

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

ORIGINAL

PRINTED: 09/26/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
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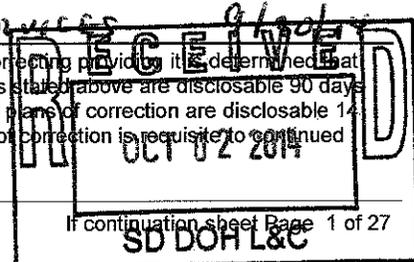
NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</b>
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F 000	INITIAL COMMENTS  Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/5/14 through 8/7/14. Avera Sr James Care Center/Avera Yankton Care Center was found not in compliance with the following requirements: F241, F250, F281, F314, F323, and F441.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and policy review, the provider failed to ensure: *One of four randomly observed residents (33) was served her meal at the same time as her table mates in building 2. *Continued feeding assistance had been provided to one of four randomly observed residents (31) in building 2. *Food had not been served before staff were available to assist one of one randomly observed resident (34) in building 2. Findings include:  1. Observation and interview on 8/5/14 from 5:10 p.m. through 6:00 p.m. in building 2 of one table which provided feeding assistant to residents during the meal service revealed:	F 241	F241 Facility will conduct Inservice for Staff on proper protocols to follow when assisting residents in the Dining Room by 9/19/14. Random Audits using an Audit Checklist of Dining Room meal pass to include residents # 33, 31, 34, & 6 will be conducted weekly for 3 weeks, then monthly for 2 months (Oct./Nov.) then quarterly thereafter. Monitoring will be done by Household Coordinators (RN) or neighborhood designee with results reported to the Director of Resident Care Services who will compile findings and report monthly for the first 3 months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.	9/14/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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*[Signature]* EXECUTIVE DIRECTOR OF SENIOR SERVICES  
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 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 241	<p>Continued From page 1</p> <p>*At 5:15 p.m. residents 6, 31, and one unidentified resident were served their meals. *Resident 33 was at the same table and had not been served her meal. *At 5:30 p.m. this surveyor interviewed certified nursing assistant (CNA) A who had been assisting resident 31. She was not sure why they had not served resident 33 her meal. She stated "They must not have had her card in the line up." *At 5:35 p.m. resident 33 was served her meal. *By that time resident 6 had already left the table.</p> <p>2. Observation on the same day and time as mentioned above revealed: *CNA A had been assisting resident 31 with her meal. *At 5:35 p.m. CNA A left resident 31 to assist resident 33 who had just received her meal. *Resident 31 had half of her tuna casserole, half of the peas, half a cup of juice, a glass of Ensure (nutritional supplement), and an individual-sized container of ice cream left to eat. *Resident 31 could not feed herself and sat there without help until staff returned ten minutes later.</p> <p>Interview on 8/5/14 at 5:40 p.m. with CNA A revealed: *She had not known if resident 31 had been done eating. *She had left her because she had not wanted resident 33's food to get cold. *Resident 31 had just taken a bite of food right before she had gotten up to help resident 33. *She "thought someone from her floor was coming to help but they had not."</p> <p>Observation on 8/5/14 from 5:45 p.m. through 6:00 p.m. of resident 31 revealed: *At 5:45 p.m. CNA A had returned to assist her</p>	F 241			

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F 241	<p>Continued From page 2 with the rest of her meal. *She had eaten more tuna casserole and all of her ice cream.</p> <p>3. Observation on 8/6/14 at 11:45 a.m. of resident 34 with the meal in progress revealed: *Her meal had been sitting in front of her, and no staff were assisting her. *She had not been able to feed herself. *At 11:55 a.m. CNA B sat down next to her and started to feed her yogurt. *The plate with her meal continued to sit there.</p> <p>Interview with dietary manager C at that time regarding resident 34's meal revealed: *The temperature of the potatoes had been 123 degrees Fahrenheit (F). *The temperature of the beef was 118 degrees F. *The temperature of the pureed beans had been 96 degrees F. *She had gotten her a new plate of hot food. *She stated: -"The meal should not have been served unless someone was there to assist her." -"The plate should not have sat there for ten minutes without staff assisting her."</p>	F 241		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p>	F 250		

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F 250	Continued From page 3  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and job description review, the provider failed to provide and document social services interventions for one of five sampled residents (5) from building 2 who had identified responses indicating concern for depression on the Minimum Data Set (MDS) assessment. Findings include:  1. Review of resident 5's 2/20/14 and 5/9/14 MDS assessment revealed he had moderately severe depression.  Review of resident 5's medical record revealed: *An admission date of 2/13/14. *A diagnosis of manic depression. *There was no social services documentation regarding interventions for depression. *There was no recommendation to the physician to refer him to mental health services for depression. *There was no documentation of one-to-one visits by social services or activities staff.  Review of resident 5's 2/24/14 care plan revealed he had problem areas that stated: **"Withdrawal from activities of interest." **"Has very little energy-and sleeps a lot during the day." **"He has a few things that he is interested in - T.V. [television], music (not much), visiting." **"He does like to talk about his family and what was important in the past." **"He likes to be read to."	F 250	<b>F250</b> Facility will review F250 along with processes for assessment, documentation, and Care Planning for those residents with depression or mental illness diagnosis with Household Guides (Activity/Social Services Designee) and licensed Social Workers. Education will be provided by 9/19/14 on appropriate interventions and documentation according to audit checklist. Random Audits of assessments, documentation, and interventions using designed Audit Checklist which includes Resident #5 will be monitored weekly times 3 weeks, then monthly for 2 months (Oct./Nov.), then quarterly thereafter. Monitoring will be conducted by Household Guides (Activity/Social Service Designee) with results reported to Director of Resident Care Services who will compile findings and report monthly to first three months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.	9/19/14

