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

ORIGINAL

PRINTED: 10/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435090		09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE COUNTIES NURSING HOME	405 6TH AVENUE WEST LEMMON, SD 57638

(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 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 9/21/15 through 9/23/15. Five Counties Nursing Home was found not in compliance with the following requirements: F156, F166, F225, F248, F252, F256, F280, F441, and F514.	F 000	*Addendums noted with an asterisk per 11/5/15 per email with facility administrator. KW/SDDOH/EL	11/12/15
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.	F 156	2015: F156 1.The Medicare Denial letter for the denial process was updated to reflect the current standardized form instituted by CMS. Forms CMS 10123-NOMNC and CMS-10124-DENC were instituted on 9/24/15. All residents who have Medicare benefits are potentially affected. MDS Coordinator will monitor CMS website monthly for updates in Medicare Denial letters. MDS Coordinator will report to QAPI committee monthly for review and recommendations. Audits will be completed weekly X4 then monthly for two more months for all residents with Medicare benefits to assure they received the correct form. MDS Coordinator will report to QAPI committee monthly for review and recommendations. RK 11-3-15	11/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chad Abel
TITLE: Administrator
(X6) DATE: 10/16/15

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.

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156	2. Residents and/or appropriate families will be notified of increases in charges by letter as soon as an increase is determined. MDS Coordinator will submit a list of residents to Business Office manager weekly. BOM will determine charges and if appropriate will mail a letter to family or resident outlining increase in charges. All residents who are Private pay are potentially affected. BOM will audit weekly x4 then monthly. BOM will report to QAPI committee for review and recommendations. BOM will report to QAPI meeting monthly. RC 11-3-15	

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F 156	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to ensure: *Notification of the Medicare denial process was accurately presented with the CMS (Centers for Medicare and Medicaid Services) standardized forms for four of four residents' (1, 5, 13, and 14). *One of one sampled resident (8) with a change in fees had been notified. Findings include: 1. Review of residents 1, 5, 13, and 14's UR (utilization review)COMMITTEE DETERMINATION ON CONTINUED STAY form revealed: *That form had been used to notify the residents Medicare would no longer pay for their services. *That form had not been the standardized form provided by and required for use by CMS. Interview on 9/23/15 at 11:00 a.m. with the business office manager revealed: *The administrator had developed the letters they	F 156		

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F 156	Continued From page 3 currently used. *The administrator had signed all of the current UR COMMITTEE DETERMINATION ON CONTINUED STAY letters. *The Minimum Data Set (MDS) assessment coordinator provided her with a copy of the signed notices. *She was not aware of a CMS standardized notification form to be used for Medicare denial notices. 2. Review of resident 8's medical record revealed the resident had been to see her physician on 11/3/15. She had received stitches on her left cheek after a surgical excision. Those stitches were to have been dressed daily. Because of that dressing change the resident's charges from the provider had increased. Neither the resident nor her husband had been informed of the change in fees (increase) prior to receiving the bill that requested the higher fee for services. Interview on 9/23/15 at 2:55 p.m. with the MDS assessment coordinator revealed she had not notified the resident or her husband of the increase in her fees. She had not asked the business office manager to notify the resident or her family of the increase in fees. She stated she never notified any of the residents when their fees had changed.	F 156		
F 166 SS=C	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.	F 166		11/12/15

