

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/05/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALCESTER CARE AND REHAB CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET ALCESTER, SD 57001</b>
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F 000	<p><i>*Addendums noted with an asterisk per 9/1/15 per telephone to the facility administrator.</i></p> <p>Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/3/15 through 8/5/15. Alcester Care and Rehab Center, Inc was found not in compliance with the following requirements: F309, F323, and F371.</p>	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review and interview, the provider failed to ensure one of one sampled resident (2) receiving dialysis (a procedure used when kidneys are no longer functioning properly) had a system in place for services. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *He had been admitted on 1/20/12. *His diagnoses had included: End Stage Renal Disease (kidneys not functioning), insulin dependent diabetes mellitus (high level of sugar in the blood), schizotypal disorder (a disruption in the thought process), hyperlipidemia (elevated</p>	F 309	<p>Resident 2's medical record was reviewed and revised to reflect a more appropriate status of care including, but not limited to receiving the progress notes from the dialysis.</p> <p>Communication will be established between the two facilities and specific instructions will be followed by staff relating to any complications with dialysis or issues with the fistula. <i>*We will take advantage of the educational offering the dialysis will provide</i></p> <p>The DON or designee will be responsible for educating nurses in the change of policy and procedures for residents returning from dialysis, updating all progress notes, and monitoring fistula care. <i>*will be a nursing home and dialysis collaborative.</i></p> <p>All other residents' receiving dialysis plans were reviewed and revised to reflect the current status of care including, but not limited to receiving progress notes from dialysis. The policy and procedure is uniform which ensures consistency for all residents who need to receive dialysis treatment.</p> <p>A health care services agreement between the dialysis facility and nursing home will be obtained. Should dialysis services occur at</p>	09/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Admission Director</i>	(X6) DATE <i>8/25/2015</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 1</p> <p>cholesterol), high blood pressure, and foot ulcers (sores).</p> <p>*He currently received dialysis three times a week (Tuesday, Thursday, and Saturday).</p> <p>*There was no documentation of communication with the dialysis facility after each visit.</p> <p>*There was no documentation of an agreement between the dialysis facility and the provider for the provision of providing that service.</p> <p>*The undated comprehensive care plan regarding the resident's dialysis revealed:</p> <p>- "Nursing concerns: I have kidney disease and a fistula [access in the forearm created for long-term dialysis] placed 2/8/13 for dialysis treatment. Goal: Follow my doctors orders concerning my kidney disease through next review."</p> <p>- There was no specific instructions for staff regarding steps to follow with regard to any potential complications of the dialysis treatments or issues with the fistula.</p> <p>Interview on 8/5/15 at 1:35 p.m. with registered nurse B regarding resident 2's dialysis treatments revealed:</p> <p>*The staff would only receive feedback regarding the dialysis visit verbally from the resident.</p> <p>*He returned from dialysis at approximately 4:00 p.m. on each Tuesday, Thursday, and Saturday.</p> <p>*Staff would take his blood pressure, pulse, and blood sugar prior to the evening meal.</p> <p>*No post-dialysis monitoring of the fistula was done.</p> <p>Interview on 8/5/15 at 2:15 p.m. with the administrator regarding resident 2's dialysis revealed:</p> <p>*There was no contract or agreement for residents receiving dialysis services.</p>	F 309	<p>any other facility, a contract or business agreement will be obtained before services are started.</p> <p>The charge nurse on duty will be responsible for acquiring the lab results and documenting the results into the resident's medical record. The DON or designee will conduct weekly audits for one month then monthly for two more months, and present the audits findings at the monthly QAPI meeting with further follow-up as recommended by the QAPI committee.</p> <p><i>*The facility will add weekly audits for lab work, dialysis progress notes, fistula care and care plan needs. SW/SDDO/H/EL</i></p>	

