

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2015
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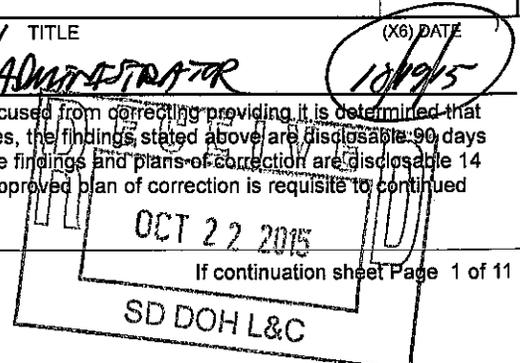
NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543
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F 000	INITIAL COMMENTS Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/28/15 through 9/30/15. Kadoka Nursing Home was found not in compliance with the following requirements: F274, F363, and F514.	F 000		
F 274 SS=E	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessments for three of six sampled residents (1, 4, and 5).	F 274	F274 The SCSA (Significant Change in Status Assessment) Policy was updated to correctly state the conditions to initiate a significant change. MDS Coordinator/nurse will assess & review records of 1, 4, & 5, & all resident current records for need for significant change according to policy. The DON will monitor the need for significant change monthly & document one or more findings on the monitoring tool & whether the significant change was done & report to QI quarterly. This will be monthly until 100% compliance is achieved. A mandatory in-service: Accurate RAI/MDS Processes will be conducted on Thursday, 10/22/15 at 10:00am MT.	10/28/15 <i>[Signature]</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO/ADMINISTRATOR	(X6) DATE 10/9/15
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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 274	<p>Continued From page 1 Findings include:</p> <p>1. Review of resident 1's medical record revealed MDS assessments had been completed on the following dates: *3/11/15 an admission assessment. *5/27/15 a quarterly assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following activities of daily living (ADL; assistance with bathing, dressing, eating, and grooming) areas were coded as follows:</p> <p>*Bed mobility (movement in bed): -On 3/11/15 she needed limited assistance (guided movement of the arms and legs) of one staff member. -On 5/27/15 she had been independent with no staff assistance needed.</p> <p>*Transfer (changing of position to standing, bed, or wheelchair): -On 3/11/15 she needed limited assistance of one staff member. -On 5/27/15 she had been independent with no staff assistance needed.</p> <p>*Walking in her room: -On 3/11/15 she needed limited assistance of one staff member. -On 5/27/15 she had been independent with no staff assistance needed.</p> <p>*Walking in the corridor: -On 3/11/15 she needed limited assistance of one staff member. -On 5/27/15 she been independent with no staff assistance needed.</p> <p>*Locomotion (moving about) in the resident's room on the unit: -On 3/11/15 she needed limited assistance of one staff member.</p>	F 274		

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F 274	<p>Continued From page 2</p> <p>-On 5/27/15 she had been independent with no staff assistance needed.</p> <p>*Locomotion within the corridor on the same floor as her room:</p> <p>-On 3/11/15 she needed limited assistance of one staff member.</p> <p>-On 5/27/15 she had been independent with no staff assistance needed.</p> <p>*Dressing:</p> <p>-On 3/11/15 she needed extensive assistance (weight-bearing support) by one staff member.</p> <p>-On 5/27/15 she had been independent with no staff assistance needed.</p> <p>*Personal hygiene (combing hair, shaving, brushing teeth, washing and drying her face and hands).</p> <p>-On 3/11/15 she needed limited assistance of one staff member.</p> <p>-On 5/27/15 she had been independent with no staff assistance needed.</p> <p>*Bathing:</p> <p>-On 3/11/15 she needed extensive assistance (weight-bearing support) by one staff member.</p> <p>-On 5/27/15 she needed limited assistance of one staff member.</p> <p>*Range of motion (movement of arms and legs):</p> <p>-On 3/11/15 she had impairment (damage) of the arms on one side of the body and no impairment of the legs.</p> <p>-On 5/27/15 she had no impairment of the arms and legs on either side of the body.</p> <p>2. Review of resident 4's record revealed MDS assessments were completed on the following dates:</p> <p>*5/6/15 had been a significant change assessment.</p> <p>*8/5/15 had been a quarterly assessment.</p>	F 274		

