

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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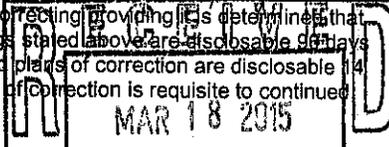
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 000	INITIAL COMMENTS Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/24/15 through 2/26/15. Riverview Healthcare Community was found not in compliance with the following requirements: F221, F280, F281, F323, F371, F441 and F514.	F 000	Addendums noted with an asterisk per 4/16/15 telephone to facility administrator. <i>CS1800011111</i>	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure the ongoing assessment and use of the least restrictive device for five of five sampled residents with half side rails (1, 3, 4, 8, and 13). Findings include: 1. Observation on 2/26/15 at 8:30 a.m. revealed resident 13 had a raised half side rail that she was attempting to get her legs and feet around in order to sit at the side of the bed. She was unable to do so without assistance. Review of resident 13's complete medical record revealed: *The care plan identified on 4/16/14 a half upper bedrail was to have been used for increasing	F 221	F221 1. Residents 1, 3, 4, 8 & 13 will be re-assessed for their ½ side rail use on or before April 17 th , 2015. 2. All residents who use ½ side rails or enabler devices on their beds are potentially at risk. 3. Any resident utilizing ½ side rails or enabler devices on their beds will be assessed prior to implementation and quarterly for least restrictive device use. Restorative Care Coordinator or designee will be responsible for completing the assessments. The DON or designee will complete written audits weekly x 4, then monthly x 3 on residents utilizing ½ side rails. Minimum of 3 residents per audit will be reviewed. 4. Results of the written audits will be taken to the facility QAPI committee by the DON or designee monthly for review and recommendations.	4/17/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tom Yaton</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/16/15</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 30 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.


MAR 18 2015
 If continuation sheet Page 1 of 29
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F 221	<p>Continued From page 1</p> <p>ability to move in bed and as an intervention to prevent falls.</p> <p>*The resident had fallen on 6/17/14 which resulted in a cut to the left side of her head.</p> <p>*Physical therapy ordered a half upper side rail for positioning on 11/26/14.</p> <p>*One side rail assessment was completed on 2/13/15.</p> <p>Surveyor: 34030</p> <p>2. Random observations from 2/24/15 to 2/25/15 at 8:00 a.m. to 5:00 p.m. of resident 1's bed revealed one- half side rail up on the top half of the bed.</p> <p>Review of resident 1's medical record revealed: *An admission date of 5/11/06. *A 2/24/15 care plan that mentioned the side rail and that it was used for positioning. *No previous ongoing assessments to show appropriate use had been done before a 2/13/15 side rail assessment.</p> <p>3. Random observations from 2/24/15 to 2/25/15 at 8:00 a.m. to 5:00 p.m. of resident 3's bed revealed one- half side rail up on the top half of the bed.</p> <p>Review of resident 3's medical record revealed: *An admission date of 10/9/13. *A 2/24/15 care plan that mentioned the side rail and that it was used for positioning. *No previous ongoing assessments to show appropriate use had been done before a 2/13/15 side rail assessment.</p> <p>Surveyor: 26180</p>	F 221			

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F 221	<p>Continued From page 2</p> <p>4. Observations of resident 8 revealed: *On 2/25/15 at 9:30 a.m., 12:45 p.m., and 2:45 p.m. he was sleeping in his bed. A siderail that extended along the upper one-half of the bed was pulled up. *Certified nursing assistant (CNA) L and an unidentified CNA assisted the resident in getting out of bed using a hooyer lift (mechanical). -After positioning the resident in his wheelchair, CNA L applied a safety belt around the resident's waist. -The resident was able to demonstrate he could have removed the safety belt. -CNA L said the safety belt was used to prevent the resident from sliding out of his wheelchair.</p> <p>Interview on 2/25/15 at 10:00 a.m. with restorative care coordinator/licensed practical nurse (LPN) B regarding resident 8 revealed: *They had just had a mock survey which identified that many resident beds had one-half side rails on them. -Many of those side rails were taken off the beds. -Resident 8's side rail was not removed because he used the side rail to reposition himself, using his right arm. *The occupational therapist (OT) had reviewed every resident who had a side rail. -She had asked the OT to look at resident 8's safety belt also. *She confirmed resident 8 was a large man and there were safety concerns with the use of the safety belt if he were to slide out of the wheelchair and possibly getting caught in the belt. *She confirmed that side rail and safety belt assessments had not been completed prior to the mock survey.</p> <p>Review of resident 8's 2/24/15 OT Plan of care</p>	F 221		
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F 221	<p>Continued From page 3 (evaluation only) revealed:</p> <ul style="list-style-type: none"> *The reason for referral was to evaluate him for the wheelchair and nursing was concerned that the patient was at risk for skin break down in his wheelchair. *Previous therapy notes stated "Pt (patient) has been seen several times for WC (wheelchair) safety." *He was a fall risk and was morbidly obese. *It had not addressed: <ul style="list-style-type: none"> -The use of the seat belt in the wheelchair. -The use of the side rails in bed. -Any safety concerns. <p>Interview on 2/25/15 at 11:15 a.m. with the administrator revealed:</p> <ul style="list-style-type: none"> *They had identified the need to look at different repositioning devices for residents including resident 8 who had one-half side rails on their beds. *They were looking at alternatives, but were considering the cost factors before deciding what they were going to do. <p>Interview on 2/25/15 at 3:00 p.m. with LPN B revealed she had found resident 8's OT daily treatment note. Review of that 2/23/15 note revealed the OT had documented "Pt demos (demonstrates ability to take off lap belt for safety but cannot get it back on." She had not addressed any risk of the resident sliding out of the wheelchair and possibly getting caught on the belt.</p> <p>Surveyor: 32355 5. Random observations of resident 4 from 2/24/15 through 2/25/15 from 8:40 a.m. to 10:30 a.m. revealed when she was in bed two-half side</p>	F 221		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2015
FORM APPROVED
OMB NO. 0938-0391