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F 166	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on document review, resident group interview, interview, and policy review, the provider failed to inform six of six active participants, who asked to remain anonymous, of any resolution to resident council grievances and/or individual resident concerns for the previous eight of twelve months (September, October, November, and December 2014 and January, May, August, and September 2015). Findings include: 1. Review of the following resident council meeting minutes revealed: *9/9/14; New Business: -Residents wanted to be notified when they have their bath days. -The fishing party was discussed and had been canceled. --No reason was given. -Motion carried to have ___ play the harp or accordion. -___ moved to have more activities on the week-end. Seconded. -___ moved to get a guinea pig for the residents to enjoy. Seconded. -___ said she would put up a "signup sheet" to play cards. -Beading should be a one-on-one activity. *10/14/14; Minutes from last meeting: -Rummage sale date was set for December 6th. -Old Business: --Playing cards sign-up sheet was still of interest. A sign-up sheet would be created and put up by the end of the month. --___ was discussed last month about coming in	F 166	Social Services or designee will use S.D. State form to record and investigate grievances voiced at Resident Council meetings. Concerns and/or grievances will be investigated by Social Services for appropriate resolutions and reported to next monthly meeting of the Resident Council as old business. All residents are potentially affected by this deficiency. Social Services or Designee will audit monthly Council meetings for appropriate reporting, investigations, and follow up with residents for satisfaction with results. Will report to QAPI committee monthly for review and recommendations. Minutes of Resident Council meeting will be signed off on by Administrator and taken to Qapi. Resident Council meets every month. Minutes of Resident Council meeting will be taken to monthly QAPI committee meetings by Social Services or designee for review.	RK 11-3-15 RK 11-3-15

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F 166	Continued From page 5 to play the harp. No mention of who would contact her. Supervisor offered to contact her. --Baths were discussed again, and it was mentioned the bath days had recently changed. Residents just needed to ask ___ in the nursing department when the baths would take place, and she could give them a day heads up. --Beads that ___ had when she worked here appear to be missing, and a resident was wondering were they were. New Business: -Activity department staff were spending money on activities out of their own pockets. ___ suggested that plans for the rummage Sale/Craft Fair to be held Saturday 12/6/14 should include giving the money earned from the sale back to the Activities Department for help with the purchase of Activity Department food and supplies for residents. --Nothing was noted about the guinea pig or activities on the week-end. *11/11/14; Old Business: -Residents asked about what was going on with the Spree residents had planned for 12/6/14. ___ mentioned she had talked to the administrator about the sale to be held. He stated the sale was not approved based on potential difficulties associated with the sale and exchange of resident's personal items. ___ added she had talked to the administrator personally, and he had stated the state would not approve the Spree because of the sale of personal items. ___ motioned the nursing home make a quilt and raffle it off and contribute those funds to activities for use for materials and snacks. It was determined that would be a scheduled activity. --Interview on 9/28/15 with the Department of Health nursing home advisor revealed she had not discussed a Spree or Fair with the	F 166		

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F 166	Continued From page 6 administrator. *12/9/14; Old Business: -Making a quilt was discussed again. The council decided if administration did not approve the quilt for sale after it was finished it would not be worth spending the time to make it. ___ would follow-up with the administrator about auctioning off the quilt and get back to the council. New Business: -___ made a motion to change the meals that were served on Sunday evening. Currently Sunday night meals were breakfast meals. That change had been voted in by residents some time ago, but now residents would like the supper to be the usual evening meals. -Resident would like to see a bigger monthly calendar as the current monthly calendars are very difficult to read. ___ said she would get back to the residents about his idea. It it was possible the new size calendar would be posted on the main board. *1/15/15; Old Business: -___ brought up the kitchen was still serving breakfast on Sunday evenings. -- Nothing was noted about the quilt or larger calendar. *5/26/15; Old Business: -"None." New Business: -___ asked if anyone would be interested in participating in a whist tournament. -___ mentioned it would be nice to have lamps over the residents mirrors so they could see themselves better. *8/5/15; Old Business: -"None." New Business: -___ suggested having a picnic on the lawn at the nursing home. Motion carried.	F 166		

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F 166	Continued From page 7 -___ asked residents if they would like to take a lake trip in the near future. Further discussion to take place. *9/2/15; Old Business: -Residents still do not have lights over their mirrors. Maintenance was asked if they could be installed several months ago. They said they would check to see and get back to the resident council. The resident group meeting on 9/22/15 at 10:30 a.m. with 18 residents (6 of whom were active and asked to be unidentified) revealed: *The residents on the west wing still had no lights over their sinks. They had brought the concern to council at least two times. *They still had breakfast for the Sunday night meal. *None of the department heads had attended the last few meetings. *They were unaware where the last Department of Health survey was posted. No one had read the latest survey to them. *The bath days had changed, and they had to find out what day their bath was from nursing. No one notified them of the change. *They were unaware who the ombudsman was and what they did. *The administrator had never been to a council meeting that they could remember. Review of the current in-use five week menus revealed all Sunday meals were breakfast items. Interview on 9/23/15 at 9:45 a.m. with the cook revealed: *Residents had requested breakfast for supper quite a few months ago. *Some of the residents now requested chef	F 166		