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F 274	<p>Continued From page 3</p> <p>Review of the above MDS assessments for the resident revealed the following ADL areas were coded as follows:</p> <p>*Bed mobility: -On 5/6/15 she had been independent with no staff assistance needed. -On 8/5/15 she needed limited assistance of one staff member.</p> <p>*Transfer: -On 5/6/15 she had been independent with no staff assistance needed. -On 8/5/15 she needed limited assistance by one staff member.</p> <p>*Walking in her room: -On 5/6/15 she had been independent with no staff assistance needed. -On 8/5/15 she needed limited assistance by of one staff member.</p> <p>*Walking in the corridor: -On 5/6/15 she had been independent with the assistance of one staff member. -On 8/5/15 she needed limited assistance of one staff member.</p> <p>*Locomotion on the unit: -On 5/6/15 she had been independent with no staff assistance needed. -On 8/5/15 she needed limited assistance of one staff member.</p> <p>*Locomotion off the unit: -On 5/6/15 she had been independent with the assistance of one staff member needed. -On 8/5/15 she needed limited assistance of one staff member.</p> <p>*Dressing: -On 5/6/15 she needed limited assistance of one staff member. -On 8/5/15 she needed extensive assistance (weight-bearing support) by one staff member.</p> <p>*Eating:</p>	F 274		

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F 274	<p>Continued From page 4</p> <p>-On 5/6/15 she had been independent with set-up staff assistance needed.</p> <p>-On 8/5/15 she had been independent with no staff assistance needed.</p> <p>*Personal hygiene:</p> <p>-On 5/6/15 she had been independent with the assistance of one staff member.</p> <p>-On 8/5/15 she needed supervision with the assistance of one staff member.</p> <p>*Range of motion:</p> <p>-On 5/6/15 impairment of the arms on one side of the body and on both sides for the legs.</p> <p>-On 8/5/15 impairment on both sides of the body for the arms and legs.</p> <p>Surveyor: 26632</p> <p>3. Review of resident 5's medical record revealed MDSs were completed on the following dates:</p> <p>*6/3/15 had been a quarterly assessment.</p> <p>*9/2/15 had been an annual assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following delirium (change in mental status), mood and behaviors, and ADL areas were coded as follows:</p> <p>*Delirium:</p> <p>-On 6/3/15 he had inattention in which the behavior fluctuated.</p> <p>-On 9/2/15 he had inattention and disorganized thinking in which the behavior fluctuated.</p> <p>*Dressing:</p> <p>-On 6/3/15 he needed extensive assistance (weight-bearing support) by one staff member.</p> <p>-On 9/2/15 he needed extensive assistance by two staff members.</p> <p>*Toilet use:</p> <p>-On 6/3/15 he needed extensive assistance by one staff member.</p>	F 274			

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F 274	<p>Continued From page 5</p> <p>-On 9/2/15 he needed extensive assistance by two staff members.</p> <p>*Personal hygiene (combing hair, shaving, brushing teeth, washing and drying face and hands).</p> <p>-On 6/3/15 he needed extensive assistance by one staff member.</p> <p>-On 9/2/15 he needed extensive assistance by two staff members.</p> <p>*Range of motion (movement of arms and legs):</p> <p>-On 6/3/15 he had impairment (damage) of the arms on one side of the body and impairment of the legs on one side of the body.</p> <p>-On 9/2/15 he had impairment of the arms on one side of the body and impairment of the legs on both sides of the body.</p> <p>*Weight:</p> <p>-On 6/3/15 his weight was 151 pounds.</p> <p>-On 9/2/15 his weight was 136 pounds.</p> <p>*Skin Conditions:</p> <p>-On 6/3/15 he had one stage one pressure ulcer listed.</p> <p>-On 9/2/15 he had one unstageable pressure ulcer listed.</p> <p>Surveyor: 32572</p> <p>4. Interview on 9/29/15 at 3:15 p.m. with the MDS nurse confirmed the above MDS assessments should have been coded as a significant change in condition. She used the current Resident Assessment Instrument (RAI) manual as a reference.</p> <p>Review of the provider's June 2014 Resident Assessment policy revealed "The purpose of the assessment is to describe the resident's capability to perform daily life functions and significant impairments in functional capacity."</p>	F 274			