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F 221	<p>Continued From page 4</p> <p>rails were pulled up on the top half of her bed.</p> <p>Review of resident 4's entire medical record revealed:</p> <ul style="list-style-type: none"> *12/2/14 a physician's order for "1/2 upper outer bed rails for positioning." *There was no restraint or side rail assessment completed until 2/13/15. *Her care plan had not been updated until 2/13/15 to address the use of both side rails when she was laying in bed. *There was no documentation to support: <ul style="list-style-type: none"> -Resident 4 had a side rail assessment completed prior to 2/13/15. -There had been a consent completed and signed by the resident, family, or legal representative to use the restraint. <p>Interview on 2/25/15 at 9:50 a.m. with licensed practical nurse (LPN) B revealed:</p> <ul style="list-style-type: none"> *She was responsible for the completion and updating of the side rail assessments. *She would have reviewed and updated them yearly. *The side rails were re-assessed quarterly during the care plan meeting. These quarterly assessments had been done verbally. *She confirmed there had been no side rail assessment completed on resident 4 until 2/13/15. <p>Review of the provider's March 2013 Physical Restraints policy revealed:</p> <ul style="list-style-type: none"> *Policy "To assure a restraint is used only when assessed as necessary to treat a medical condition and/or an appropriate measure to be used to provide resident safety. Least restrictive device will be the ultimate goal." *"When a restraint is requested the facility has 	F 221		

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F 221	Continued From page 5 the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment." **"Depending on the use of device and the resulting restriction of movement, restraints may include seatbelts, lap buddies, pummel wheelchair cushions, recliner chairs with foot rests extended, hand restraints, and bed side rails." **"Consent to use the restraint must be obtained from the resident, family, or legal representative." **"Facility must provide ongoing assessments and evaluation as to the use of a restraint including less restrictive methods of providing safety."	F 221		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1. Residents 5 & 8 care plans will be updated to reflect their current status on or before April 17 th , 2015. 2. All residents are potentially at risk. 3. All nurses and the Interdisciplinary team will be educated on the care planning process on or before April 17 th , 2015. Education will be provided by the DON or designee. The DON or designee will complete written audits weekly x4, then monthly x 3 on care planning of resident's needs. A minimum of 3 residents will be reviewed per audit. 4. Results of the written audits will be taken to the facility QAPI committee by the DON monthly for review and recommendations.	4/17/15

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F 280	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure two of thirteen sampled resident's care plans (5 and 8) were kept current and reflected the resident's needs. Findings include:</p> <p>1. Random observation of resident 8 from 2/24/15 at 10:30 a.m. through 2/26/15 at 8:30 a.m. revealed he: *Was laid down in bed in between meals. -When he was in bed a one-half siderail was pulled up on the top half of his bed. *He had: -A bariatric (oversized) wheelchair. -An oversized bed. -An oversized commode (portable toilet) in his room. -A safety belt fastened around his abdomen when he sat up in the wheelchair. *Sat at a table at all meals by himself and his chair faced the wall.</p> <p>Observation and interview on 2/25/15 at 9:30 a.m. with certified nursing assistant L after he got resident 8 up for breakfast revealed: *The resident used the side rail to reposition himself. He could use his left side. *He applied a safety belt around the resident's waist. The resident used the safety belt to prevent him from sliding out of the wheelchair.</p> <p>Interview on 2/25/15 at 11:30 a.m. with the social services designee regarding resident 8 revealed: *He sat at the table by himself because he used to have an electric wheelchair that did not fit</p>	F 280			

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F 280	<p>Continued From page 7 under the table.</p> <p>*Now he had a standard wheelchair but he would ram the arms of the wheelchair into the table, and his tablemates had not liked it.</p> <p>*He was starting to have hallucinations (seeing or hearing things that were not there).</p> <p>*He used to fixate (dwell on) female staff so they needed to always assign a male caregiver to take care of him. That behavior had improved with that plan.</p> <p>*He refused the mental health services that were offered him. Although there was a new counselor, she wondered if he might agree to meeting with her.</p> <p>Review of resident 8's 1/22/15 care plan revealed:</p> <p>*He received counseling services from a community mental health agency.</p> <p>*He was to have been encouraged to interact with others.</p> <p>*It had not addressed:</p> <ul style="list-style-type: none"> -The use of the safety belt and plans to release it. -His refusal of the mental health services and alternative treatment plans. -Why he sat at a table by himself. -The need for the oversized wheelchair, bed, and commode. -The need for a male caregiver to help manage behaviors. <p>Interview on 2/25/15 at 4:00 p.m. with the director of nursing (DON) revealed she agreed resident 8's care plan had not addressed everything it should have.</p>	F 280		

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F 280	Continued From page 8 Surveyor: 33265 2. Review of resident 5's complete medical record revealed: *The undated care plan stated there had been a mobility pad (pad on bed that alarms if motion is detected) on the bed under the fall risk focus area and under an unidentified focus area. Both listed the start date as 12/10/14. *Documentation on the treatment administration sheet identified the mobility pad had been discontinued on 1/30/15. Interview on 2/26/15 at 9:00 a.m. with the DON revealed she believed the care plans should have been updated within one week of a change in treatment. Review of the provider's undated Care Plan policy revealed: *The care plans were to have been updated as there were changes in the resident's condition. *Changes requiring updates to the care plan included health, mood, or behavior. *Interventions concerning falls, skin integrity, resident-to-resident altercations, or new physician orders were to have been added to the care plan when these events occurred. *Handwritten additions were to include the date and initials of the person making the update. *Discontinued interventions were to have been yellowed with the date and initials of the person making the update included.	F 280		
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.	F 281		4/17/15