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F 166	Continued From page 8 salads and sandwiches for the supper meal. *The kitchen had not been told residents had requested to have a regular supper meal now instead of breakfast. Interview on that same day at 3:00 p.m. with the resident 9 president of the resident council revealed: *She thought the council had not been very active. No one voiced concerns or wants at the resident council as nothing gets done. Or, if they came up with a "good" idea, the administration would not approve of the idea. *Many of the concerns addressed had never been acted on or answered by the particular person in charge of the area or the department. *The activity supervisor may not be aware she was to respond to the residents' concerns. *She had asked to have the thermostat "looked at" in her room about a month ago as she thought it may not be working. No one had checked it as of yet. Surveyor: 29162 Interview on 9/23/15 at 1:30 p.m. with the activity director revealed: *She was the staff designee for the resident council and attened the resident council meetings. *She reported to the social service designee (SSD). Interview on 9/23/15 at 4:20 p.m. with the SSD revealed she: *Had not attended any recent resident council meetings. She had attended a few meetings a while ago but had been unsure when that was. *Was not aware of any concerns from the resident council. *Had told the activity director to "get back to the	F 166		

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F 166	Continued From page 9 department if there had been a concern" from resident council. *Had not kept a grievance file for concerns from residents or resident council. Surveyor: 20031 Review of the unsigned and undated resident council policy revealed: *3. Responsibilities of the group council may include: -c. Making recommendation for the improvement of the resident services provided by the facility. --f. Studying problem areas and making recommendation for their solution. *7. A Resident Council Response Form would be utilized to track issues and their resolution. The facility department related to any issues will be responsible to address the item(s) of concern. *8. Minutes included issues discussed and follow-up on prior issues. *9. The Administrator reviews the minutes and any responses from the departments within the facility. Responses were presented at the next meeting or sooner, if indicated.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		11/12/15

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F 225	Continued From page 10 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review, interview, and policy review, the provider failed to document and report extensive bruising and a skin tear, both of unknown origin (the cause unknown), for one of three sampled residents (9). Findings include: 1. Review of resident 9's medical record revealed: *She had been readmitted to the facility on 5/4/15 after a stay in the hospital.	F 225	F225 1.Nursing staff will assess and notify family and PCP when any injury of unknown origin is discovered to a resident. Also, this injury of unknown origin will be reported to state agencies and investigated according to event reporting protocol. Injuries of unknown origin include but are not limited to any bruise or skin tear that the source is not definitively known. 2.All residents residing within the facility are potentially at risk . 3.Education given to Nursing Staff beginning on October 7th with completion by October 31,2015 regarding the event reporting protocol. Education to be given by the DON. New and incoming staff will read and sign statement of event reporting protocol prior to 1st shift on the floor. 4.DON will audit nursing documentation weekly x 4, and then monthly to ensure that all documentated injuries of unknown origin are reported per event reporting protocol. 5. Don will bring results of the written audits to the facility QAPI committee monthly for review and recommendations. Resident #9's incident took place in the past therefore no corrective measures could be taken. Resident #9 will be included in audits if she has any more incidents. RJL 11-3-15	

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F 225	Continued From page 11 *The admission skin assessment completed upon her return by the director or nursing (DON) revealed: -"Resident skin assessment revealed: -Large dark purple and green bruise extending from the top right of inner thigh down to mid calf. -Bruise extends from medial [inner] aspect to mid posterior [outer] of right leg from top of thigh to mid calf. -Also mons pubis [groin] is dark purple/green bruised as well. -Left lateral antecubital (inside of elbow) and left hand has purple/pink bruise -Right forearm and hand has purple bruise. -Left lateral calf has quarter size purple bruise. -Right forearm skin tear 8 cm [centimeters: approximately three inches] wide." Interview on 9/23/15 at 3:45 p.m. with the DON revealed: *Resident 9 had returned from the hospital with the bruises and skin tear. *She had called the hospital to acquire how the resident had received the bruises and skin tear. She stated the hospital had noticed some small bruising but was not aware of the extent or how the resident got the bruises and skin tear. *She did not report the incident or fully investigate the incident. *She stated she had not thought of reporting or investigating the incident as it had not happened at the facility. *The bruising continued over the next few days until it covered her left foot. Interview with the social services designee at that same time revealed she was aware of resident 9's condition when she returned from the hospital. She was not aware the DON had not reported the	F 225		