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F 250	<p>Continued From page 4</p> <p>Interventions for those problem areas included the following:</p> <ul style="list-style-type: none"> <li>*Interests included arts, cards, fishing, rodeo, T.V., music, reading, politics, and football.</li> <li>*Staff were to have assisted him with calling his family after supper some nights.</li> <li>*Staff were to have read books to him.</li> <li>*Stated he was not motivated to do much.</li> </ul> <p>Review of resident 5's 5/9/14 care plan revealed the same problem areas and interventions as listed above.</p> <p>Interview on 8/6/14 at 7:30 a.m. with household coordinator G revealed they had not made any referrals to a mental health provider to address resident 5's depression.</p> <p>Interview on 8/6/14 at 7:45 a.m. with licensed social worker D and activities/social services staff E regarding resident 5 revealed they had:</p> <ul style="list-style-type: none"> <li>*Not documented one-to-one visits because there was no place to document them.</li> <li>*Not made any referrals to mental health services.</li> <li>*Staff had not assisted with calling his family in the evenings.</li> <li>*Agreed withdrawal from activities could have been a symptom of his depression.</li> </ul> <p>Review of the provider's social worker job description revealed they were responsible to have:</p> <ul style="list-style-type: none"> <li>*Worked in collaboration with physicians and other health care professionals in resident evaluation and treatment to understand significant social and emotional factors that might affect their health.</li> <li>*Provided or arranged for counseling needed by</li> </ul>	F 250		

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F 250	Continued From page 5 the resident to assist in dealing with emotional, family, financial, or other interaction problems. *Utilized community resources to assist residents to live life to the fullest extent possible. *Considered all behavior as an attempt to communicate. *Acted as an advocate for residents. *Provided one-to-one interactions with residents based upon preferences.	F 250			
F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review and interview, the provider failed to ensure one of one sampled resident (13) in Building 1 with a physician's order for evaluation by a pain specialist had been followed. Findings include:  1. Review of resident 13's physician's orders revealed she had been admitted on 6/6/14. A physician's order on that date stated "Refer to [pain specialist name] for back pain."  Review of resident 13's entire medical record revealed: *There had been no documented follow-up on the referral to the pain specialist from 6/6/14 through 7/18/14. *On 7/18/14 a fax was sent to her physician stating "[Admitting physician's name] ordered referral to [pain specialist name] for pain on	F 281	<b>F281</b> Facility had already made the Pain Specialist appointment before completion of survey for resident #13. An Inservice will be conducted for all nurses and HUC's to address physician orders being carried out timely, as well as process to follow-up immediately with supervisors if unsure how to carry out the physician order. Random Audits using Audit Checklist, to included Resident #13 of physician orders for timely completion will be conducted weekly times 3 weeks, then monthly for 2 months (Oct./Nov.), then quarterly thereafter. Monitoring will be done by Household Coordinators (RN) or neighborhood designee with results reported to the Director of Resident Care Services who will compile findings and report monthly for the first 3 months, then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.	9/19/14	

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F 281	<p>Continued From page 6</p> <p>admission. He does not see pts [patients] at [name of clinic]. We have adjusted Duragesic [narcotic pain medication] x2 [twice] and added prn [as needed] tramadol [pain medication]. Do you want any other referral? Can we d/c [discontinue] [name of pain specialist] referral? Yes/no."</p> <p>-The physician responded on 7/18/14 "He sees patients at [name of hospital]. Please have [name of pain specialist] eval [evaluate] there."</p> <p>Interview on 8/5/14 at 4:00 p.m. with registered nurse/household coordinator H regarding resident 13 revealed:</p> <p>*She had been admitted under the care of a different attending physician, because her usual physician had been out on medical leave.</p> <p>*The pain specialist the resident had been referred to was unfamiliar to them.</p> <p>*They could not locate where the pain specialist was located and when he provided services in the area.</p> <p>*She confirmed they had not contacted the resident's physician to seek clarification on contacting the pain specialist in a timely manner.</p> <p>*The health unit coordinator (HUC) was responsible for setting up those appointments.</p> <p>*The resident had an appointment now to see the pain specialist, but that appointment would not occur until 9/8/14. That was three months after the original referral.</p> <p>Interview on 8/6/14 at 9:30 a.m. with HUC V regarding resident 13 revealed:</p> <p>*The above interview with RN H had been accurate.</p> <p>*She had tried when the order was received to locate the pain specialist using Google (a general search of the web).</p>	F 281			