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F 274	Continued From page 6 Review of the RAI manual, Version 3.0, October 2014, page 2-20, revealed the definition of a significant change in a resident's status as: *"A decline or improvement of a resident's status that : -Will not normally resolve itself without intervention by staff or by implementing standard disease related interventions, is not self-limiting. -Impacts more than one area of the resident's health status. -Requires interdisciplinary review and/or revisions of the care plan."	F 274			
F 363 SS=C	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Surveyor: 26632 Based on observation, record review, and interview, the provider failed to follow the written menu for all breakfast meals. Findings include: 1. Observation and interview on 9/29/15 at 8:30 a.m. with certified dietary manager revealed: *Oatmeal, toast, and one-half of a banana were served to the residents. They also received juice, coffee, water, and milk. *All residents were offered eggs when served.	F 363	F-363 A 6 week cycle menu has been written and approved by the Consultant Dietician. She has written extensions for all diets served at the facility. These menus will be followed and served as written by the dietary staff for all meals. The C.O.O. will monitor serving of breakfast 1 time a week for 6 weeks, then 1 time a month until compliance has been met. These findings will be reported to the Quarterly QI by the C.O.O.	11/5/15 	

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F 363	Continued From page 7 *Eggs were only offered Monday, Wednesday, and Fridays. *Hot cereal of different types was served daily. *Agreed the breakfast menu that had been written and approved by the registered dietician on 5/21/15 had not been followed that morning. Review of the 9/29/15 breakfast menu revealed six ounces of orange juice, one-half cup of cream of wheat, scrambled eggs, bran muffin, and fresh fruit were to have been served. 2. Interview on 9/29/15 at 10:30 a.m. with resident 12 revealed she had not been offered any eggs at the breakfast meal. Surveyor: 32572 Interview on 9/29/15 at 10:30 a.m. with a group of unidentified residents revealed eggs were offered at breakfast only on Monday, Wednesday, and Fridays. They were not offered eggs every time they were served breakfast.	F 363			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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.	F 514	F514 Charting & Documentation Policy was updated to ensure accurate documentation is complete, accurate, & accessible.	10/28/15 <i>(Signature)</i>	

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F 514	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to have complete and accurate documentation for one of ten sampled (5) residents regarding a possible eye infection, a reddened and blistered area on his back, and antibiotic use for a lower respiratory infection. Findings include: 1. Review of resident 5's interdisciplinary progress notes revealed: *An 8/29/15, 2:30 p.m. note "Res. [resident] has had greenish drainage from both eyes. Falls asleep, his eyes get stuck together, also has dry crusty drainage noted on eye lashes - warm packs before cleaning them." *An 8/30/15 at 1:00 a.m. note "At 0010 [12:10 a.m.] this writer [nurse writing note] et [and] CNA [certified nursing assistant] [CNAs name] repos. [repositioned] res., noted 28 cm [centimeter] L [long] x [by] 8 cm W [width] reddened area to (R) [right] back near spine with various size intact blisters lengthwise to (R) back near spine. Res. [resident] grimacing when repos. , Tylenol 650 mg [milligram] supp. [suppository] (R) [rectal] given at 0030 [12:30 a.m.] per [staff name]. Areas cleansed and left OTA [open to air]. Will update oncoming staff. Res. cont. [continues] with greenish drainage from both eyes, eyes cleansed after wm. [warm] packs applied." *An 8/30/15 at 5:00 a.m. noted "Res. resting comfortably @ [at] this time. Blisters remain intact, redness has decreased somewhat. Greenish drainage to eyes remain, eyes cleansed after wm. packs applied."	F 514	A mandatory in-service: Nurses Responsibility For Assessment & Documentation Process to Review & Revise Policies & Procedures About Ensuring Accurate & Timely Resident Assessment & Documentation, and Accurate RAI/MDS Processes will be conducted on Thursday, 10/22/15 at 10:00am MT. Initial wound assessment flowsheet has been implemented for ongoing documentation of treatment to ensure continued monitoring until resolved for resident 5 & for all residents. An Illness/Antibiotic flowsheet will be initiated by 10/28/15 to ensure complete documentation & follow through for resident 5 & for all residents. The DON/ADON will monitor all resident records weekly x 1 month then will monitor 4 random resident records on a monthly basis until 100% compliance is achieved & will report to QI meeting quarterly.		

