

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY POST OFFICE BOX 486 HUDSON, SD 57034
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 26180 An initial certification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/27/15 through 5/28/15. Hudson Care and Rehab Center was found not in compliance with the following requirement: F520. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 000	not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: Incorporate our Medical Director into our quarterly QAPI meetings. The Administrator, Director of Nursing, and Medical Director scheduled future QAPI meetings to coincide with scheduled monthly rounds. The Administrator will complete monthly audits for three months on the QAPI program to ensure that it meets all member requirements. Administrator will report findings from the monthly audits at the monthly QAPI meetings for review.	07/14/15
F 520 SS=C		F 520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sindsey Olson TITLE: Administrator (X6) DATE: 06/11/15

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.

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

PRINTED: 06/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY POST OFFICE BOX 486 HUDSON, SD 57034
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F 520	<p>Continued From page 1 by: Surveyor: 26180 Based on interview, the provider failed to ensure the physician participated in the quarterly Quality Assurance (QA) Committee Meetings. Findings include:</p> <p>1. Interview on 5/28/15 at 11:35 a.m. with the director of nurses revealed the QA committee: *Met monthly. *Involved all the departments at the facility. *Rotated involvement by other staff, so all the staff became aware of what the committee was doing. *They had a new medical director. *The previous medical director/physician had not attended the meetings. -They had reviewed the minutes with the physician from the meetings quarterly.</p> <p>Interview on 5/28/15 at 1:15 p.m. with the administrator confirmed the physician had not attended the QA committee meetings.</p>	F 520	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>Incorporate our Medical Director into our quarterly QAPI meetings. The Administrator, Director of Nursing, and Medical Director scheduled future QAPI meetings to coincide with scheduled monthly rounds.</p> <p>The Administrator will complete monthly audits for three months on the QAPI program to ensure that it meets all member requirements.</p> <p>Administrator will report findings from the monthly audits at the monthly QAPI meetings for review.</p>	07/14/15
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____	(X3) DATE SURVEY COMPLETED 05/26/2015
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY POST OFFICE BOX 486 HUDSON, SD 57034
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/26/15. Hudson Care and Rehab Center LLC was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Suzdney Olson* TITLE *Administrator* (X6) DATE *6/11/15*

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.

JUN 15 2015
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FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2015
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034
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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 5/27/15 through 5/28/15. Hudson Care and Rehab Center was found in compliance.	S 000		

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

Sundsey Olson

TITLE

Administrator

(X6) DATE

RECEIVED
JUN 15 2015
SD DOH L&C

If continuation sheet 1 of 1