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F 281	Continued From page 7 *That search revealed the pain specialist's medical practice was in a nearby community. *They were unsure how the resident would have gotten there. *She had worked with the nurses to further evaluate how this resident would have been seen by him, but there were delays because of her other responsibilities. *She further explained she was relatively new in the position and was still learning some of the ins and outs of the job. *She confirmed the follow-up to the resident seeing the pain specialist had not occurred in a timely manner.  No policy regarding this type of issue had been provided to the surveyor upon request.  Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 305, revealed "Nurses follow health care provider's orders unless they believe the orders are in error or harm patients."	F 281	<b>F314</b> Facility will review and revise as necessary the Policy for skin care, pressure ulcer prevention and pressure ulcer treatment. Inservice will be conducted for all nursing staff regarding Policy & Procedures for pressure ulcer prevention, skin assessment to include assessment and re-assessment, recognition and assessment of risk factors, intervention/treatment in accordance with resident needs and goals, potential for infection, pain management, monitoring/evaluating response to interventions & treatments, and revising as approaches as necessary, and documentation (including education for noncompliance). Random Audits using Audit Checklist, to include Resident #9 of pressure ulcer prevention, skin, and wound assessment, documentation, & care plans conducted weekly times 3 weeks, then monthly for 2 months (Oct./Nov.), then quarterly thereafter. Monitoring will be done by Household Coordinators (RN) or neighborhood designee with results reported to the Director of Resident Care Services who will compile findings and report monthly for the first 3 months, then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.	9/19/14	
F 314 SS=G	<b>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</b>  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced	F 314			

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F 314	<p>Continued From page 8</p> <p>by: Surveyor: 32332</p> <p>Based on observation, record review, interview, and skin/wound care guideline review, the provider failed to ensure adequate interventions were in place for the prevention of pressure ulcers for one of four sampled residents (9) in building 1. Findings include:</p> <p>1. Review of resident 9's medical record revealed: *A diagnosis of multiple myeloma (a type of cancer). The disease had been in remission. A blood test and bone biopsy confirmed he was no longer in remission. The resident began chemotherapy. *He had episodes of skin breakdown in the past including a skin ulcer to his left upper leg in November, 2012. *He had been evaluated by the physician on 4/21/14 for a stage II (partial thickness of skin loss) pressure ulcer to his right upper thigh, over the bone. That ulcer had developed into a stage IV (a full-thickness tissue [muscle/bone] loss) on 5/20/14. *A physician report of a stage II ulcer to his left upper thigh on 5/23/14. *Documentation in the skin care report of blisters to his left and right heels on 5/20/14, 6/3/14, 6/13/14. *On 6/16/14 the physician was notified of an open right heel ulcer and requested orders for treatment.</p> <p>Review of resident 9's Minimum Data Set (MDS) assessment on 9/26/13 revealed: *He required extensive assistance of two staff for bed mobility (moving in bed) and transfers. *He required extensive assist of one staff for</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>toileting.</p> <p>*He was frequently incontinent of (leaked) urine.</p> <p>*He was not at risk for skin breakdown.</p> <p>*Treatment for skin prevention included a pressure-relieving mattress and a chair cushion.</p> <p>*His Care Area Assessment (CAA) for pressure ulcers indicated he was incontinent of urine and required assist with bed mobility.</p> <p>A 9/26/13 Braden (an assessment to measure risk for skin breakdown) score indicated he was at mild risk for skin breakdown.</p> <p>The 3/27/14 MDS revealed:</p> <p>*He required extensive assistance of two staff for bed mobility and transfers.</p> <p>*He was occasionally incontinent of bowel and frequently incontinent of urine.</p> <p>*He was not at risk for skin breakdown.</p> <p>*He was not on a repositioning program.</p> <p>A 3/27/14 Braden score indicated he was at mild risk for skin breakdown.</p> <p>The 5/28/14 MDS revealed:</p> <p>*He required extensive assist of two staff for bed mobility and transfers.</p> <p>*He was frequently incontinent of urine.</p> <p>*He was at risk for skin breakdown.</p> <p>*He had one stage IV ulcer.</p> <p>*Treatment for skin prevention included a pressure-relieving mattress and chair cushion, ulcer care, dressing changes, and ointment.</p> <p>*His CAA for that MDS assessment indicated:</p> <p>-He had a stage IV ulcer.</p> <p>-He had been sitting in his chair for long periods of time.</p> <p>-He was incontinent of urine with leaking, spilling, and not getting cleaned up.</p>	F 314			

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</b>		
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F 314	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>-He would eat breakfast and then left the unit to visit his wife.</li> <li>-He remained off the unit in his chair for long periods of time, returning only for his evening medication.</li> <li>-He would try to use the urinals, and it would spill.</li> </ul> <p>A 5/28/14 Braden score indicated he was at moderate risk for skin breakdown.</p> <p>Review of resident 9's 6/25/14 care plan revealed:</p> <ul style="list-style-type: none"> <li>*A problem of impaired skin integrity evidenced by limited mobility and breakdown under his knee braces.</li> <li>*The goal for that problem was to be free from red or open areas.</li> <li>*5/13/14: Staff were to encourage him to reposition in bed and chair every two hours.</li> <li>*5/28/14: Dressing change to his right buttock.</li> <li>*7/10/14: Dressing change to his lift hip.</li> <li>*There was no mention of the ulcers on his left or right heels nor any treatment for his heels.</li> </ul> <p>Interview on 8/5/14 at 8:00 a.m. with registered nurse (RN) O revealed:</p> <ul style="list-style-type: none"> <li>*The resident was active and doing well, leaving the unit daily to visit his wife, and remaining off the unit until after supper.</li> <li>*He became ill quickly and worsened after the chemotherapy had begun.</li> <li>*The ulcers had opened a week after beginning chemotherapy.</li> <li>*He spent most of his time in bed due to the pain from the pressure ulcers.</li> <li>*He was already wearing heel protectors (padded heel covers) when he developed the heel ulcers.</li> <li>*The care plan had not indicated the heel protectors were to have been used.</li> </ul>	F 314			