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F 225	Continued From page 12 incident. 2. Continued review of resident 9's progress notes revealed: *9/6/15; 08:00 (8:00 a.m.): -"Resident noted to have a skin tear present on her left shin approx. [approximately] 2.3 cm in size [about one inch]. Area was cleaned with Normal Saline and 7 Steri strips [flexible topical sutures] applied to the skin tear." *It was monitored for the next two days. *9/13/15; 22:26 (10:26 p.m.): -"Wound on left calf was bleeding. The dressing was intact. Dressing was removed and wound was cleaned with sterile saline. 4 x 4 [bandage] was applied and wrapped with gauze. Verbalized pain and rated it as a 4 or 5 [on a scale of 1 to 10, with 10 the worst]. She states that 'it is one of those things that hurts all the time'. Will continue to monitor." *9/14/15; 08:36 (8:36 a.m.): -"Skin tear is present on the left calf continues to have 2 steri strips in place. -Per resident's request, Telfa [gauze] and Kling [sticky tape] was placed over wound bed for protection." Interview on 9/23/15 at 3:30 p.m. with licensed practical nurse (LPN) G revealed she had done the initial assessment and bandaged resident 9's wound on 9/6/15. She stated she had questioned the resident how she might have gotten the wound, and the resident was unsure. LPN G revealed she did not report the incident of unknown origin or investigate the incident. Interview on that same day with resident 9, whose score on a brief mental status was 15 (highest score) revealed:	F 225		

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	435090		09/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE COUNTIES NURSING HOME	405 6TH AVENUE WEST LEMMON, SD 57638

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F 225	Continued From page 13 *She could not remember how she got the bruises or cut while she was in the hospital last May. *She could not remember how she got the wound on her left shin this month. -She had told her daughter the leg of the wheelchair rubbed on her leg. -Her daughter had wrapped bubble wrap around the left metal leg of her wheelchair. *She stated the metal leg of the wheelchair rubbed on her leg before and after the wound. Interview on that same day at 4:15 p.m. with the DON revealed: *She had not completed a report for injury of unknown origin. *Charge nurses normally completed the reports with her help as needed. *She confirmed any type of unknown serious injury should have been investigated and reported. Review of the provider's undated and unsigned abuse policy revealed: *All reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management. *An investigation of all unexplained injuries (including bruises, abrasions, and injuries of unknown source) will be conducted by the DON, and/or other individual appointed by the administrator, to ensure that the safety of our resident has not been jeopardized. *Should a resident be observed with unexplained injuries (including bruises, abrasions, and injuries of unknown source), the Nurse supervisor on duty must complete an accident/incident form. *Documentation shall include information relevant to risk factors and conditions that could cause or	F 225		

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F 225	Continued From page 14 predispose someone to similar signs and symptoms.	F 225		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on interview, record review, job description review, and policy review, the provider failed to ensure: *An effective activities program had been maintained for all residents within the facility. *A one-to-one activities program had been initiated and maintained for residents who could benefit from the program . *Requested activities had been instituted to the best of their ability. *The activities met the residents' interests and needs. Findings include: 1. Review of the resident council minutes for the previous eight of twelve months (September, October, November, and December of 2014 and January, May, August, and September of 2015) revealed: -The fishing party was discussed and had been canceled. --No reason was given. -___ moved to have more activities on the	F 248	F248 This defiency has the potential to affect all residents. Monitor and set up a program for residents one on ones, who do not attend activities. Educate the staff by letting them know whenever a one on one is completed with any resident, it needs to be documented. All documents mentioned can be put in a section activity participation note under point click care. All one to ones need to be at least 15 minutes or longer. To monitor one to ones done, activity director or designee will use care tracker report. Staff and residents input will be a tool used to determine one to ones. Activity Director or designee will report findings to QUPI monthly for further review. Residents who do not attend group activities will be provided with a one to one program that meets their interests and needs. All residents will be reassessed for satisfaction with current activity programs offered by [redacted] → 11/12/15 KW/SDDON/EL Results will determine new/updated program of activities that will be offered to meet resident needs. Activity programs that are tailored to individual residents interests and needs will be provided on a schedule that each resident will determine meet their needs. Activities Director or designee will report information from satisfaction survey to monthly QAPI meeting for further review and recommendations. RK 11-3-15	11/12/15

