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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435029 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/15/2015 |
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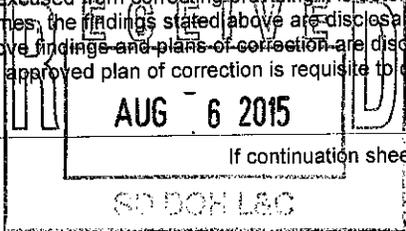
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| NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533 |
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| F 000 | INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/13/15 through 7/15/15. Avera Rosebud Country Care Center was found not in compliance with the following requirements: F323 and F325. | F 000 | <i>Addendums noted with an asterisk per 8/20/15 telephone to facility administrator. PE/SADPH/JJ</i> | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, interview, record review, and policy review, the provider failed to ensure side rails had been assessed for safety and entrapment (getting caught in) risk for three of three sampled residents (6, 8, and 9) reviewed. Findings include: 1. Observation on 7/15/15 at 8:00 a.m. of resident 9's bed revealed a quarter side rail up on the top half of his bed. Review of resident 9's medical record revealed the side rail/grab bar assessment had been completed on 6/17/15. The assessment had not included safety and entrapment risk of the side | F 323 | All residents, including 6, 8 and 9 were assessed for safety and entrapment for side rails. Resident policy was updated to include safety and entrapment as part of assessment of restraints. This policy will be discussed at the In-service meeting on August 4, 2015. Assessment for safety and entrapment will be completed at admission, readmission, quarterly, significant change, annual MDS and as needed [*] by DON or designee. Auditing for compliance will be completed by the Director of Nursing or designee weekly for one month, then monthly for eleven months. [*] these results will be reported at the next QA meeting on August 28, 2015 and then quarterly until the QA Committee advises to discontinue. PE/SADPH/JJ | 8-6-15 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Trish Jensen</i> | TITLE CFO | (X6) DATE 8-5-15 |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| F 323 | <p>Continued From page 1 rail/grab bar.</p> <p>Surveyor: 32332</p> <p>2. Observation on 7/15/15 at 10:00 a.m. of resident 6's bed revealed one side rail up on the top half of her bed.</p> <p>Review of resident 6's medical record revealed the side rail/grab bar assessment had been completed on 4/29/15. The assessment had not included safety and entrapment risk of the side rail.</p> <p>3. Observation on 7/15/15 at 10:05 a.m. of resident 8's bed revealed one side rail up on the top half of her bed.</p> <p>Review of resident 8's medical record revealed the side rail/grab bar assessment had been completed on 5/20/15. The assessment had not included safety and entrapment risk of the side rail.</p> <p>4. Interview on 7/15/15 at 10:10 a.m. with the director of nursing revealed: *The residents were assessed for appropriateness of and ability to use the side rails/grab bars prior to use and with each Minimum Data Set assessment and as needed. *There were approximately twenty-two beds with attached side rails. *Not all of those side rails were being utilized. *Those beds with side rails had open areas between the rails measuring no larger than nine inches and no smaller than five and three-quarter inches. *Residents with those side rails including residents 6, 8, and 9 had not been assessed for possible entrapment hazard.</p> | F 323 | | |

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| F 323 | Continued From page 2 | F 323 | | |
| F 325 SS=D | <p>Review of the provider's revised May 2014 Restraints policy had not included the need to monitor the residents for potential of entrapment by side rails or grab bars.</p> <p>483.25(j) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to monitor appropriately for fluid intake for one of one sampled resident (5) on a fluid restriction. Findings include:</p> <p>1. Review of resident 5's dietary notes revealed: *A 6/15/15 nutritional note by the consultant registered dietitian (RD) indicated: -A history of congestive heart failure (heart not working properly) and hyponatremia (low sodium). -She was to have received a heart healthy diet with 2500 milliliter (ml) fluid restriction daily.</p> | F 325 | <p>For resident 5 all intakes are recorded in Milliliters (ml)/cc. For all residents intakes will be recorded in ml/cc.</p> <p>Hydration policy was updated to include that intakes be reported in ml/cc. This policy will be discussed at the in-service meeting on August 4, 2015. Director of Nursing or designee will conduct an audit weekly for one month, then monthly thereafter. Director of Nursing will report any identified concerns to the administrator at the QA committee quarterly. These results will be reported at the next QA meeting on August 28, 2015 and then quarterly until the QA committee advises to discontinue.</p> <p><i>of individuals on fluid restrictions PELSONH / JJ</i></p> | 8-6-15 |