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F 314	<p>Continued From page 11</p> <p>*Since the development of the ulcers there had been no new interventions for the heels other than the dressings.</p> <p>Documentation in the medical record reflected an air mattress had been ordered on 5/9/14. RN O indicated it had taken two or three weeks for the mattress to have been delivered due to the large bed size.</p> <p>*The resident had not liked the mattress so he had it removed after approximately two weeks. Chart documentation indicated the mattress had been removed on 7/15/14.</p> <p>*When asked if staff had used pillow support to keep the heels off the bed, she reported they did do that.</p> <p>Random observations from 8/5/14 through 8/7/14 revealed no pillow support had been used to raise the heels off the surface of the bed. The heels, covered only by the heel protectors, had remained on the bed.</p> <p>Observation on 8/6/14 at 12:10 p.m. of RN U performing a dressing change to resident 9's heels revealed:</p> <p>*The nurse applied fluffed gauze to the right heel to protect it, then secured it with a gauze wrap.</p> <p>*She applied an OpSite (a transparent clear dressing) to the left heel.</p> <p>Review of resident 9's medical record revealed:</p> <p>*An 8/4/14 order to discontinue the current right heel dressing of Allevyn (a foam covering) and begin Silvadene ointment (for treating infections and burns), gauze, and tape.</p> <p>*No physician's order could be located for the OpSite to the left heel.</p> <p>*A 6/16/14 physician's order had indicated the use of Allevyn to both heels.</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>Interview on 8/6/14 at 5:45 p.m. with RN U and RN O revealed:            *Both nurses had been aware the dressing to the right heel had been incorrect.            *They decided not to remove it and redress it with the correct dressing, because it was scheduled to be done by the evening nurse.            *There was not an order for the OpSite to the left heel; RN U had just placed it there for protection.            *When asked how they knew what dressing was to be applied to the heels RN U reported there was a place on the electronic record called an "I did it" that indicated what they were supposed to dress the ulcers with.            *RN U pulled up the "I did it" on the computer screen which reflected she had dressed the right heel with the Silvadene ointment. RN U agreed she had not used that type of dressing.</p> <p>Interview on 8/7/14 at 9:45 a.m. with the director of nursing revealed:            *The resident was up and about prior to his illness.            *She was not sure what the indication on the MDS of "No risk" for skin breakdown had meant.            *She was not sure if "mild risk" on the Braden assessment had indicated "no risk" for skin breakdown.            *The resident was resistive with assistance and had not wanted to return to the unit when he was off-unit for the day.            *His treatment for skin prevention had included a pressure-relieving mattress and a chair cushion prior to the skin breakdown.            *He was not really incontinent of urine but spilled urine when he attempted to use a urinal by himself.            *She did not think the previous MDS</p>	F 314		

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F 314	<p>Continued From page 13</p> <p>assessments (9/26/13 and 3/27/14) had reflected his true status, because he required more assistance now.</p> <p>*She agreed the heel ulcers had not been care planned.</p> <p>Interview on 8/7/14 at 12:35 p.m. with the DON and RN O revealed:</p> <p>*RN O had miscoded the risk for skin breakdown on the MDS.</p> <p>*She believed the resident had not been at risk, because the preventative measures of the pressure-relieving mattress and chair cushion had taken care of the risk.</p> <p>*She reported resident 9 had not wanted to return to the unit to receive assistance with toileting when he was visiting his wife. That had changed only after the family complained about the odor.</p> <p>*The DON was asked to locate documentation of education provided to the resident with the risks for not complying with skin care.</p> <p>*Documentation provided by the DON on 8/4/14 had included resistance with behaviors, but it had not included documentation of education.</p> <p>Review of the provider's July 2005 Skin/Wound Care Guidelines revealed:</p> <p>*The objectives were:</p> <ul style="list-style-type: none"> <li>-To implement appropriate measures on admission and with changes in condition.</li> <li>-To assess for risk of pressure ulcers.</li> </ul> <p>*General instructions had included:</p> <ul style="list-style-type: none"> <li>-A skin assessment would be done on admission and repeated regularly and with changes.</li> <li>-Interventions from the Braden Protocol were to have been included.</li> </ul> <p>*Those Braden interventions for mild risk of skin breakdown had included:</p> <ul style="list-style-type: none"> <li>-Managing moisture.</li> </ul>	F 314			

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F 314	Continued From page 14 -Protect heels. *Braden interventions for moderate skin breakdown had included: -Foam wedges for thirty degree lateral positioning to have kept the resident from laying flat. -No wedges had been utilized. *Recommendations were to have been added to the care plan. *Treatment plans for wounds were to be re-evaluated every two to four weeks to determine a need for a change in treatment. *If a resident refused or was resistant to staff interventions to reduce the risk of skin breakdown or treat ulcers they would receive education of potential consequences.	F 314	<b>F323:</b> All safety tabs have been replaced on all resident stands and lifts. Maintenance will monitor weekly times 3 weeks, then monthly using Preventive Maintenance (PM) Checklist. Nursing will be inserviced by 9/19/14 to report cracked or missing safety tabs to maintenance for proper repair. Housekeeping Cars are to be kept locked and chemicals not left out when unattended or not in visual sight. Locks and keys were adjusted, education provided to housekeeping staff on 8/14/14 and facility inservice for all staff by 9/19/14. Housekeeping Supervisor will monitor housekeeping carts using Audit Checklist weekly time 3 weeks, then monthly for 2 months (Oct./Nov.), then quarterly thereafter. Maintenance and Housekeeping Supervisor will report results to Director of Resident Care Services who will compile findings and report monthly for the first 3 months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.	9/14/14	
F 323 SS=E	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: 32335 Based on observation, interview, and manufacturer's instructions review, the provider failed to ensure: *Safety tabs were in place on six of six observed mechanical lifts in building 2. *Cleaning chemicals were locked up in the housekeeping carts during two of two random observations in building 2.	F 323			