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F 281	Continued From page 9 This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Policy and procedure for administering nebulizer treatments had been followed by one of one observed medication aide (MA) (E) for one of one observed resident (17). *A self-medication assessment had been completed for one of one observed resident (17) who self-administered a nebulizer treatment. Findings include: 1. Observation on 2/25/15 at 11:15 a.m. of MA E preparing and administering a nebulizer treatment to resident 17 revealed: *She had gathered all of the necessary supplies to give the resident a nebulizer treatment. *She had entered the resident's room and retrieved the nebulizer mouth piece and chamber. The nebulizer mouth piece and chamber had been all together and attached to the machine. *She removed the nebulizer mouth piece and chamber from the machine, went to the bathroom, took it apart, and rinsed it with water. *She placed the medication inside of the chamber and attached the mouth piece. *She asked the resident to hold the mouth piece and chamber for administration and left the room. *At 11:25 a.m. she returned to the resident's room to check on her and administer another nebulizer treatment. *She had not: -Assessed the resident's pulse, respiratory rate, and listened to her lung sounds before and after the nebulizer treatment. -Encouraged the resident to take deep breaths,	F 281	F281 1. Resident #17 will be re-assessed for self-administration of nebulizer medication on or before April 17 th , 2015. 2. All residents receiving nebulizer treatments are potentially at risk. 3. The facility will review and revise as necessary their policy on nebulizer treatments, including assessment and self-administration on or before April 17 th , 2015. All nurses and med aides will be educated on the nebulizer policy on or before April 17 th , 2015. The DON or designee will complete [REDACTED] audits on nebulizer self-administration weekly x 4, then monthly x3. A minimum of 3 residents will be reviewed per audit. 4. The DON or designee will bring the results of the written audits to the facility QAPI committee monthly for review and recommendations.	