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| F 325 | <p>Continued From page 3</p> <ul style="list-style-type: none"> -Her fluid intake was "75-100% [percent] on 2500 fluid restriction." -Her weight had been 177 pounds. -There had been a gradual weight gain of approximately 4% in ninety days and 7% in 180 days. -The dietary department was to have given 540 ml at breakfast and 360 ml each at lunch and supper meals. -The nursing department was to have given 1240 ml of fluid throughout the day. *A 7/6/15 nutritional note from the certified dietary manager (CDM) indicated: -She continued on a 2500 ml fluid restriction with no changes how the fluids were distributed throughout the day. -Her fluid intakes were: "Breakfast-50-100%, Lunch-25-100%, Supper-25-100%." -Her weight had been 181 pounds. <p>Review of resident 5's 1/9/14 care plan revealed:</p> <ul style="list-style-type: none"> -She was to have a 2500 ml fluid restriction. -It had not indicated how the fluids were to have been given to her. <p>Review of resident 5's 7/10/15 physician's orders revealed:</p> <ul style="list-style-type: none"> -The nursing department was to have given her one bottle of Gatorade every twenty-four hours. -The orders had not indicated how many milliliters or ounces the bottle should have contained. -The resident was to have continued on a fluid restriction. <p>Review of resident 5's June 2015 and July 2015 intake and output (I & O) records revealed no documentation of her intake totals.</p> <p>Interview on 7/15/15 at 10:00 a.m. with the</p> | F 325 | | |
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| F 325 | <p>Continued From page 4</p> <p>director of nursing revealed:</p> <ul style="list-style-type: none"> *The dietary department recorded fluid intakes in percentages rather than milliliters. *The recorders had not been trained to record in milliliters. *The only time her fluids were measured in milliliters would have been during an acute illness. *Resident 5 had been doing well. *There had been discussion of discontinuing the fluid restriction, but the nursing department felt she would have taken fluids in excess if the fluid restriction had been removed. *She agreed there would have been no way of knowing the exact fluid intake for resident 5. *She agreed restricted fluids should have been documented in milliliters for accuracy. <p>Interview on 7/15/15 at 11:00 a.m. with the consultant RD regarding resident 5 revealed:</p> <ul style="list-style-type: none"> *She had been aware the dietary department had been documenting her fluid intake in estimated percentages rather than milliliters. *She agreed the fluid restriction should have been documented accurately in milliliters. <p>Interview on 7/15/15 at 2:15 p.m. with the CDM regarding resident 5 revealed:</p> <ul style="list-style-type: none"> *She had not known the fluid intake required more accurate documentation. *She agreed there would have been no way of knowing exactly what her intake had been. <p>Review of the provider's undated Fluid Restrictions for Long-term Care policy revealed:</p> <ul style="list-style-type: none"> *The nursing department was to have recorded the resident's intake of fluids during meals and medication passes using the facility input and output documentation. | F 325 | | | |

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| F 325 | Continued From page 5 Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, p. 1152, revealed: *"The nurse may delegate I&O recording to assistive personnel with competent skills in measurement and calculation with accuracy, not estimation, and timeliness." *Recording I&O is essential for obtaining an accurate database. This information helps maintain an ongoing evaluation of the client's hydration status to prevent severe imbalances." | F 325 | | | |