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F 323	<p>Continued From page 15</p> <p>Findings include:</p> <p>1. Observation on 8/5/14 from 9:15 a.m. through 10:30 a.m. in building 2 revealed: *Two mechanical lifts on Dakota hall with four of four safety tabs broken. *Two mechanical lifts on Willowlake hall with four of four safety tabs broken. *Two mechanical lifts on Chalkstone hall with four of four safety tabs broken.</p> <p>Random observations in building 2 throughout the rest of the survey from 8/5/14 through 8/7/14 revealed the safety tabs on all six lifts remained broken.</p> <p>Interview on 8/7/14 with maintenance man F revealed he knew the safety tabs were broken. He could not recall the last time the safety tabs had been on the lifts. Checking the safety tabs had not been included on his maintenance of the lifts.</p> <p>Review of the EZ Stand Maintenance Checklist revealed the safety tabs were to be checked to make sure they were not torn or broken.</p> <p>2. Observations on 8/5/14 at 10:10 a.m. in building 2 revealed the housekeeping cart on Dakota hall was by a resident room. It was unlocked with the key in the lock. There was no housekeeper in sight. The cleaning chemicals on the cart included floor cleaner, stool cleaner, furniture polish, glass cleaner, and a disinfectant.</p> <p>Observation and interview on 8/6/14 at 10:50 a.m. with housekeeper W revealed the housekeeping cart on Dakota hall was by a resident room. It had been unlocked with the key</p>	F 323			

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F 323	Continued From page 16 in the lock. The same cleaning chemicals were on the cart. She had known she was to have locked the cart but had not done so. She agreed on both days the cart had been unlocked.  Interview on 8/7/14 at 9:30 a.m. with the housekeeping supervisor revealed the housekeeping carts should have been locked while in the halls. The key should not have been left in the lock. The provider had no policy on chemical storage.	F 323			
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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	F 441	<b>F441</b> Facility will review/revise as necessary Policy and Procedures about Infection Prevention and Control relevant to dressing changes, handwashing, nebulizers, bathing procedures including hair rollers by 9/1/14. An inservices will be conducted for all staff including beauticians regarding the above stated Infection Policy & Procedures by 9/04/14. Audits will be conducted on dressing changes, handwashing, nebulizers, bathing procedures including hair rollers along with resident #3, #4, #9, #21, & #30 utilizing facility Audit Checklist. Random Audit Checklist will completed weekly for 3 weeks, then monthly for 2 months (Oct./Nov.), then quarterly thereafter. Monitoring will be done by Household Coordinator (RN) or neighborhood designee with results reported to the Director of Resident Care Services who will compile findings and report monthly for the first 3 months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.	<b>9/19/14</b>	

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F 441	<p>Continued From page 17</p> <p>direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 A. Based on observation, interview, and policy review, the provider failed to ensure proper infection control was maintained during two of three sampled residents' (4 and 9) dressing changes. Findings include:</p> <p>1. Observation on 8/6/14 at 12:10 p.m. of resident 9 receiving a dressing change revealed registered nurse (RN) U: *Applied an isolation gown and gloves and washed her hands. *Removed a dressing from the resident's pressure ulcer (skin breakdown caused by pressure) on his buttocks. *Removed bowel movement from and cleansed the resident's buttocks. *Removed her soiled gloves and applied clean gloves. *Sprayed a wound cleanser onto the pressure ulcer wound. *Removed the soiled gloves and applied clean gloves. *Filled the wound with a sponge and applied a</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>clean dressing. *Removed the soiled gloves and applied clean gloves. *Picked up a gauze dressing and fluffed the dressing into a ball. *Applied the gauze to the resident's right heel ulcer. *Applied more gauze to cover the heel and around the foot. Then she secured the gauze cover with tape. *With the same gloves she applied an OpSite dressing (a clear plastic dressing) to cover the pressure area on the left heel. *Removed the soiled gloves. *Only then did she wash her hands.</p> <p>Interview on 8/7/14 at 10:15 a.m. with RN U regarding the above dressing changes revealed she stated: *She used a gel cleanser to cleanse her hands between each glove change. *She applied clean gloves in the bathroom after applying the gel which had been sitting on the counter below the gloves. *She had washed her hands four times during the dressing changes.</p> <p>This writer had direct vision of the glove container and the resident's sink during the above dressing change. The only observation of RN U cleansing her hands had been after all the dressing changes had been completed.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo, 2013, page 414, revealed hand hygiene was to have been performed before resident contact, and immediately after gloves were removed.</p>	F 441			