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F 281	<p>Continued From page 10</p> <p>cough, and exhale throughout the treatment.</p> <ul style="list-style-type: none"> -Occasionally tapped the nebulizer chamber to ensure any droplets on the sides were released. -Remained with the resident during the nebulizer treatment. <p>Interview on 2/25/15 at the time of the above observation with MA B revealed:</p> <ul style="list-style-type: none"> *She would not have stayed with the resident to ensure she had received all of the medication. *She stated resident 17 was alert enough to administer the medication on her own. *She would have frequently checked on any confused resident to ensure the administration of the medication had been complete. She stated "If they are confused we just go back and forth to check on them." <p>Review of resident 17's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 3/24/12. *No physician's orders for self-administering of medications. *Her 6/13/14 care plan revealed no focus area or approach for her to self-administer the nebulizer treatments. *No self-medication administration assessment. <p>Review of the provider's September 2010 Medication Administration for Nebulizers policy revealed:</p> <p>*Procedures:</p> <ul style="list-style-type: none"> -"Obtain baseline pulse, respiratory rate and lung sounds." -"Instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughout treatment." -"Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer." 	F 281		
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F 281	<p>Continued From page 11</p> <p>-"Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup." -"Encourage the resident to cough and expectorate as needed." -"Obtain post-treatment pulse, respiratory rate and lung sounds and document findings on the medication administration record or in the resident' medical record following facility policy."</p> <p>Review of the provider's April 2013 Self-Administration of Medication policy revealed: **"Upon admission to the facility and at any point during the resident's stay (through the care planning process with the health care team), a resident who chooses to may self-administer medication. The medical provider is included in the health care team and an order is obtained when appropriate if the resident has been determined to be capable of this task." **"Monitoring will occur on a daily basis by staff to assess the resident's continued ability to self-medicate." **"A resident's decision and support by staff to self-medicate will be noted on the resident's care plan." **"Review of self-medication for each resident will be done quarterly by the health care team and also when a significant change occurs."</p> <p>Interview on 8/26/15 at 8:20 a.m. with the director of nursing revealed she would have expected the staff to follow the policy for nebulizer administration and self-administration of medication as stated above."</p>	F 281		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p>	F 323		4/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	
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F 323	<p>Continued From page 12</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to: *Secure chemicals in two of two soiled utility rooms. *Complete ongoing smoking assessments for one of one sampled resident (9) who smoked. Findings include:</p> <p>1. Observation on 2/24/15 at 8:30 a.m. during the initial tour of the facility revealed: *An unlocked soiled utility room upstairs in the resident care area containing: -A container of Clorox bleach in an unlocked cupboard under the sink. -Multiple chemicals in an unlocked cupboard above the sink that included Febreeze deodorizer and Vindicator plus (a corrosive cleanser). *An unlocked soiled utility room downstairs in the resident care area containing the same non-secured chemicals as above. *Multiple residents in the area including those with dementia (decreased mental ability) who would have been able to access the chemicals.</p> <p>Interview on 2/25/15 at 1:00 p.m. with the maintenance supervisor revealed he agreed the chemicals should have been secured.</p>	F 323	<p>F323</p> <p>1. All chemicals are securely stored in the facility. Resident #9 & all residents who smoke will have a smoking assessment completed on or before April 17th, 2015 and then quarterly thereafter, to coincide with their MDS schedule.</p> <p>2. All residents are potentially at risk.</p> <p>3. All staff will be educated on chemical storage on or before April 17th, 2015. All residents who smoke will have an assessment completed on admit and quarterly by the SS designee or designee. The facility Administrator or designee will complete written audits weekly x4, then monthly x 3 on chemical storage and smoking safety.</p> <p>4. The Administrator or designee will bring the results of the written audits to the facility QAPI committee monthly for review and recommendations.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 323	<p>Continued From page 13</p> <p>Interview on 2/26/15 at 8:30 a.m. with the director of nursing revealed she would have expected the chemicals to have been secured from the residents.</p> <p>Review of the provider's December 2013 chemical safety policy revealed "All chemicals such as those used for sanitizing or cleaning will be kept locked away from residents who are at risk, such as residents with confusion or dementia".</p> <p>Surveyor: 32355</p> <p>2. Observation and interview on 2/24/15 at 8:10 a.m. with resident 9 revealed he:</p> <ul style="list-style-type: none"> *Had several burn holes on the front of his shirt. *Went outside and smoked independently on a daily basis. *Kept the cigarettes in his room. *Was not required to inform the staff of when he went outside to smoke. *Would have gone outside to smoke three or more times a day. <p>Review of resident 9's complete medical record revealed he had a history of smoking on a daily basis. A smoking assessment was located to support he had been safe to smoke independently upon admission on 9/27/13. No further smoking assessments had been found in his medical record to support he continued to be safe with smoking.</p> <p>Review of resident 9's 9/26/14 care plan revealed no documentation to support he smoked independently on a daily basis. There was no documentation he was responsible for the storage of the cigarettes.</p>	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 323	<p>Continued From page 14</p> <p>Interview on 9/24/15 at 9:10 a.m. with licensed practical nurse C confirmed resident 9 had been:</p> <ul style="list-style-type: none"> *Able to smoke independently. *Was not required to check with staff prior to going outside to smoke. *Kept the cigarettes in his room. <p>Interview on 2/24/15 at 5:00 p.m. with the social worker revealed:</p> <ul style="list-style-type: none"> *She had been responsible for completing the smoking assessments. *She would have done the smoking assessments upon admission and as needed thereafter. *Resident 9 had been admitted with burn holes in his clothes. *They had attempted to provide resident 9 with a protective apron to use while smoking. He had refused to use the apron. *She could not provide documentation to support the use and refusal of the protective apron for the resident. *She agreed she probably should have been assessing the residents who smoked more often to ensure the continued capability and safety while smoking. <p>Review of the provider's October 2008 Smoking policy revealed:</p> <ul style="list-style-type: none"> *Residents were to have smoked in designated areas. *"To maintain smoking privileges at [provider name], compliance to the smoking policy is required at all times. An incident of non-compliance to the smoking policy will result in the resident losing their smoking privileges for 24 hours." *Required the signature from the resident or responsible party. 	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 323	Continued From page 15	F 323		
F 371 SS=F	<p>The provider was not able to provide any further policy and procedure for residents who smoked.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354</p> <p>Surveyor: 35121 Preceptor: 29354 Based on observation, interview, and policy review, the provider failed to: *Maintain proper cold food temperatures for two of two meal observations. *Maintain the kitchen in a sanitary manner. *Ensure foods in one of one walk-in cooler and one of one dry food storage were not expired or outdated. *Ensure proper storage of food items. *Maintain proper hair covering for staff at one of two meal observations. *Maintain proper hand hygiene for dietary staff at one of two meal observations. Findings include:</p>	F 371	<p>F371</p> <p>1. No residents were specifically cited in the deficiency.</p> <p>2. All residents are potentially at risk.</p> <p>3. All dietary staff will be educated on food storage, prep and sanitation on or before April 17th, 2015. Education will be completed by the Dietary Service Manger or designee.</p> <p>a. Food Temps – the facility purchased and implemented a new refrigerator to be kept on 2nd floor dining room as a means to keep foods at appropriate temperatures until served. This was completed on 3-12-15.</p> <p>b. Storage – the facility freezer door and fan has been cleaned and are on the kitchen cleaning schedule for routine cleaning. No staff and resident foods will be co-mingled in the facility. Areas that were un-cleanable in the dietary areas have been replaced or refinished / painted, so they are now cleanable.</p> <p>c. Expired foods – all expired foods have been discarded.</p> <p>d. Food labeling – all foods are labeled appropriately now to include dates opened.</p>	4/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 371	<p>Continued From page 16</p> <p>1. Observation on 2/24/15 at 1:15 p.m. of dietary aide (DA) G in the main dining room revealed: *There was half a tray of ground turkey salad sandwiches on the counter. *She took the temperature (temp) of the ground turkey salad sandwiches. *The temp of the ground turkey salad sandwiches was 45 degrees F (Fahrenheit). *Interview at that time with DA G revealed she should have discarded the sandwiches. *Interview on 2/24/15 at 3:05 p.m. with the certified dietary manager (CDM) regarding the ground turkey sandwiches revealed: *There was "No need to temp if you move quickly." *"We don't temp before we put back in cooler after they [sandwiches] are prepared."</p> <p>Observation and interview on 2/24/15 from 12:50 p.m. through 1:45 p.m. during the noon meal revealed: *At 12:50 p.m. a closed food cart left the kitchen for the activity dining room. *At 1:35 p.m. there were three individual serving plates of turkey salad sandwiches on the serving table in the activity dining room. *Interview at that time with DA F in the above location revealed: -She had not checked the temperature of the turkey salad sandwiches. -She was unable to find a thermometer. -She then left the area and returned with a thermometer. -Without sanitizing the thermometer she placed it into one of the plates of turkey salad. -The temperature of the turkey salad sandwich was 64 degrees F. -She stated "I don't know what they will eat now."</p>	F 371	<p>e. hand hygiene – all dietary associates will be educated on hand hygiene / cough etiquette on or before April 17th, 2015.</p> <p>The Dietary Services Manager or designee will complete audits on the areas noted above weekly x 4, then monthly x3.</p> <p>4. Results of the written audits will be taken the facility QAPI committee monthly by the DSM for review and recommendations.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 371	<p>Continued From page 17</p> <p>*Interview on 2/24/15 at 1:43 p.m. with the CDM revealed she:</p> <ul style="list-style-type: none"> -Came to the activity dining room area and was informed of the temperature of the turkey salad sandwiches. -Stated "That's not a good deal!" -Left the area and returned with a food alternative for the resident's turkey salad sandwiches servings. <p>Observation on 2/24/15 at 4:40 p.m. of DA H in the main dining room revealed:</p> <ul style="list-style-type: none"> *There was a tray of single serve containers of tartar sauce. *There was a tray of single serve containers of sour cream. *The tartar sauce was 50 degrees F. *The sour cream was 48 degrees F. *Interview at that time with DA H confirmed "I can't serve it." <p>According to the United States Public Health's Food and Drug Administration recommendation: *3-501.16 Potentially hazardous Food (Time/Temperature control for Safety Food) cold holding, shall be maintained at 41 degrees F for cold food items.</p> <p>Review of the provider's October 2007 Policy for Taking/Recording Food Temperatures revealed: **"Riverview Health Services, Inc. will take and record food temperatures on all food being served to ensure safe handling and that hot food is served hot and cold food is served cold." **"Food temperatures should be taken when cooking/preparing, before being taken upstairs, before you start serving, during service and just before finished."</p>	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 371	<p>Continued From page 18</p> <p>2. Observation on 2/24/15 at 8:30 a.m. in the walk-in cooler, freezer, the dishwashing area, and the dry foods storage revealed:</p> <ul style="list-style-type: none"> *Two totes (tubs) in the dry goods storage room were visibly dirty on the outside. *The walk-in freezer door was visibly dirty on the outside. *A refrigerator freezer in the activity room had commingling (mixing together) of staff food items with resident food items. *The shelves used to store glasses had unfinished wood (an uncleanable surface) in two of the eight cupboards in the dining room. *The drawers used to store knives and scoops had unfinished wood in two of the six drawers in the kitchen. *The shelves used to store food items had unfinished wood in the walk in cooler and the walk in freezer. *A box fan was visibly dirty and had been blowing on the clean side of the dishwashing area. *There were three tubs of margarine not stored in the original containers. <p>3. Observation on 2/24/15 at 8:30 a.m. in the walk-in cooler and the dry foods storage revealed:</p> <ul style="list-style-type: none"> *Visibly spoiled items including: <ul style="list-style-type: none"> -A box of lettuce leaves. -Eleven heads of lettuce in a box. -Two heads of lettuce in a bin. -Four lemons. -Four grapefruit. -An unopened bag of cauliflower. -One half of a bag of opened tortilla shells. -Four bananas. *Expired or outdated food items with the dates items had been opened: <ul style="list-style-type: none"> -Taco shells 12/5/14. 	F 371		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 371	<p>Continued From page 19</p> <ul style="list-style-type: none"> -Tortilla shells 2/1/15. -Kidney beans 2/14/15. -Chicken pot pie 2/16/15. -Tomato soup 2/16/15. -Ranch dressing 2/17/15. -Cauliflower 2/18/15. -One case of oatmeal with expiration date of 11/2014. -Greek yogurt with the expiration date of 2/16/15. <p>4. Observation on 2/24/15 at 8:30 a.m. in the walk-in cooler, the kitchen, and the walk-in freezer revealed opened, undated, and unlabeled food items including:</p> <ul style="list-style-type: none"> -Two partial packages of cheese slices. -Five pudding dishes. -Two one-half bags of shredded mozzarella cheese. -One-half bag of green beans. -One-half bag of asparagus. -One-half bag of Splenda. -One-half bag of gluten free bread. -One-half bag of shredded wheat cereal. <p>Review of the provider's November 2008 Storage of Leftovers policy revealed:</p> <p>***The dietary manager is responsible to ensure that leftovers are stored properly.</p> <p>***Leftover containers must be covered loosely and clearly labeled with the name of the contents and the date.</p> <p>***All potentially hazardous food [foods which consist entirely of or contain one of the following items: meat, fish, poultry, eggs, milk and cheese] must be used within 48 hours or discarded. Cooked vegetable and fruits up to 5 days.</p> <p>***Leftover foods may be frozen by packaging in small, airtight units for quick freezing; labeling contents and dating.</p>	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 371	<p>Continued From page 20</p> <p>Review of the provider's undated Contamination During Storage and Cross Contamination policy revealed:</p> <ul style="list-style-type: none"> **All opened packages are stored in air tight container and properly labeled." **Food that is inadequately packed or contained in damaged packaging could become contaminated." **Packaging must be appropriate for preventing the entry of contaminants such as chemicals." **These contaminants may be present on the outside of containers and may contaminate food if the packaging is inadequate or damaged, or when the packaging is opened." **Pathogens [an agent that causes infection or disease] can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized." **Food that comes into contact directly or indirectly with surfaces that are not cleaned and sanitized is liable to such contamination." <p>Review of the provider's undated CDM job description revealed job responsibilities including:</p> <ul style="list-style-type: none"> **Manages kitchen supplies and equipment using safety, sanitation and efficiency principles." **Utilizes and oversees proper product rotation." **Inspect and try to correct sanitary conditions in kitchen and dish washing room." <p>5. Observation on 2/24/15 at 1:42 p.m. in the activity dining room of DAF revealed she:</p> <ul style="list-style-type: none"> *Coughed into her arm three different times while serving the food. *Had not performed hand hygiene during any of that time. <p>Interview on 2/26/15 at 8:30 a.m. with the CDM</p>	F 371		
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 371	Continued From page 21 revealed she agreed hand hygiene should have been performed whenever anyone coughed or sneezed during food preparation or serving of food.	F 371		
F 441 SS=E	Review of the provider's undated Hand Washing for Food Preparation and Delivery policy revealed "Hands must be washed after coughing, sneezing, using a tissue, using tobacco, eating or drinking." 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.	F 441	F441 1. Resident 18 nebulizer is clean and disinfected per policy. 2. All residents are potentially at risk 3. All housekeeping staff will be educated on cleaning procedures on or before April 17 th , 2015. This will be completed by the Administrator or designee. All Nursing staff will be educated on the facility policy for nebulizer cleaning and storage on or before April 17 th , 2015. The Administrator or designee will complete _____ audits on CS/SDO/IME housekeeping cleaning procedures weekly x 4, then monthly x 3 The DON or designee will complete written audits on nebulizer storage and sanitation weekly x 4, then monthly x 3 4. The administrator or designee & DON or designee will report the results of the audits the facility QAPI committee monthly for review and recommendations.	4/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 441	<p>Continued From page 22</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: 34030 A. Based on observation, interview, and product label review, the provider failed to have one of one observed housekeeper (A) disinfect resident sink and toilet surfaces to prevent the spread of infection for all of the upstairs residents' rooms. Findings include:</p> <p>1. Observation and interview on 2/25/15 at 11:15 a.m. of housekeeper A cleaning a resident's room revealed: *The room housed two residents and the sink was shared by them. The toilet was shared by them plus a third resident in the room next door. *The housekeeper sprayed the sink with disinfectant, and without waiting wiped it with a dry cloth. *After cleaning the rest of the room he sprayed disinfectant on the toilet surfaces. He continued by placing toilet bowl cleaner inside the toilet and scrubbed that clean. *He then wiped the toilet surfaces with a dry cloth after the disinfectant had been left on for two minutes. *When asked by this surveyor, he answered he</p>	F 441		