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| K 000 | INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 07/14/15. Avera Rosebud Country Care Center 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 07/14/15 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 K017, K021, K130, and K155 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | Addendums noted with an asterisk per 7/17/15 telephone to facility Chief financial officer. CH/soaH/JJ | |
| K 017 SS=C | NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 | K 017 | Doors in restorative therapy room were hung. *The environmental services manager will report the completion of door installations to the QA committee. CH/soaH/JJ | 8-6-15 |

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

TITLE

(X8) DATE

Trish Jensen

CFO

8-5-15

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 017 | Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to separate one randomly observed treatment area from the corridor (restorative therapy). Findings include: 1. Observation at 9:30 a.m. on 7/14/15 revealed the restorative therapy treatment room had two door frames without doors and were open to the corridor. Interview with the environmental services manager at the time of the observation confirmed that condition. She was unaware that latching doors were required to separate a treatment room from the corridor. She added a new therapy area was under remodeling/construction in the north wing that would relocate the existing restorative therapy. This would affect one of three resident sleeping wing smoke compartments. | K 017 | | |
| K 021 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: | K 021 | West egress stair enclosure was sanded and is shutting properly. Audit of the facility's door closures will be conducted by the plant operations supervisor monthly for four months and | 7-14-15 |

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| K 021 | Continued From page 2 a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain a protected path of egress from the west stair enclosure to the exterior of the building. The lower level 90 minute fire-rated door into the stair enclosure would not latch with the operation of the closer. Findings include: 1. Observation at 11:00 a.m. on 7/14/15 revealed the west egress stair enclosure led from the main floor to the ground level at the lower floor. The 90 minute fire-rated door from the lower level into the stair enclosure was standing ajar. Testing of the operation of the door at the time of the observation revealed the door would not latch with the operation of the closer. Interview with the environmental services manager at the time of the observation confirmed that condition. The deficiency affected one of numerous egress | K 021 | Continued From page 2 then quarterly. Results of the review will be reported to the Environmental Services Manager who will report any identified concerns to the administrator at the QA committee quarterly. These results will be reported at the next QA meeting on August 28, 2015 and then quarterly thereafter until the QA committee advises to discontinue. | <i>CH/Saom/JJ</i> |

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| K 021 | Continued From page 3 requirements for the west resident wing and the stair enclosure. | K 021 | | | |
| K 028 SS=C | NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and measurement, the provider failed to maintain clear door widths of at least 32 inches in two smoke barriers (central core area to the north wing and west wing). Findings include: 1. Observation and measurement at 10:30 a.m. on 07/14/15 revealed each leaf of the two sets of smoke barrier doors for the central core area to the north wing and the west wing were only 30 inches wide. Those door leafs did not provide the required clear opening width of 32 inches. This would affect two of three resident smoke compartments. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000. | K 028 | | F | |
| K 038 SS=C | NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily | K 038 | | F | |