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F 441	Continued From page 19  Surveyor: 32355 2. Observation on 8/6/14 at 5:20 p.m. of resident 4 receiving a dressing change revealed RN N: *Retrieved all of the necessary supplies for a dressing change to the resident's left heel. *Had laid all of the supplies directly on the resident's bed without a barrier between the items and the bedspread. *Washed her hands and put on a pair of gloves. With those gloved hands she removed a dressing from the resident's left heel. *Removed those soiled gloves and put on a clean pair of gloves. She had not washed or sanitized her hands between changing her gloves. With those gloved hands she had: -Retrieved a spray bottle of wound cleanser and sprayed several gauze 4x (by) 4 sponges with the cleanser. -Wiped around the inside and outside perimeter of the pressure ulcer. -Retrieved an ointment from inside a plastic bag lying directly on the resident's bedspread. -Placed some of the ointment on the 4x4 sponges, applied it to the pressure ulcer, and wrapped the wound with a gauze wrap. -Removed the soiled gloves and washed her hands. This had been the only time during the dressing change she had cleansed her hands. -Retrieved the spray bottle of wound cleanser and two gauze 4x4 sponge packages that had been laying directly on the bedspread. She placed those supplies on top of her medication cart.  Interview on 8/6/14 at the time of the above observation with RN N revealed: *She agreed improper technique had been used during the dressing change. *She should have:	F 441			

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F 441	<p>Continued From page 20</p> <ul style="list-style-type: none"> <li>-Washed or sanitized her hands prior to changing her gloves after removal of the old dressing.</li> <li>-Washed or sanitized her hands between cleansing of the wound and applying a new dressing.</li> <li>-Placed a barrier between the clean dressing supplies and the resident's bedspread or left the supplies in her room.</li> </ul> <p>*There had been potential for cross-contamination (passing of bacteria from one patient to another) due to the unsanitary procedure that was used with improper hand washing and placement of dressing supplies.</p> <p>Interview on 8/7/14 at 9:15 a.m. with the DON revealed:</p> <ul style="list-style-type: none"> <li>*All of the supplies for the dressing change should have been located in the resident's room.</li> <li>*She would have expected the RN to have performed hand hygiene after changing gloves.</li> <li>*She would have expected the RN to perform hand hygiene between the dirty to clean process of the dressing change.</li> </ul> <p>Review of the provider's undated Wound Care and Dressings policy revealed:</p> <ul style="list-style-type: none"> <li>*The staff were to have cleaned off an over the bed table and placed all the necessary supplies for the dressing change on that table.</li> <li>*Gloves were to have been changed between removal of the old dressing and cleansing of the wound.</li> <li>*Hand Washing should have occurred prior to the set-up for the dressing change and upon completion of the dressing change.</li> <li>*The policy had not mentioned the proper technique for when to perform hand hygiene when working from a dirty to clean area.</li> </ul>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</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
F 441	<p>Continued From page 21</p> <p>Review of the provider's June 2014 Infection Control in Patient Care Services policy revealed: *Purpose: "To prevent the transmission of a communicable or healthcare-associated infection between personnel, patient [resident], and visitors." **"Hands are to be cleaned prior to and after use of gloves."</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained in building 2: *To prevent the potential for cross-contamination during and after a shower for one of one observed resident (3) with a supra-pubic catheter (tube inserted into the abdomen and into/or bladder to help with the draining of urine). *To prevent the potential for cross-contamination after the disinfecting of one of one shower chairs. *For the disinfecting process of one of one shower chair after bathing a resident infected with clostridium difficile (C-diff) (bacterial infection that affects the digestive system). *For unobserved residents who received hair care by one of one beautician. *For nebulizer machines cleaned after use for two of two observed residents (21 and 30) who required nebulizer treatments. Findings include:</p> <p>1. Observation on 8/6/14 at 7:55 a.m. of resident 3 receiving a shower in building 2 from certified nursing assistant (CNA) L revealed: *The resident had been sitting in his wheelchair (w/c) with a catheter bag attached to the bars underneath it. *Without washing her hands and putting on gloves she: -Removed the catheter bag from his w/c and laid</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</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
F 441	<p>Continued From page 22</p> <p>it directly on the floor while assisting him to transfer from his w/c to the shower chair.</p> <p>-Moved him to the shower area and turned on the water to the shower.</p> <p>-Retrieved two clean washcloths from a clean linen cart.</p> <p>-Gave one to the resident to wash his face.</p> <p>-Opened several cupboard doors and touched several bottles of body wash and shampoo looking for personal care cleansing items to be used for his shower.</p> <p>-Retrieved a bottle of body wash and put some on the other washcloth.</p> <p>-Assisted him to wash the upper part of his body.</p> <p>-Retrieved two large towels from the clean linen cart and assisted him with drying including his bottom and perineal area (private).</p> <p>*Applied a pair of gloves and replaced the Foley drainage bag with a new one.</p> <p>*She removed the soiled gloves, assisted him with dressing, and only then did she wash her hands.</p> <p>Interview on 8/6/14 after the above observation with CNA L revealed:</p> <p>*She should not have laid the catheter bag directly on the floor. The floor was dirty and had created a situation for cross-contamination to occur.</p> <p>*She agreed improper technique and sanitary precautions had been broken prior, during, and after the shower.</p> <p>Interview on 8/7/14 at 9:15 a.m. with the director of nursing (DON) confirmed sanitary precautions had been broken. There was potential for cross-contamination and infection.</p> <p>Review of the provider's June 2014 Infection</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</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
F 441	<p>Continued From page 23</p> <p>Control in Patient Care Services policy revealed: **Perform hand hygiene immediately before and after any manipulation of the catheter site or apparatus including the drainage bag." **Do not allow the catheter tubing, bag or spigot to touch the floor."</p> <p>2. Observation on 8/6/14 at 8:25 a.m. of CNA L during and after the disinfecting of the shower chair in building 2 revealed: *She had prepared to disinfect the shower chair after bathing resident 3. *She retrieved a bottle labeled Penner Patient Care disinfectant cleaner. *She applied the disinfectant cleaner to the shower chair, let it sit on the shower chair for ten minutes, and then rinsed the shower chair off. *She had not scrubbed the shower chair prior to rinsing which would have included underneath the seating area. *She had not diluted the Penner Patient Care disinfectant cleaner per instructions for use on the bottle.</p> <p>Review of the provider's undated Directions for Use of the Penner Patient Care Disinfectant Spray revealed: **For routine disinfection, proper dilution of 2 ounces of Penner Patient Care Whirlpool Disinfectant Cleaner per gallon of water." **Prepare a fresh dilution for each use."</p> <p>Interview on 8/7/14 at 9:25 a.m. with the DON regarding the above observation revealed: *She would have expected the CNA to scrub down the shower chair after applying the disinfectant cleaner and prior to rinsing. *The CNA should have diluted the disinfectant cleaner per instructions from the manufacturer.</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/07/2014
NAME OF PROVIDER OR SUPPLIER  AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078		
(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	Continued From page 24  3. Interview on 8/6/14 at 8:30 a.m. with CNA L regarding the bathing and disinfecting process with residents who have C-diff revealed: *She would have given those residents with C-diff a shower. *Those residents would have been bathed last on the shower list for the day. *She would have used 3M HB Quaternary disinfectant cleaner to clean the shower chair.  Review of the provider's August 2012, 3M HB Quat Disinfectant Cleaner Concentrate description and directions for use pamphlet revealed the disinfectant was not effective against C-diff.  Interview on 8/7/14 at 9:30 a.m. with the DON revealed: *She was aware the above disinfectant cleaner would not have been effective against C-diff. *The staff were to have cleansed the shower chair with a bleach solution. *She had been unaware the above CNA had not known the proper disinfecting process for residents who had C-diff.  4. Interview on 8/6/14 at 9:00 a.m. with the facility beautician in building 2 revealed she: *Washed and used hair rollers on twenty of the residents in the facility each week. *Brought in her own rollers to use on the residents. *Did not have separate hair rollers to use for each resident. *Would have used the same hair rollers on all twenty of the residents. *Did not disinfect the hair rollers between each use.	F 441		