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F 514	<p>Continued From page 9</p> <p>*An 8/30/15 9:30 a.m. note "Report was given from night nurse about rash/blisters to back along right side of spine. When aides were getting him up for the day I was called into his room to observe the rash/blisters. Also reported to me were that his eyes were matted and oozing a green pus. I felt this needed to be addressed so I called the on call PA [physician assistant]. He asked that I send him a picture of the rash. After his assessment and my report to him orders were received. I will give a detailed report to the next nurse on duty and continue to monitor/care for closely."</p> <p>*There was no further documentation regarding resident 5's eyes or the rash and blisters on his back.</p> <p>*A 9/18/15 1:00 p.m. note "Resident was seen et examined by [physician's name]. New order for Ceftin 500 mg BID [twice daily] X [times] 10 days, Robitussin ES - Decadron - give 10 mls [milliliter] TID [three times daily] et HS [bedtime]. Dx: [diagnosis] Lower resp. [respiratory] infection."</p> <p>*There was no further documentation regarding resident 5's lower respiratory infection.</p> <p>Review of the provider's undated Charting and Documentation policy revealed no procedure related to the ongoing documentation of a resident's change in condition.</p> <p>Interview on 9/30/15 at 9:30 a.m. with the director of nursing and the assistant director of nursing confirmed no follow-up for the medical issues listed above had been documented. They agreed further documentation should have included progression of the healing of his rash/blisters, his eye infection, and his lower respiratory infection.</p>	F 514			

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F 514	Continued From page 10 She agreed the documentation and charting policy needed to be updated to current standards.	F 514			

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/30/15. Kadoka Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review, observation, and interview, the provider failed to ensure the kitchen hood fire suppression system was tied into the buildings fire alarm signaling system for one of one kitchen hood. Findings include: 1. Document review at 9:30 a.m. on 9/30/15 revealed a commercial kitchen equipment inspection report dated 3/24/15. That report was prepared by Shaw Fire and Safety Inc. The report revealed no indication if the commercial kitchen hood fire suppression system was connected to the building fire alarm signaling system. Observation at 11:10 a.m. on 9/30/15 in the	K 069	K-069 Shaw Fire System will provide a supervisory sensor indicating that the fire suppression system is not tied to the building fire signaling system. This will be inspected and corrected by 11/15/15. The C.O.O. will monitor and instruct Shaw Fire Systems and report to the next quarterly Q.I. meeting	11/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/ADMINISTRATOR	(X6) DATE 10/9/15
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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.

OCT 22 2015
SD DOH L&C
If continuation sheet Page 1 of 2

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

PRINTED: 10/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/30/2015
NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543		
(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 069	Continued From page 1 dietary kitchen revealed a Protex 2000 fire suppression system was installed for the commercial kitchen hood. That system was not provided with a supervisory sensor indicating that fire suppression system was not tied to the buildings fire alarm signaling system. Interview with the maintenance supervisor and chief operating officer at the time of the above observation confirmed that condition.	K 069			

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/30/2015
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NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543
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S 000	Initial Comments Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/28/15 through 9/30/15. Kadoka Nursing Home was found not in compliance with the following requirements: S155 and S294.	S 000		
S 155	44:04:02:11 WATER SUPPLY AND TEMPERATURES The facility's water supply must be obtained from a public water system or, in its absence, from a supply approved by the Department of Environment and Natural Resources. Private water supplies must have a water sample bacteriologically tested at least monthly. The volume of water must be sufficient for the needs of the facility, including fire fighting requirements. The hot water system must be capable of supplying the work and resident areas with water at the required temperatures. Maximum hot water temperatures at plumbing fixtures used by residents may not exceed 125 degrees Fahrenheit (52 degrees centigrade). The minimum temperature of hot water for patient and resident use must be at least 100 degrees Fahrenheit (38 degrees centigrade). This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to maintain temperature logs for the resident hot water system. Findings include:	S 155	S-155 The water temperature in the resident's rooms and common areas will be maintained between 100-125 degrees. The maintenance supervisor will check 3 random rooms or areas weekly to maintain temperatures of 100-125 degrees. This will be recorded and actions taken to correct if not the right temperature range. This will be monitored monthly by the C.O.O. and reported to the quarterly Q.I. meeting.	10/28/15 <i>(Signature)</i>