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| K 038 | Continued From page 4 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to install a paved path of exit discharge to the public way at three exits (the middle of the west wing, the end of the west wing, and the exit out of the connecting link for the hospital). Findings include: 1. Review of the previous survey revealed: *The exit in the middle of the west wing basement had a landing that ended approximately 150 feet from the nearest public way. *The exit at the end of the west wing in the basement had a landing that ended approximately 200 feet from the nearest public way. Interview with the environmental services director at 1:15 p.m. on 07/14/15 confirmed that condition. She added they had been clearing a path from those exits to a public way when any snow fell. This would not affect any of the resident smoke compartments. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. | K 038 | | | |
| K 130 SS=D | NFPA 101 MISCELLANEOUS | K 130 | Pavement will be extended on the south wing from the discharge exit to | * 9/3/15 CH/SDAHL/JJ | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435029 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 07/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 130 | <p>Continued From page 5 OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>A. Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at one of four exits (Moonglow-the south wing). Findings include:</p> <p>1. Observation at 10:15 a.m. on 7/14/15 revealed the exit from the south wing (Moonglow) had a landing that ended approximately 35 feet from the nearest public way.</p> <p>Interview with the environmental services manager at the time of the observation confirmed that condition. She added they had been clearing a path from that exit to the public way when any snow fell.</p> <p>This would affect one of three resident sleeping wing smoke compartments.</p> <p>B. Based on observation and interview, the provider failed to provide exiting for one of three resident wing smoke compartments (the north wing) due to remodeling construction work. Findings include:</p> <p>1. Observation at 10:15 a.m. on 7/14/15 revealed the north wing was under remodeling construction. Cross-corridor doors had been installed between the remodeling construction area and the existing resident room compartment in the north wing creating a dead end approximately 60 feet long. There was not any</p> | K 130 | <p>Continued From page 5</p> <p>the nearest public way. A Time-Limited Waiver for Life Safety is being requested for this deficiency.</p> <p>No "EXIT" sign was posted on the therapy area separation doors. Procedure for proper exit in an emergency during construction was written and will be addressed at in-service training on 8-4-15. Environmental Services Manager will audit the signage monthly until construction is completed. Any concerns will be reported at the next QA meeting on August 28, 2015 and then quarterly thereafter until the QA committee advises to discontinue.</p> | <p>* [REDACTED] CH/S2004/BJ</p> |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533 | | |
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| K 130 | Continued From page 6 signage indicating NO EXIT at the therapy area separation doors. A procedure to properly exit the smoke compartment in an emergency during the construction was not available. Interview with the environmental services manager at the time of the observation confirmed that condition. She stated she thought the residents could exit through the remodeling construction area of the wing. | K 130 | | | |
| K 155 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider did not perform a fire watch for the therapy addition in the north resident wing during construction. Findings include: 1. Observation at 8:30 a.m. on 7/14/15 revealed the provider had begun remodeling construction for a new therapy area in the north resident wing. The smoke detection and fire sprinkler system were not in service for that area. The area was | K 155 | Fire watches will be conducted 24/7 until sprinkler and fire alarm systems are operable. Forms will be completed daily and reviewed weekly by the Environmental Services Manager or designee. Any identified concerns will be reported to the administrator at the QA committee meeting quarterly. These results will be reported at the next QA meeting on August 28, 2015 and then quarterly thereafter until systems are operable. <i>*The environmental Services manager will report to the administrator and will also report to the QA committee. CH/SOON/JJ</i> | 8-6-15 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER avera rosebud country care center | | | STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK STREET POST OFFICE BOX 408 GREGORY, SD 57533 | | |
| (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 155 | <p>Continued From page 7</p> <p>not separated from the existing construction with one-hour fire-rated construction. A fire watch was not being performed.</p> <p>Interview with the environmental services manager at the time of the observation revealed she was unaware a fire watch needed to be performed due to the remodeling construction in the north wing.</p> <p>The deficiency had the potential to affect egress for 100% of the residents of the north wing.</p> | K 155 | | | |

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South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10625 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/15/2015 |
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| NAME OF PROVIDER OR SUPPLIER AVERA ROSEBUD COUNTRY CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 300 PARK AVENUE POST OFFICE BOX 408 GREGORY, SD 57533 |
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|--------------------|--|---------------|---|--------------------|
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| S 000 | <p>Initial Comments</p> <p>Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/13/15 through 7/15/15. Avera Rosebud Country Care Center was found in compliance.</p> | S 000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Irish Lusser

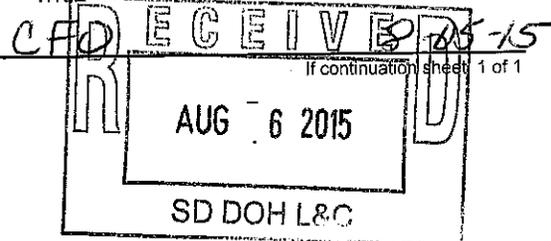
TITLE

(X6) DATE

STATE FORM

6899

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If continuation sheet 1 of 1