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</b>		
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F 441	<p>Continued From page 25</p> <p>*Would have only disinfected the hair rollers weekly.</p> <p>*Agreed using the same rollers for all the residents without disinfecting in between each use was not a good practice.</p> <p>Interview on 8/7/14 at 9:40 a.m. with the DON revealed:</p> <p>*She had not been aware the beautician was using the same hair rollers for all of the residents.</p> <p>*She would have expected the residents to have their own hair rollers to use.</p> <p>*She would have expected the beautician to disinfect the hair rollers after each use.</p> <p>*She agreed that had not been a sanitary practice.</p> <p>*No policy or procedure existed for the cleansing of multi-use resident care items.</p> <p>5. Random observations from 8/5/14 through 8/6/14 throughout the facility revealed:</p> <p>*Several residents who had nebulizer treatment sets in their rooms.</p> <p>*Those nebulizer treatment sets had not been taken apart. The complete nebulizer apparatus had been hanging off the shelf next to the machines.</p> <p>Observation on 8/5/14 at 4:15 p.m. of licensed practical nurse (LPN) K revealed:</p> <p>*She had retrieved the necessary supplies to give resident 21 a nebulizer treatment.</p> <p>*She entered the resident's room and retrieved the apparatus. She placed the medication inside of the chamber for administration.</p> <p>*The mask and chamber had been not been taken apart and was hanging off the shelf next to the nebulizer machine.</p> <p>*She placed the mask and chamber on the</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</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
F 441	<p>Continued From page 26</p> <p>resident's face for administration and left the room.</p> <p>*When the medication had been administered she had removed the nebulizer apparatus and replaced it on the shelf next to the machine.</p> <p>*She had not rinsed the mask and chamber after the administration of the medication.</p> <p>Observation on 8/6/14 at 7:50 a.m. of registered nurse (RN) J revealed:</p> <p>*She had performed the same process as above with resident 30.</p> <p>*She had not rinsed the mask and chamber after the administration of the medication.</p> <p>Interview on 8/6/14 at the time of the above observation with RN J revealed she would have rinsed the nebulizer masks and chambers daily.</p> <p>Interview on 8/7/14 at 9:45 a.m. with the DON revealed the nebulizer masks and chambers should have been taken apart after each medication administration and rinsed.</p> <p>The provider's June 2014 Infection Control policy for cleansing nebulizer apparatuses revealed no mention of how often they should be cleaned after use.</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/06/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>avera sr james care center/avera yankton care cent</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/6/14. Avera Sister James Care Center/Avera Yankton Care Centers (Building 01 Sister James Care 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		9/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>EXECUTIVE DIRECTOR OF Senior Services</b>	(X6) DATE <b>8/29/14</b>
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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 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.