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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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
F 441	<p>Continued From page 23</p> <p>cleaned all of the upstairs residents' rooms and he would clean them all in this way.</p> <p>Review of the product label revealed it was called "Hillyard germicidal cleaner". To provide optimal disinfection it should have been left on the surfaces for ten minutes before being wiped off.</p> <p>Interview on 2/25/15 at 4:00 p.m. with the housekeeping supervisor revealed he agreed the disinfectant had not been left on long enough to prevent the spread of infection. He stated there was no provider policy or procedure to address this.</p> <p>Interview on 2/26/15 at 8:30 a.m. with the director of nursing revealed she also agreed adequate disinfection of resident sinks and toilets had not been done.</p> <p>Surveyor: 32355</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure the policy and procedure for cleaning nebulizer equipment was followed for two of two observed residents (17 and 18). Findings include:</p> <p>1. Observation on 2/24/15 at 8:30 a.m. of resident 18's room revealed a nebulizer machine sitting on his bedside table. The nebulizer mouth piece and chamber had been put together and were attached to the nebulizer machine. Next to the machine was a small white basket with a paper towel inside.</p> <p>2. Observation on 2/25/15 at 11:15 a.m. of medication aide (MA) E preparing and administering a nebulizer treatment to resident 17 revealed:</p> <p>*She had gathered all of the necessary supplies</p>	F 441		