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F 309	Continued From page 2 *He was not aware an agreement with the dialysis facility was needed.  Interview on 8/5/15 at 3:15 p.m. with the director of nursing regarding resident 2's dialysis revealed: *There was a physician's name on the front of the resident's chart to contact with any issues with the fistula. *There was no consistent communication between the dialysis facility and the provider with each visit. *The communication with the dialysis facility only occurred when additional information or clarification was needed regarding the resident's medications or laboratory values. *She acknowledged there was no agreement in place with the dialysis facility and the provider regarding the care for residents receiving dialysis. *There was no provider policy in place regarding care of residents receiving dialysis.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation, interview, and review of the manufacturer's safety and maintenance	F 323	Maintenance supervisor and Interdisciplinary team reviewed and revised as necessary the policy and procedures for effective use of safety tabs for the EZ Way Stand Lifts.  All lifts were reviewed to ensure that they had all the manufacture recommended safety devices. The safety tabs were ordered and installed on both EZ Way Stand lifts.  Maintenance supervisor and Administrator made changes to the preventative maintenance policy and procedure manual.	09/24/15	

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F 323	<p>Continued From page 3</p> <p>checklist and operating instructions, the provider failed to ensure two of two observed EZ Way stand lifts (mechanical lifts used for transferring residents) had safety tabs per manufacturer's instructions. Findings include:</p> <p>1. Random observations from 8/3/15 through 8/5/15 revealed two EZ Way stand mechanical lifts had no safety tabs attached to the harness attachment area. Those safety tabs were to ensure the sling loops were secured within the harness hookup, so residents would not have fallen from the mechanical lift.</p> <p>Review of the preventative maintenance log policy and procedure manual and interview with the maintenance supervisor on 8/5/15 at 8:45 a.m. revealed inspection of the EZ Way stand lifts was scheduled semi-annually. He stated problems with the lifts were entered into the computer maintenance log by nursing staff.</p> <p>Inspection on 8/5/15 at 9:00 a.m. of the EZ Way stand lifts with the maintenance supervisor confirmed the safety tabs were not in place. He had not received a work order to replace the safety tabs.</p> <p>Review of the EZ Way stand Safety and Maintenance Checklist revealed: *"The manufacturer suggests that the following components and operating points be scheduled for inspection at intervals not greater than one month. Any detected deficiency must be rectified before the stand is put back into service." *"5. Safety tabs need to be checked to make sure they are installed correctly, not missing or torn."</p> <p>Review of the EZ Way stand Operating</p>	F 323	<p><i>* checked weekly SWP/DDH/EL</i></p> <p>The lift will be _____ by the maintenance supervisor and if any safety mechanisms fail during this time are determined to be damaged or missing, the equipment will be taken out of use until repairs are made.</p> <p>Maintenance supervisor or designee will re-educate the nursing staff the importance of safety tabs and how they are properly used. Staff will be able to use a checklist that is fastened to the lift for a reference guide and will include information on other important safety measures. Staff will be educated on notifying the maintenance supervisor on a defective or missing part.</p> <p>The Maintenance supervisor will conduct audits twice a month for the first month, then audit once a month for two more months; and report all audits findings at the monthly QAPI meeting for further review and recommendation by the QAPI committee.</p>	

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F 323	Continued From page 4 Instructions revealed: **2) ...Verify the loops are properly hooked inside the "pigtail" at the end of the EZ Way stand arms and the Safety Catch is in place, blocking the strap from exiting through the pigtail."	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, testing, manufacturer's product information, and policy review, the provider failed to ensure sanitary conditions in the kitchen were maintained for the following: *The wiping cloths used to wipe down the food counters and equipment were placed in a sanitizing solution. *One of one counter located below the pull-down kitchen window had cleanable surfaces. Findings include: 1. Observation on 8/3/15 in the kitchen from 4:20 p.m. through 5:00 p.m. revealed: *A wet cloth laying on the handle of a three-tiered cart next to a food production counter.	F 371	Dietary Manager and RD reviewed and revised as necessary the policy and procedure for effective sanitary conditions in the kitchen regarding wiping cloths and counters and maintaining and testing of sanitizing solution.  The Dietary Manager will be responsible for educating the staff that is responsible for the task of maintaining and testing sanitizing solution and ensuring the proper use and storage of wiping cloths.  The Dietary Manager or designee will conduct _____ to verify the sanitizer solution container is within normal limits and reports the audit findings at the monthly QAPI meeting for further review and recommendation.  The dietary manager or designee will complete audits for abandoned wiping cloths in the kitchen _____	09/24/15	