SEP 03 2014  
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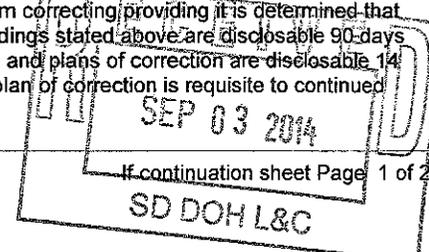
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - BUILDING 02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/06/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/6/14. Avera Sister James/Avera Yankton Care Centers (Building 02 Yankton Care Center) was found not 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 upon correction of deficiency identified at K029 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 029 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain proper separation of one randomly observed hazardous area in building</p>	K 029	<p><b>K029</b> Identified Door was repaired when identified by surveyor. Inservice will be completed for all staff by 9/19/14 to notify maintenance if they find any self closing fire door that does not latch into the door frame. Facility will conduct Random audits of Self closing fire doors using Audit Checklist weekly time 3weeks, then monthly for 2 months (Oct/Nov), then quarterly thereafter. Monitoring will be done by Maintenance personnel with results reported to the Director of Resident Care Services who will compile findings and report monthly for the first 3 months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.</p>	9/19/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 8/29/14

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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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 WEST 11TH STREET YANKTON, SD 57078</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 029	Continued From page 1 02. The soiled linen storage room would not latch into the door frame. Findings include:  1. Observation at 10:30 a.m. on 8/6/14 revealed the soiled linen storage room door in building 02 would not latch into the door frame. Further observation indicated the latch bolt was stuck in the retracted position preventing the door from latching. Interview with the maintenance person at the time of the observation revealed the latch bolt was bent and required replacement. This deficiency would affect one of five smoke compartments.	K 029			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10716</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES/AVERA YANKTON CARE CE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 W 11TH STREET YANKTON, SD 57078</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments  Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/5/14 through 8/7/14. Avera Sr James Care Center/Avera Yankton Care Center was found not in compliance with the following requirement: S130.	S 000		
S 130	44:04:02:06 FOOD SERVICE  Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, manufacturer's product information review, and policy review, the provider failed to maintain sanitation in three of three kitchens (Country, Cabin, and Riverfront) of the induction ranges (heats cookware with magnetic energy) with the potential of cross-contamination (bacteria transferred from one area to another). Findings	S 130	S130 Facility Maintenance personnel replaced the rubber seal on each the Riverfront and Country neighborhood Induction Ranges on 8/27/14. Cabin Induction Range was cleaned when noted by surveyor. An inservice will be conducted for neighborhood pantry personnel on maintaining equipment clean according to cleaning schedules. Monitoring of cleaning schedules will be done by Neighborhood CDM weekly for 3 weeks, then monthly for 2 months (Oct./Nov.), then quarterly thereafter. Results of audit will be reported to the Director of Resident Care Services who will compile findings and report monthly for the first 3 months and then quarterly for one year thereafter to facility QAA committee for review and appropriate recommendations.	9/19/14

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

STATE FORM 6899 W95X11

EXECUTIVE DIRECTOR OF SENIOR SERVICES

SEP 03 2014

SD DOH L&C

If continuation sheet 1 of 3

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10716</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES/AVERA YANKTON CARE CE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 W 11TH STREET YANKTON, SD 57078</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
S 130	<p>Continued From page 1</p> <p>include:</p> <ol style="list-style-type: none"> <li>1. Observation on 8/6/14 at 4:25 p.m. of the induction range in the kitchen (Country) revealed: <ul style="list-style-type: none"> <li>*Many yellow, tan, and brown spots along the sides on the edge of the cooking plate.</li> <li>*On the bottom and sides of this induction range there were a few liquid dried spots and dried food debris.</li> </ul> <p>Interview on 8/6/14 at 4:35 p.m. in the kitchen (Country) with dietary manager S revealed he agreed the induction range:</p> <ul style="list-style-type: none"> <li>*Had yellow, tan, and brown spots along the sides on the edge of the cooking plate.</li> <li>*Was not clean on the bottom and sides of the induction range.</li> </ul> </li> <li>2. Observation on 8/6/14 at 4:45 p.m. in the kitchen (Cabin) revealed one induction range that had on the bottom of it a few liquid dried spots and dried food debris.</li> <li>3. Observation on 8/6/14 at 4:50 p.m. in the kitchen (Riverfront) revealed: <ul style="list-style-type: none"> <li>*One induction range with many yellow, tan, and brown spots along the sides on the edge of the cooking plate.</li> <li>*On the bottom of this induction ranges there were a few liquid spots and dried food debris.</li> </ul> <p>Interview on 8/7/14 at 10:15 a.m. with the nutrition coordinator and certified dietary manager I regarding the induction ranges in the kitchens on Country, Cabin, and Riverfront revealed:</p> <ul style="list-style-type: none"> <li>*The seal along the sides on the edge of the cooking plates in Country and in Riverfront had sections that had worn off which had been collecting food.</li> <li>*That area on the ranges was no longer a cleanable surface and had a potential of</li> </ul> </li> </ol>	S 130		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10716</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/07/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVERA SR JAMES/AVERA YANKTON CARE CE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2111 W 11TH STREET YANKTON, SD 57078</b>
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S 130	<p>Continued From page 2</p> <p>cross-contamination. *The bottoms and sides of the ranges in each of the kitchens needed to have been cleaned more frequently.</p> <p>4. Review of the posted Pantry Cleaning Lists in the kitchen (Country) revealed the following cleaning schedule for the induction range included a monthly deep cleaning of the range. Any build-up was to have been removed.</p> <p>Record review of the manufacturer's product information sheet for the induction ranges revealed to maintain the appearance and increase the service life the induction range should have been cleaned at least daily.</p> <p>Review of the provider's 2005 Sanitation of Food Service Department policy revealed the food service staff should have maintained the sanitation of the food service department through compliance with a written, comprehensive cleaning schedule.</p>	S 130		