

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER DIAMOND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N MAIN ST POST OFFICE BOX 300 BRIDGEWATER, SD 57319
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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: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/23/15 through 6/25/15. Diamond Care Center was found not in compliance with the following requirement: F441.	F 000		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F441 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: 1. The whirlpool tub is being disinfected per manufacturer's recommendations. 2. All staff responsible for cleaning, care, and operation of the whirlpool tub were re-educated to the policy for disinfecting the whirlpool tub on 7/7/2015 by the Director of Nursing. 3. Director of Nursing/Designee will audit the disinfection of the Whirlpool Tub one time per week for 3 months. The data collected will be taken to the QA Committee monthly by the Director of Nursing/Designee for discussion and review. At this time the committee will make the decision for any necessary follow up studies. 4. Completion Date: 7/15/2015	7/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kimberly Donje</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>7/14/2015</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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2015	
NAME OF PROVIDER OR SUPPLIER DIAMOND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 N MAIN ST POST OFFICE BOX 300 BRIDGEWATER, SD 57319		
(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 1 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: 18560</p> <p>Surveyor: 35121 Based on observation, interview, and disinfection instructions guide review, the provider failed to follow manufacturer's instructions for disinfecting one of one whirlpool tub. Findings include:</p> <p>1. Observation and interview on 6/23/15 from 1:27 p.m. until 1:32 p.m. with certified nurse aide (CNA) A regarding the disinfecting of the whirlpool tub revealed she: *Poured a small amount of a disinfectant from the container into the whirlpool tub. *Added water to the tub until it covered the whirlpool chair. *Used the disinfectant between each resident. *Used the disinfectant and a cleaning solution after the last whirlpool bath of the day. *Had not known: -How much disinfectant she had added to the water. -The length of time the disinfectant should have been left on the tub surface.</p> <p>Observation on 6/24/15 at 2:04 p.m. with CNA B regarding the disinfecting of the whirlpool</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER DIAMOND CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 N MAIN ST POST OFFICE BOX 300 BRIDGEWATER, SD 57319		
(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 2</p> <p>revealed she:</p> <ul style="list-style-type: none"> *Dispensed the recommended amount of disinfectant into the whirlpool tub. *Added water to the tub until it covered the whirlpool chair. *Used a hand towel instead of the recommended tub brush to scrub the tub surface. <p>Review of the provider's undated Intermediate-Level Disinfection Policy and Procedure regarding disinfecting the whirlpool revealed to "follow the Apollo Manufacturer Recommendations for cleaning and disinfecting."</p> <p>Review of the undated Apollo cleaning and disinfecting process instruction guide revealed to:</p> <ul style="list-style-type: none"> *Turn selector knob to "tub cleaner." *Use tub brush to scrub tub surface and chair. *Have cleaning solution "come out of the outlets for about 30 seconds or when there is about 1 inch of cleaning solution in the foot well." *Turn selector knob to "disinfectant." *Fill with disinfectant until "there is about 1 inch of disinfectant in the foot well." *"Using the tub brush, apply the disinfectant solution to the tub surface and the chair." *"Let stand for ten minutes." <p>Interview on 6/24/15 at 3:00 p.m. with the director of nursing revealed she agreed they had not followed the manufacturer's instructions for the cleaning and disinfecting of the whirlpool.</p>	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/23/2015
NAME OF PROVIDER OR SUPPLIER DIAMOND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 N MAIN ST POST OFFICE BOX 300 BRIDGEWATER, SD 57319	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/23/15. Diamond 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		

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

Kimberly Doney

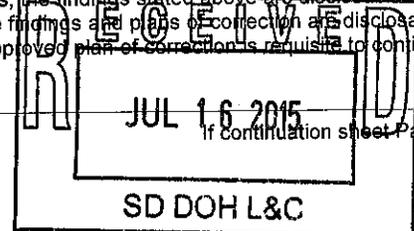
TITLE

Executive Director

(X6) DATE

7/14/2015

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40597	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER
DIAMOND CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
**901 N MAIN ST POST OFFICE BOX 300
BRIDGEWATER, SD 57319**

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S 000	Initial Comments Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/23/15 through 6/25/15. Diamond Care Center was found in compliance.	S 000		

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

Kimberly Dony

TITLE

Executive Director

(X6) DATE

7/14/15

STATE FORM

6899

RDG811