*audits five times a week for two weeks, then two times a week for two weeks, SWISDDCH/EL*

*Next page*

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F 371	Continued From page 5 *One cloth soaking in a liquid solution in a red pail located in the first sink of the two-compartment sink. *A counter located below the pull-down kitchen window had a significant amount of peeling, chipped, and scarred surfaces on the top that were uncleanable. -Approximately four feet of that counter had exposed sides exposing bare wood creating an uncleanable surface.  Observation, testing, and interview with the dietary manager (DM) and cook A on 8/3/15 at 5:00 p.m. in the kitchen revealed: *One cloth soaking in a liquid solution in a red pail located in the first sink of the two-compartment sink. -The DM stated that pail contained a sanitizing solution and a wiping cloth. -Testing of the solution with a QT-40 Hydrion test strip (a treated paper for testing) in that pail revealed a sanitizing level of 0 parts per million (ppm). *The DM and cook A both stated the wiping cloth located in the above pail was used to clean the food counters and the equipment in the kitchen. *The DM stated that pail had last been changed on 8/3/15 at 1:00 p.m. after the noon meal. *The DM then discarded the solution and refilled the red pail with a liquid solution from a dispenser located above the two-compartment sink. -That dispenser was connected to a clear tubing that went into a gallon container located on a pallet on the floor next to the sink. -The gallon container was labeled TMA Quaternary (Quat) Sanitizer (kills germs). -The solution in that gallon container was tested, and it revealed a level of 400 ppm.	F 371	<p>██████████ and report audit findings at the monthly QAPI meetings for review and further follow-up as recommended.</p> <p>The kitchen counter with the peeling side surface has been removed from daily operation for the preparation and serving of food. The counter will be replaced with a stainless steel countertop. All other counter tops in the kitchen were reviewed to ensure a cleanable surface.</p> <p>The dietary manager or designee will audit cleanable surfaces in the kitchen once a week for the one month then monthly for two more months; and report audits findings at the monthly QAPI meetings for review and further follow-up as recommended.</p> <p><i>...five times a week for two weeks, then two times a week for two weeks, then once a month for two months.</i> SW/SDD04/EL</p>		

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F 371	<p>Continued From page 6</p> <p>*The solution in the red pail that had been refilled from the dispenser was tested again with a QT-40 Hydrion test strip. -Testing of the solution in that pail revealed a level of 0 ppm. *The DM stated a level of 0 ppm was not at a sanitizing level when the wiping cloths taken out of the solution were used on the food counters and the equipment. -She stated that level needed to have been at 150-200 ppm for proper sanitizing. *Both agreed the wiping cloths used from the liquid solution in the red pail for wiping down the food counters and the equipment was not at an adequate level for proper sanitizing of those surfaces. -That level needed to have been 150-400 ppm for proper sanitizing of those surfaces. *The DM stated the kitchen staff would be using a bleach solution for sanitizing the wiping cloths until the above could be resolved.</p> <p>Interview on 8/3/15 at 5:40 p.m. with the DM and at 6:10 p.m. with the maintenance supervisor revealed both stated: *There had been a problem with the tubing connected from the quat sanitizer container to the dispenser. *The levels of the sanitizer had been checked and were within the recommended levels. *Those levels needed to have been 150-400 ppm for proper sanitizing.</p> <p>Observation, testing, and interview on 8/4/15 at 10:10 a.m. with the DM in the kitchen revealed: *There was one wiping cloth in the liquid solution in the red pail in the first sink of the two-compartment sink. -That solution was tested with a QT-40 Hydrion</p>	F 371		