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

PRINTED: 03/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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F 441	<p>Continued From page 24</p> <p>to give the resident a nebulizer treatment. *She had entered the resident's room, retrieved the nebulizer mouth piece and chamber. The nebulizer mouth piece and chamber had been all together and attached to the machine. *Next to the nebulizer machine was a small white basket with a paper towel inside. *She removed the nebulizer mouth piece and chamber from the machine, went to the bathroom, took it apart, and rinsed it with water. *She placed the medication inside of the chamber and attached the mouth piece.</p> <p>Interview on 2/25/15 at the time of the observation with MA E revealed: *She should have found the nebulizer mouth piece and chamber taken apart and inside of the basket. *The above equipment was to have been taken apart, rinsed with water, and placed in the basket to air dry after it had been used. *Whoever had assisted resident 17 with her last nebulizer treatment had not followed the provider's policy and procedure for cleaning of the nebulizer equipment after use.</p> <p>Interview on 2/26/15 at 8:25 a.m. with the director of nursing confirmed the staff were to have rinsed the nebulizer equipment with water after each use and put it in the basket to air dry.</p> <p>Review of the provider's June 2013 Nebulizer Cleaning policy revealed: *Policy "To assure infection control practices are followed when resident receiving nebulizer treatments." *Procedure "After each use, the mask/reservoir will be wiped with warm soapy water, rinsed and placed upside down to dry on a paper towel."</p>	F 441		

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F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354</p> <p>Surveyor: 35121 Preceptor: 29354 Based on record review, interview, and policy review, the provider failed to ensure complete and accurate documentation was maintained for two of thirteen sampled residents (2 and 5). Findings include:</p> <p>1. Review of resident 2's medical record on 2/24/15 revealed physician's orders had: *The director of nursing's (DON) signature and date of 2/3/15. *There was no physician's signature. *The date of 2/3/15 had been entered on the physician signature line.</p> <p>Review of resident 2's medical record on 2/25/15 revealed:</p>	F 514	<p>F514</p> <p>1. Residents 2 & 5 areas noted in the 2567 are unable to be corrected for past non-compliance.</p> <p>2. All residents are potentially at risk.</p> <p>3. All nurses and the HIC (health information coordinator) will be educated by the DON or designee on or before April 17th, 2015 on signing and dating of physician orders and order dates.</p> <p>The DON or designee will complete written audits on the areas noted above weekly x 4, then monthly x 3</p> <p>4. The DON or designee will report results of the written audits to the facility QAPI committee monthly for review and recommendations.</p>	4/17/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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F 514	<p>Continued From page 26</p> <p>*The physician had signed his name on the line next to the 2/3/15 date on 2/25/15 during his physician rounds.</p> <p>*The physician's signature date had not been changed to reflect actual date it was signed.</p> <p>Interview on 2/24/15 at 2:34 p.m. with the health information manager (HIM) revealed: *The HIM printed the physician's orders every other month. *The DON checked them and had the physician sign the orders during his next facility visit.</p> <p>Interview on 2/25/15 at 3:06 p.m. with the DON revealed: *She confirmed the physician had signed the 2/3/15 physician's orders on 2/25/15. *She confirmed the date of 2/3/15 was written on the physician signature line of the physician's orders on 2/3/15 when the orders were updated after resident 13 had returned to the facility following a hospital stay. *She stated she did not want the physician to use the date of 2/25/15 because that would have made those orders effective 2/25/15 and some of those orders had been changed since 2/3/15.</p> <p>Interview on 2/26/16 at 8:07 a.m. with the DON revealed she agreed the physician's signature should have been dated the day the physician signed the orders.</p> <p>Surveyor: 33265 2. Review of resident 5's complete medical record revealed: *Physician's orders dated 2/3/15 included continuation of: -Zinc to slit on right groin area twice a day until</p>	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/26/2015
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F 514	<p>Continued From page 27</p> <p>resolved which had started on 9/20/14.</p> <p>-Normal saline (salt water) cleaning of skin tear to left forearm with gauze dressing for protection every day as needed which had started on 12/25/14.</p> <p>*The treatment administration record (TAR) for January 2015 identified:</p> <p>-Zinc to slit on right groin area twice a day until resolved which had started on 9/20/14 was twice a day as needed.</p> <p>-Normal saline (salt water) cleaning of skin tear to left forearm with gauze dressing for protection every day as needed had been discontinued on 1/25/15.</p> <p>*The treatment administration record for February 2015 revealed:</p> <p>-Both treatments listed above were printed on the form.</p> <p>-Both treatments had hand written additions that identified neither treatment was being done.</p> <p>Interview on 2/26/15 at 9:00 a.m. with the director of nursing (DON) revealed:</p> <p>*She had not been aware that orders already discontinued were being entered onto a new physician's order sheet and a new TAR.</p> <p>*The medical records coordinator reviewed physician's order sheets each month before physician's rounds.</p> <p>Review of the provider's November 2010 Doctor's Orders policy revealed "New orders are to be immediately noted by the Charge nurse, initialed as per the physician's instructions and properly recorded in the medical record."</p> <p>Review of the provider's July 2013 Documentation System policy revealed:</p> <p>**The resident's medical record is a legal</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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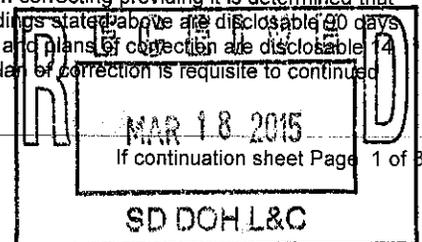
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F 514	Continued From page 28 document." **"The resident's medical record should be up-to-date at all times reflecting the current status of the resident." **"All documentation is to be neat and legible and include the date, signature and title of the person making the entry."	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2015
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028	