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

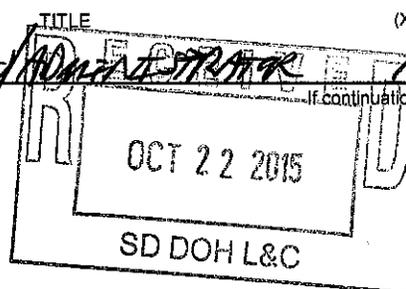
Scott Olson

TITLE

Chief Administrative Officer

(X6) DATE

10/28/15



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/30/2015
NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543		
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S 155	Continued From page 1 1. Record review at 9:30 a.m. on 9/30/15 revealed incomplete log sheets for recording temperatures for the resident hot water system. Water temperatures shall be checked to ensure hot water is maintained between 100 and 125 degrees Fahrenheit. Interview with the maintenance supervisor at the time of record review revealed he had stopped recording resident room water temperatures in March 2015. He believed recording water temperatures for all resident rooms was not necessary. He believed checking and recording just the kitchen hot water temperature was required. Further interview with the chief operating officer at the time of the exit interview at 12:00 noon on 9/30/15 revealed there must have been some miscommunication with the maintenance supervisor. She confirmed resident room water temperature checks should be conducted.	S 155		
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	S 294	S-294 A 6 week cycle menu has been written, approved and signed by the Consultant Registered Dietician. When substitutions are made on the menu, these substitutions will be recorded in a notebook and reviewed by the Consultant Registered Dietician on a monthly basis when she does her monthly visit to the facility. These changes will be discussed with the CDM and signed by the RD and CDM each month. This will be monitored by the C.O.O. monthly for 6 months or until in compliance and will be reported to the quarterly Q.I. meeting.	10/28/15 <i>[Signature]</i>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2015
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NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543
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S 294	<p>Continued From page 2</p> <p>as served must be filed and retained for 30 days.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and policy review, the provider failed to ensure the menu changes for all residents on oral diets were reviewed and approved from month-to-month by the registered dietitian (RD). Findings include:</p> <p>1. Interview on 9/29/15 at 10:30 a.m. with the certified dietary manager (CDM) revealed the following statements: *Changes were made on the menu if a certain food was not available or if a resident requested a substitute to what was being served. *She had no documentation of those changes for the RD to review and to approve on the menu. *She was not aware any menu changes were to have been documented, reviewed, and approved by the RD. *She had no process in place to document menu substitutions. *She could not find a policy in regards to menu substitutions.</p> <p>Continued interview on 9/30/15 at 9:30 a.m. with the CDM revealed: *She had found the substitution policy with the RDs assistance that morning. *The provider was not following their policy for menu substitutions, as the policy could not be found until 9/30/15.</p> <p>Interview on 9/30/15 at 10:30 a.m. with the RD revealed:</p>	S 294		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10637	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2015
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NAME OF PROVIDER OR SUPPLIER KADOKA NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 605 MAPLE ST W POST OFFICE BOX 310 KADOKA, SD 57543
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S 294	<p>Continued From page 3</p> <p>*The provider was not documenting changes to the menu for her to review and approve those changes to the menu.</p> <p>*She agreed there needed to have been a process in place to document menu substitutions for her review.</p> <p>*She agreed the menu had not been changed since she had first reviewed it on 6/17/05.</p> <p>Review of the provider's 7/22/04 Substitution policy revealed:</p> <p>*Substitutions of like nutritional value would be offered for those foods the resident did not like.</p> <p>*It was signed by the RD on 9/29/15.</p> <p>*The RD had not been in the facility until 9/30/15.</p> <p>*The RD had not made any revisions to the policy when she had signed it.</p> <p>*There was no procedure listed for:</p> <ul style="list-style-type: none"> -Menu changes to have been evaluated periodically by the RD or designee. -Records would have been reviewed periodically by the CDM and/or RD or designee to assess for any concerns that might have needed to have been addressed. 	S 294		