

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

PRINTED: 07/13/2015  
FORM APPROVED  
OMB NO. 0938-0391

**ORIGINAL**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435107</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/01/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BOWDLE NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428</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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F 000	INITIAL COMMENTS  Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/29/15 to 7/1/15. Bowdle Nursing Home was found not in compliance with the following requirement: F281.	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 18560  Surveyor: 35121 Based on record review, interview, and policy review, the provider failed to follow professional nursing standards for one of one sampled discharged resident (10) by not ensuring: *A physician's order to release the body had been obtained. *Nurses had not declared the resident's death. Findings include:  1. Review of resident 10's closed (no longer at the facility) medical record revealed: *She had been admitted on 12/11/13. *She had died on 5/11/15. *Documentation by licensed practical nurse (LPN) A on 5/11/15 revealed: -At 8:00 a.m. the "Nurse Declared [declared] res. [resident] absent of apical pulse and respirations." -At 8:10 a.m. she had notified the physician that	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sandra Schlechter</i>	TITLE <b>CEO</b>	(X6) DATE <b>07/22/15</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.

**RECEIVED**  
**JUL 23 2015**  
SD DOH L&C

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F 281	<p>Continued From page 1 the resident had died. *Her body had been released to the funeral home. *No order to release the body had been found.</p> <p>Interview on 7/1/15 at 9:00 a.m. with the director of nursing regarding resident 10's death revealed: *The nurse had notified the physician the resident had died. *The nurses usually pronounced death. *Declaration of death was out of the scope of practice for a nurse. *The body had been released to the funeral home. *A physician's order to release the body had not been obtained. *The nurses usually had not received an order to release the body. *The provider's policy had not reflected current standards of practice regarding resident death.</p> <p>Review of the provider's August 2006 Death of a Resident policy revealed "A resident may be declared dead by a Licensed Physician or Registered Nurse with physician authorization in accordance with state law."</p> <p>Review of the South Dakota Board of Nursing 8/4/14 letter clarifying the intent of SDCL 34-25-18 and 34-25-18.1 pronouncement of death revealed: "The Board of Nursing has been advised by legal counsel that in order for pronouncement of death to be effective it must be accompanied by a certificate, which the law recognizes, stating the party died with the cause of death and since a nurse cannot sign a death certificate, a nurse cannot pronounce death."</p>	F 281	<p>This deficiency has the potential to affect all residents. The policy regarding facility death of a resident has been revised to reflect current regulations and states that the physician, physician's assistant, or nurse practitioner shall declare death of a resident, write the order for the body to be released to the funeral home, and sign the death certificate. At a staff meeting on July 21, 2015 the RNs and LPNs were instructed on the revised policy. The DON will monitor this monthly. The DON will report results to the QA committee quarterly until the committee recommends to discontinue.</p> <p style="text-align: right;">July 21, 2015</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>BOWDLE NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8001 W 5TH STREET POST OFFICE BOX 556 BOWDLE, SD 57428</b>	
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K 000	INITIAL COMMENTS  Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/30/15. Bowdle Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K050 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Surveyor: 32334 A. Based on record review and interview, the provider failed to demonstrate that quarterly fire drills had been conducted during four of the last four yearly quarters for each of the three working shifts. Findings include:	K 050		

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

*Sandra Schlecter*

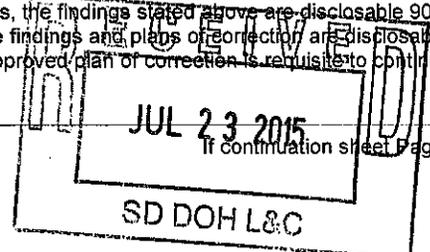
TITLE

*CEO*

(X6) DATE

*07/22/15*

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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K 050	<p>Continued From page 1</p> <p>1. Review of the fire drill records revealed missing records for four of the last four yearly quarters. Fire drills shall be conducted at a minimum of once per shift per quarter. Fire drill records indicated drills had not been documented for every shift during each of the last four quarters.</p> <p>Interview with the environmental services manager during the document review confirmed those conditions. He further stated he was new to the position and was in the process of trying to get documentation in order.</p> <p>Interview with the chief executive officer during the exit interview revealed she could not provide any insight as to why training had not been provided to ensure the new staff was familiar with the fire drill documentation requirements.</p> <p>B. Based on observation and interview the provider failed to properly conduct a fire drill procedure during the onsite fire drill scenario. Findings include:</p> <p>1. Observation at 12:45 p.m. on 6/30/15 during the onsite fire drill revealed staff involved in the fire drill did not follow the provider's fire drill policy. Upon hearing the code red over the paging system and fire alarm activation staff began closing resident room doors. Staff however did not clear the corridor of wheel chairs and lifts.</p> <p>The corridor shall be cleared of obstruction in the event that fire and rescue personnel deem it necessary for evacuation. Obstructions in the corridor during life rescue and evacuation operation could impede rescue personnel and creates a life safety hazard.</p>	K 050	<p>This deficiency has the potential to affect all residents. The maintenance supervisor will conduct and document quarterly fire drills on each shift. Quarterly fire drills will be added to the maintenance supervisor's monthly checklist. The maintenance supervisor will monitor this monthly. The maintenance supervisor will report results to QA committee quarterly until the committee recommends to discontinue.</p> <p>An all staff inservice will be held on August 19, 2015. The maintenance supervisor will instruct staff on the facility fire drill policy which states that corridors must be cleared of obstruction in the event of a fire. The maintenance supervisor will insure that corridors are cleared during quarterly fire drills. The maintenance supervisor will monitor this monthly. The maintenance supervisor will report results to QA committee quarterly until the committee recommends to discontinue.</p>	8-19-15