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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/24/15. The original 1967 Riverview Healthcare Community (building 01) 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 and the Fire Safety Evaluation System (FSES) dated 2/24/15 upon correction of the deficiency identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 020 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain the one hour fire	K 020		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 3/16/15

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2015
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NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 2ND AVE FLANDREAU, SD 57028
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K 020	<p>Continued From page 1</p> <p>resistive rating of vertical openings. The front exit stair enclosure was separated by wire glass vision panels. The door from the stair enclosure to the lower level was not equipped with latching hardware. Findings include:</p> <p>1. Observation at 10:30 a.m. on 2/24/15 revealed the north exit stair enclosure used large wire glass vision panels as the vertical separation. Further observation revealed the wire glass door leading from the stair enclosure to the lower level lobby was not equipped with latching hardware. Review of previous survey data confirmed that condition had existed since the building was constructed.</p> <p>This deficiency would affect 100% of the building occupants.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiency identified in K000.</p> <p>K 062 SS=E NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable</p>	K 020	<p>K062</p> <p>1. An annual sprinkler inspection will be scheduled and or completed by April 17th. A smaller test drain will be established on or before April 17th.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Maintenance staff will be educated on quarterly flow and tamper testing along with correct way to document such tests. The facility will conduct a one-time audit to ensure test drain has been updated and that an annual sprinkler inspection has been completed. The facility will also complete audits on documentation for quarterly flow and tamper testing of the sprinkler system. Audits will be completed quarterly for one year to ensure completion.</p> <p>4. The Administrator or designee will bring the results of the written audits to the facility QAPI committee monthly for review and recommendations.</p>	<p>F</p> <p>4/17/15</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2015
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K 062	<p>Continued From page 2</p> <p>operating condition, and it was inspected and tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection, testing, and maintenance reports at 1:30 p.m. on 2/24/15 revealed an annual inspection was completed by Building Sprinkler Company on 4/9/14. Further review indicated no documentation of the required additional quarterly flow and tamper testing. Interview with the maintenance supervisor at the time of the record review revealed he was running water to the main drain weekly but did not activate the fire alarm system. That would indicate water was not flowing past the system flow sensors. Further interview with the maintenance supervisor indicated the taper switches were also not being tested.</p> <p>2. Observation of the automatic sprinkler system test drain at 1:45 p.m. on 2/24/15 revealed the test drain opening was a two inch pipe which would not represent the flow of a single sprinkler. Interview with the maintenance supervisor at the time of the observation revealed he was unaware the smaller drain opening was required.</p> <p>The deficiency had the potential to affect 100% of the building occupants.</p>	K 062			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1989 ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2015
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/24/15. The 1989 Addition to Riverview Healthcare Community (building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000	Addendums noted with an asterisk per 3/18/15 telephone to facility administrator. JBKDDH/MF	
K 062 SS=E	<p>The building will meet the requirements of the 2000 LSC for existing health care occupancies to indicate the provider's intent to correct the deficiency identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition, and it was inspected and tested periodically in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include:</p> <p>1. Review of the provider's automatic sprinkler</p>	<p>* K062</p> <p>K 062</p>	<p>1. An annual sprinkler inspection will be scheduled and or completed by April 17th. A smaller test drain will be established on or before April 17th.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Maintenance staff will be educated on quarterly flow and tamper testing along with correct way to document such tests. The facility will conduct a one-time audit to ensure test drain has been updated and that an annual sprinkler inspection has been completed. The facility will also complete audits on documentation for quarterly flow and tamper testing of the sprinkler system. Audits will be completed quarterly for one year to ensure completion.</p> <p>4. The Administrator or designee will bring the results of the written audits to the facility QAPI committee monthly for review and recommendations.</p> <p style="text-align: right;">JBKDDH/MF</p>	<p>4/17/15</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435086	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 1989 ADDITION B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2015
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K 062	<p>Continued From page 1</p> <p>system inspection, testing, and maintenance reports at 1:30 p.m. on 2/24/15 revealed an annual inspection was completed by Building Sprinkler Company on 4/9/14. Further review indicated no documentation of the required additional quarterly flow and tamper testing. Interview with the maintenance supervisor at the time of the record review revealed he was running water to the main drain weekly but did not activate the fire alarm system. That would indicate water was not flowing past the system flow sensors. Further interview with the maintenance supervisor indicated the taper switches were also not being tested.</p> <p>2. Observation of the automatic sprinkler system test drain at 1:45 p.m. on 2/24/15 revealed the test drain opening was a two inch pipe which would not represent the flow of a single sprinkler. Interview with the maintenance supervisor at the time of the observation revealed he was unaware the smaller drain opening was required.</p> <p>The deficiency had the potential to affect 100% of the building occupants.</p>	K 062			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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S 000	Initial Comments Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/24/15 through 2/26/15. Riverview Healthcare Community was found not in compliance with the following requirements: S294, S301, S355, S466 and S475.	S 000	Addendums noted with an asterisk per 4/17/15 telephone to facility administrator. CS/SDDOH/ME	
S 294	44:04:07:04 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 29354 Surveyor: 35121	S 294	S294 Menus 1. No residents were specifically cited in the deficiency 2. All residents are potentially at risk. 3. The facility RD consultant will complete menu reviews annually and will be completed on or before April 17 th , 2015. 4. The administrator or designee will report any issues w/ the menu signatures to the facility QAPI monthly for review and recommendations.	4/17/15