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F 371	<p>Continued From page 7</p> <p>test strip, and it had a level of 200 ppm. *The DM stated there had not been monitoring of the ppm levels in that red pail prior to 8/4/15. *She was uncertain on how long the wiping cloths in the solution had not been at the minimum sanitizing level.</p> <p>Observation and interview on 8/4/15 at 5:05 p.m. with the DM in the kitchen revealed: *One wet wiping cloth laying on the food production counter. *The red pail located in the first sink of the two-compartment sink contained a liquid solution with one cloth located in the pail. -The solution in that pail was tested with a QT-40 Hydrion test strip and it had a level of 200 ppm. *The DM stated that wiping cloth had needed to have been in the sanitizing solution when not in use. *She agreed there needed to have been consistent use by all dietary staff with proper storage of the wiping cloths in a sanitizing solution when not in use.</p> <p>Interview on 8/4/15 at 2:45 p.m. with the customer service representative from the TMA Quat Sanitizer company revealed: *The product was used as a food contact sanitizer. *The solution needed to have been 150-400 ppm with a minimum of one minute contact time for proper sanitizing.</p> <p>Review of the TMA Quat Sanitizer manufacturer's product label revealed the solution needed to have been at 150-400 ppm for a contact time of one minute for usage as a food contact sanitizer.</p> <p>Review of the provider's 2000 Dietary Infection</p>	F 371		

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F 371	<p>Continued From page 8</p> <p>Control policy revealed standards and regulations were to have been followed to ensure a safe and sanitary dietary department.</p> <p>Review of the provider's 2000 Cleaning Counter Space policy revealed: *The counter spaces were to have been wiped and sanitized prior to and following food preparation, meal service, and as needed. *The policy had not included any further information regarding how the equipment was to have been sanitized using the wiping cloths.</p> <p>Review of the providers 2000 Cleaning Cloths, Pads, Mops, and Buckets policy revealed: *The wiping cloths were to have been kept in a container of clean, sanitized solution between uses. *The policy had not included any further information regarding how the food surfaces were to have been sanitized using the wiping cloths.</p> <p>2. Interview on 8/4/15 at 10:55 a.m. with cook A regarding the counter located below the pull-down kitchen window revealed he: *Stated the counter was used to store resident meal trays and the menu sheets. *Agreed there was a significant amount of peeling, chipped, and scarred surfaces on the top and the sides that were uncleanable.</p> <p>Observation and interview on 8/4/15 at 5:30 p.m. with the DM regarding the counter located below the pull-down kitchen window revealed: *The counter was holding resident trays, straws, menu sheet information, foam cups turned over on top of the counter, and plastic silverware. -It was located next to a cart that contained the resident silverware in opened containers for</p>	F 371		

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F 371	<p>Continued From page 9 knives, forks, and spoons. *The DM agreed there was significant amount of peeling, chipped, and scarred surfaces on the top and sides that were uncleanable surfaces.</p> <p>Interview on 8/4/15 at 4:20 p.m. with the maintenance supervisor regarding the counter located below the pull-down kitchen window revealed: *He agreed the counter had a significant amount of peeling, chipped, and scarred surfaces on the top and sides that were uncleanable. *He stated the counter needed to have been replaced as it was no longer a cleanable surface.</p> <p>Review of the provider's 2000 Cleaning Counter Space policy revealed: *The counter spaces were to have been wiped and sanitized prior to and following food preparation, meal service, and as needed. *The policy had not included any further information regarding repair or replacement of a counter that contained uncleanable surfaces.</p>	F 371		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/05/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ALCESTER CARE AND REHAB CENTER, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CHURCH STREET ALCESTER, SD 57001</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<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 8/5/15. Alcester Care and Rehab Center, Inc. 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*W. K. ...* *Administrator* *8/25/2015*

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.

**AUG 28 2015**  
If continuation sheet Page 1 of 1  
**SD DOH L&C**

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PRINTED: 08/18/2015  
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10591	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  08/05/2015
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NAME OF PROVIDER OR SUPPLIER  ALCESTER CARE AND REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 CHURCH ST ALCESTER, SD 57001
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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 000	<p>Initial Comments</p> <p>Surveyor: 34030 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/3/15 through 8/5/15. Alcester Care and Rehab Center, Inc. was found in compliance.</p>	S 000		

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

*[Signature]*

TITLE

*Administrator*

(X6) DATE

*8/25/2015*

STATE FORM

KORK11

If continuation sheet 1 of 1

