 19, 20, 21, 22, 23, 25, & 26 have all had follow up urinalysis and are negative for urinary tract infections as of November 26 th , 2014. Resident # 24 has a UA pending. 2. All residents who are dependent upon staff for Peri-care are at risk for developing UTI's.*See page 5 of 8, 2a. 3. The nurse educator or designee will provide education and demonstration on appropriate peri-care the week of November 30. Return demonstration will be completed by all licensed and unlicensed nursing personnel staff by December 5th. Audits will be performed three times weekly on various shifts for two months and thereafter will be determined by the Quality Assurance team based on audit review. *See page 5 of 8, 3a 4. To assure continued compliance, a yearly competency audit for staff during their anniversary period will be completed by the Director of Nursing or designee. *See page 5 of 8, 4a 5. The Director of Nursing will be responsible to ensure ongoing compliance. This deficiency will be corrected by December 5th, 2014. 12.05.2014	

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014	
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 4 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy review, the provider failed to ensure an effective infection control program was in place and had included: *Education and audits for staff to ensure correct techniques had been used for resident perineal care (cleaning of the bottom area after toileting). *Interventions for 11 of 11 sampled residents (8, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26) who had been treated for urinary tract infections in the months of September and October 2014 to prevent a possible re-occurrence of that infection. Findings include:</p> <p>1. Review of the provider's Infection Control Meeting minutes from December 2013 through October 2014 revealed the following number of urinary tract infections (UTI) per month: *January 2014 - six. *February 2014 - four. *April 2014 - three. Those minutes had not addressed UTIs specifically regarding possible causes or interventions except to list the occurrences of UTIs in those months.</p> <p>Review of the provider's Quality Committee Minutes from January 27, 2014 through September 29, 2014 revealed the following: *January 27, 2014 minutes had listed six UTIs for residents without a catheter and one resident with a catheter.</p>	F 441	<p>F441 *2a Audits will be completed on fresh water passes and fluid intakes weekly times 3 months and then quarterly times one until the QA committee can validate compliance. The audit will be reported to the QA committee by the DON. </p> <p>F441 *3a. The DON will conduct audits weekly times 3 months and then quarterly times one until the QA can validate compliance. Nurses will be completing the audits. DON will report to the committee. </p> <p>All residents at risk will be provided education by nurses as needed. Education will be audited by DON weekly times 3 months and then quarterly times one until QA committee can validate compliance. </p> <p>F441 *4a. Results of competency audits will be reported by DON and/or infection control nurse. Infection Control nurse employment has been postponed until January, 2015 and infection control will be monitored by a Pathway Health nurse consultant until that time. Education will be provided to Infection Control nurse by Sanford Health specialist. The training has been </p>	

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2014
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 5</p> <p>*February 17, 2014 minutes had listed four resident UTIs.</p> <p>*May 19, 2014 minutes had listed seven resident UTIs.</p> <p>-New infection control program was to have been started in the next week by the interim director of nursing (DON).</p> <p>*June 16, 2014 minutes revealed a facility map was in process to be used to track infections.</p> <p>*July 21, 2014 minutes had listed the number of residents with UTIs had decreased. It had not listed how many UTIs there had been.</p> <p>-They had attributed that to better handwashing.</p> <p>*August 18, 2014 minutes had stated UTIs for short term residents had increased since June.</p> <p>-Water consumption was encouraged for those residents.</p> <p>-Good handwashing was being encouraged by the staff.</p> <p>*September 29, 2014 minutes had listed four residents with UTIs.</p> <p>-The interim DON had introduced McGeers (a quality improvement process used in the long term care setting) to the nurses and physicians to be used to address infections.</p> <p>-They had not used it at the time of the survey.</p> <p>*No other information had been documented in regards to residents UTIs in the above monthly minutes.</p> <p>Review of unnamed infection rate graphs received from the interim DON revealed the following number of resident UTIs:</p> <p>*April 2014 had three UTIs.</p> <p>*May 2014 had six UTIs.</p> <p>*June 2014 had one UTI.</p> <p>*July 2014 had two UTIs.</p> <p>*August 2014 had five UTIs.</p> <p>*September 2014 had seven UTIs.</p>	F 441		

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 441	<p>Continued From page 6 October 2014 had seven UTIs.</p> <p>Review of the provider's infection control reports revealed residents 8, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26 had UTIs in September and October 2014. Review of their most current Minimum Data Set (MDS) assessments (assesses a resident's level of care need) revealed:</p> <ul style="list-style-type: none"> *All thirteen residents had been dependent on staff for toileting and hygiene (peri-care). *The level of care required ranged from a limited assistance of one staff to total dependence with assistance of two staff to complete those cares. *None of those residents had been independent with those cares. <p>Interview on 11/5/14 at 11:15 a.m. with the interim DON confirmed:</p> <ul style="list-style-type: none"> *She had compiled the infection rate graphs and posted them for staff to review. *An in-service had been provided to staff after she had been hired that had encouraged residents to drink more water. *Fresh water was to have been passed twice every day. *No audits had been completed to ensure that had been done. *There had been no in-services provided to staff regarding proper peri-care for the residents since she had started in May 2014. *No audits had been completed regarding staff performance of peri-care since May 2014. *No education had been provided to the residents in regards to proper peri-care since May 2014. *She had just instituted on 11/1/14 audits to be completed by the nurses for all care provided by the staff. *Confirmed the infection control data had not 	F 441		
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

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

PRINTED: 11/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2014
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 7</p> <p>been specific to the long term facility until she had started in May 2014.</p> <p>*The staff to include the nurses and physicians had refused to use the McGeers process to address the UTIs.</p> <p>Interview on 11/5/14 at 4:15 p.m. with the interim DON confirmed when she had been hired in May 2014 as the interim DON there had been no infection control nurse for the long term care facility. She had been covering it as much as possible in addition to being the DON since she had been hired. She had recruited a nurse to start as the infection control nurse in December 2014.</p> <p>Review of the provider's 12/6/05 Peri-Care policy revealed the correct technique must be used to prevent the spread of infection. It had not addressed staff education or audits of staff performance of that care.</p> <p>Review of the provider's September 2014 Infection Prevention and Control Policy revealed: *Guidelines were to be established for procedures in resident care that were known to be associated with an increased risk of nosocomial infections (facility acquired infections). *Required training was to be provided to all departments related to infection prevention and control. *It had not addressed audits to ensure training had been effective.</p>	F 441			

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

ORIGINAL

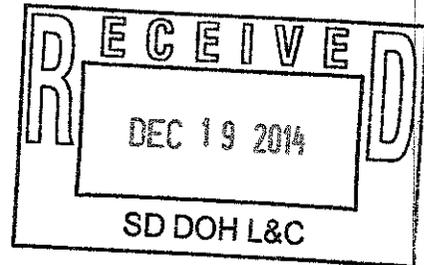
PRINTED: 11/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2014
--------------------------------------------------	-------------------------------------------------------------------------	---------------------------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580
------------------------------------------------------------------------------	-----------------------------------------------------------------------------------

(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/4/14. Winner Regional Healthcare Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
-------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--



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

CEO

12/12/14

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.

DEC 01 2014

SD DOH L&C