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

STATE FORM

6899

QTKV11

TITLE: *Administrator*

RECEIVED

DATE: 3/16/15

MAR 18 12:00 PM

SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015
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S 294	<p>Continued From page 1</p> <p>Preceptor: 29354 Based on record review and interview, the provider failed to ensure the planned menus for regular and therapeutic (treatment of disease) diets for all residents on oral diets was reviewed and approved by the consultant registered dietitian (RD) at least annually. Findings include:</p> <p>1. Record review on 2/25/15 of the planned menu for regular and therapeutic diets revealed: *The menus had been last reviewed and approved on 1/25/14 by the consultant RD. *The menu review and approval had not been completed at least annually.</p> <p>Interview on 2/26/15 at 8:30 a.m. with the dietary manager revealed she agreed the menus for regular and therapeutic diets for all residents on oral diets had not been reviewed and approved at least annually.</p>	S 294		
S 301	<p>44:04:07:16 Required dietary in-service training</p> <p>The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by:</p>	S 301	<p>S301 Dietary In-servicing</p> <p>1. No specific residents were cited in the deficiency.</p> <p>2. All residents are potentially at risk</p> <p>3. All dietary associates will be in-serviced on the required state required dietary in-services on or before April 17th, 2015 by the facility Dietary Services Manager or designee. In-servicing will be completed upon hire and annually going forward.</p> <p>4. The DSM or designee will report any issues w/ required in-servicing to the facility QAPI committee for review and recommendations.</p>	<p>4/17/15</p> <p><i>kimberly c. [signature]</i></p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2015	
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HEALTHCARE COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 611 E 2ND AVE FLANDREAU, SD 57028		
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S 301	<p>Continued From page 2</p> <p>Surveyor: 35121 Preceptor: 29354</p> <p>Based on record review and interview, the provider failed to ensure all newly hired dietary staff had received a formal orientation program. Findings include:</p> <p>1. Record review revealed the last dietary in-service was held on 2/10/14.</p> <p>Interview on 2/26/15 at 8:30 a.m. with the certified dietary manager (CDM) revealed: *There had been no formal orientation training for newly hired dietary staff. *There had been no formal review of food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, or sanitization. *The CDM stated she had been giving a quick review of the kitchen and diets to newly hired staff.</p> <p>Review of the provider's May 2008 Inservice Education Policy states "the Administration, in cooperation with the Dietician, Certified Dietary Manager, and the Director of Nurses, will have monthly in-service training which is mandatory for all kitchen staff. Subjects will include, but not be limited to the following: sanitation in preparing food, sanitation in food handling, sanitary handling of dishes and glasses, sanitary personal habits, the art of serving food, the procedure for bussing dishes, cleaning the dining room tables, food costs, food waste and review of job descriptions, etc."</p> <p>The facility had no specific policy regarding newly</p>	S 301		

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S 301	Continued From page 3 hired dietary staff. Surveyor: 29354	S 301		
S 355	<p>44:04:12:05 PROVISION OF SOCIAL SERVICES</p> <p>A nursing facility must provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee must be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility must have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on interviews, the provider failed to ensure they had a contract with a licensed social worker to offer consultation for social services. Findings include:</p> <p>1. Interview on 2/24/15 at 11:45 a.m. with the administrator revealed: *Social services was provided by a social services designee. *They currently did not have a contract with a licensed social worker (LSW) to provide consultation in social services. *They were working on getting a contract with a LSW.</p>	S 355	<p>S355 SS Consultation</p> <ol style="list-style-type: none"> 1. No specific residents were cited in the deficiency 2. All residents are potentially at risk 3. The facility Administrator or designee will secure a contract for SS consultation for the SS designee on or before April 17th, 2015. Consultation will occur quarterly going forward. 4. The facility Administrator or designee will report any issues w/ the SS consultation to the facility QAPI committee monthly for review and recommendations. 	4/17/15

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S 355	Continued From page 4 Interview on 2/25/15 at 11:30 a.m. with the social services designee revealed she had not received any social services consultation since August 2014.	S 355		
S 466	<p>44:04:18:06 Nursing facility required to pay costs</p> <p>A nursing facility must pay all costs of nurse aide training and competency evaluation or reimburse the nurse aide for the cost incurred in completing the program if the facility employs the aide within twelve months following completion of the training program. Reimbursement maybe made during the first twelve months of employment by installments.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview and record review, the provider failed to cover all charges for one of four nursing assistant students (K) enrolled in their training program. Findings include:</p> <p>1. Interview on 2/25/14 at 4:20 p.m. with registered nurses I and J revealed they had not paid for the retesting of the one nursing assistant student (K) who had not passed the test on the first try.</p> <p>Interview on 2/26/15 at 9:35 a.m. with the human resource coordinator revealed the nursing assistant who needed to retake the test offered to pay for her own repeat testing and was allowed to</p>	S 466	<p>S466 Pay costs</p> <ol style="list-style-type: none"> 1. No specific residents were cited in this deficiency 2. All residents are potentially at risk. 3. The facility has revised its practices of current training program costs to follow state guidelines, on or before April 17th, 2015. The facility HR Coordinator and Administrator oversee the testing charges and will assure the practice is followed. 4. The facility Human Resources coordinator will report any concerns with testing costs to the facility QAPI committee for review and recommendations. <p>x MONTHLY ASSESSMENT</p>	4/17/15

South Dakota Department of Health

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S 466	Continued From page 5 do so. Policies concerning the nurse aide training program were requested. None were received before the end of the survey.	S 466		
S 475	44:04:18:13 Supervision of Students Students in a nurse aide training program may not perform any services unless they have been trained and found to be proficient by the instructor. Students in a training program may perform services only under the supervision of a licensed nurse. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview and record review, the provider failed to provide the required sixteen hours of direct supervision by a licensed nurse for four of four nursing assistant students (K, M, N, and O) in their training program. Findings include: 1. Interview on 2/25/14 at 4:20 p.m. with registered nurses I and J revealed they had provided five hours of direct supervision of each nursing assistant student providing cares to residents. Review of the untitled document which described the training each nursing assistant student received in their program revealed the students were under the direct supervision of a licensed nurse during the: *Four hours of training on the unit with a certified nursing assistant (CNA) instructor.	S 475	S475 Supervision of Students 1. No residents were cited in the deficiency. 2. All residents are potentially at risk 3. The facility utilized an RN instructor / clinician for the Nurse Aide Training Program. This program provides 1:1 student time w/ the instructor for a minimum of 16 hours. A student record of hours is kept for each student and it includes a spot for RN signature and date completed for each section. The DON or designee will monitor compliance with the NA training program on an ongoing basis. 4. The DON or designee will report any compliance issues to the facility QAPI committee monthly for review and recommendations. <i>*including nursing assistant students K, M, N and O, CS/SDDOH/MF</i>	4/17/15

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S 475	<p>Continued From page 6</p> <p>*One hour of training on feeding with a CNA instructor.</p> <p>Policies concerning the nurse aide training program were requested. None were received before the end of the survey.</p>	S 475		