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K 050	Continued From page 2 Interview with the staff upon completion of the above fire drill revealed the things in the corridors were usually removed. They were unsure why those things had not been removed during this fire drill scenario.	K 050			

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## South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10596</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/01/2015</b>
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S 000	Initial Comments  Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/29/15 through 7/1/15. Bowdle Nursing Home was found not in compliance with the following requirements: S206 and S210.	S 000		
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.	S 206		

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

*Sandra Schlichter*

TITLE

CEO

(X8) DATE

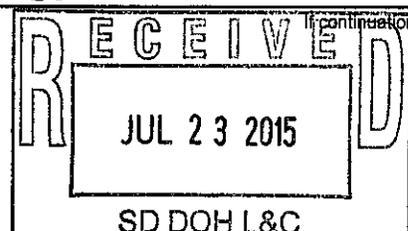
07/22/15

STATE FORM

6899

OMBJ11

If continuation sheet 1 of 4



South Dakota Department of Health

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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32332</p> <p>Based on employee file review and interview, the provider failed to ensure one of five sampled employees (B) had received mandatory orientation training for four of ten mandatory topics (proper use of restraints; care of the residents with unique needs; dining assistance, nutritional risk, and hydration needs of residents; and mandatory reporting of incidents and diseases). Findings include:</p> <p>1. Review of employee B's employment checklist revealed: *She was hired on 3/13/15. *She had received mandatory employee training on 3/13/15. *Areas not dated or initialed to indicate the training had been received had been: -Proper use of restraints. -Care of the residents with unique needs. -Dining assistance, nutritional risk, and hydration needs of residents. -Mandatory reporting of incidents and diseases.</p> <p>Interview on 6/30/15 at 4:15 p.m. with the director of nursing revealed: *She agreed employee B had not received the above mandatory training topics. *She had believed the new on-line training programs had begun, but it was not to have begun until September. *The above training should have occurred with employee B's orientation.</p>	S 206	<p>Employee B will view the mandatory training DVD on proper use of restraints, care of the residents with unique needs, dining assistance, nutritional risk, and hydration needs of residents and mandatory reporting of incidents and diseases. All new hires will view the mandatory training DVD within two weeks of their hire date. Department supervisors will monitor their new hires to insure that the training is completed within two weeks of hire date. Department supervisors will monitor this monthly. Department supervisors will report results to QA committee quarterly until the committee recommends to discontinue.</p>	7-31-15
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM	S 210		

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S 210	<p>Continued From page 2</p> <p>The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32332 Based on employee file review and interview, the provider failed to ensure five of five sampled employees (B, C, D, E, and F) had been evaluated by a health professional to determine they were free from a reportable communicable disease before they were assigned to duties. Findings include:</p> <p>1. Review of employees B, C, D, E, and F's employee files revealed: *They had all been employed by the provider since December 2014. *They had not been evaluated by a health professional to determine they were free from a reportable communicable disease.</p> <p>Interview on 6/30/15 at 4:15 p.m. with the director of nursing revealed:</p>	S 210	<p>This deficiency has the potential to affect all residents. The employee health nurse has evaluated Employees B, C, D, E, and F and determined them to be free from a reportable communicable disease. The employee health nurse will evaluate all employees and determine that they are free from a reportable communicable disease prior to the employee being assigned to duty. A statement certifying that the employee has been determined to be free from a reportable communicable disease has been added to the employee health form. The employee health nurse will monitor this monthly to insure compliance. The employee health nurse will report results to the QA committee quarterly until the committee recommends to discontinue.</p> <p style="text-align: right;">7-21-15</p>	

South Dakota Department of Health

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S 210	Continued From page 3  *She had not been aware of that requirement. *Their policy would have been to follow the state requirements. *The employee health records had not included that requirement.	S 210		