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F 248	Continued From page 15 weekend. Seconded. -___ moved to get a guinea pig for the residents to enjoy. Seconded. -___ said she would put up a "signup sheet" to play cards. -Motion carried to have ___ play the harp or accordion. -___ moved to have activities on the week-end. Seconded. -___ moved to get a guinea pig for the residents to enjoy. Seconded. -___ said she would put up a "signup sheet" to play cards. -Beading should be a one-on-one activity. -Rummage sale date was set for December 6th. -Activity department staff were spending money on activities out of their own pockets. ___ suggested that plans for the rummage Sale/Craft Fair to be held Saturday 12/6/14 should include giving the money earned form the sale back to the Activities Department for help with the purchase of Activity Department food and supplies for residents. -Residents asked about what was going on with the Spree residents had planned for 12/6/14. ___ mentioned she had talked to the administrator about the sale to be held. He stated the sale was not approved based on potential difficulties associated with the sale and exchange of resident's personal items. ___ added she had talked to the administrator personally, and he had stated the state would not approve the Spree because of the sale of personal items. --Interview on 9/28/15 with the Department of Health nursing home advisor revealed she had not discussed a Spree or Fair with the administrator. ___ motioned the nursing home make a quilt and raffle it off and contribute those funds to activities	F 248	Activities Director will repeat satisfaction survey monthly X3, then quarterly until QAPI committee recommends discontinuation. Activities Director will report to QAPI committee monthly.	RK 11-3-15

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F 248	Continued From page 16 for use for materials and snacks. It was determined that would be a scheduled activity. -Making a quilt was discussed again. The council decided if administration did not approve the quilt for sale after it was finished it would not be worth spending the time to make it. ___ would follow-up with the administrator about auctioning off the quilt and get back to the council. -___ asked if anyone would be interested in participating in a whist tournament. -___ suggested having a picnic on the lawn at the nursing home. Motion carried. -___ asked residents if they would like to take a lake trip in the near future. Further discussion to take place. Resident group meeting on 9/22/15 at 10:30 a.m. with 18 residents (6 of who were active participants and asked to be unidentified) revealed: *They wanted more activities but there was no money. *There had been no activities outside the nursing home. *They had asked to go fishing and to the lake but were told it was too expensive. *They had asked if they could eat on the deck. *None of the department heads had attended the last few meetings. *There were no particular activities for men. *There were no one-on-one activities. *There were only two activities on the weekends and that included church on Sunday. Interview on that same day at 3:00 p.m. with resident 9 president of the resident council revealed: *They had dropped the the idea of the spree and quilt. It seemed if they had come up with a "good"	F 248		

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F 248	Continued From page 17 idea, the administration would not approve of the idea. *They had complained about the lack of activities on the week-ends. *They was no money for activities, and there were not enough staff. *The activity program and activities "seemed to be all about what money they do and don't have." Interview on 9/22/15 at 4:00 p.m. with the activity aide revealed: *They had no money to take the residents out on a drive or to an outside activity. *There were not enough activity staff to go with residents if they wanted to do an outside activity. So they did not go on outings. *She worked the afternoons until 7:00 p.m. to help with activities. *They took turns on the weekends to do activities. *They did not do any one-on-one activities for those who did not come to the activity room. But thought several of the residents would benefit from one-on-one activity. *They had tried to set-up card games. She would get frustrated as she always had to help initiate the games as they did not always know what to do. She thought they would play cards by themselves if they had the sign-up sheet. *She had been told there was no more money and no more staff for activities. *They had not contacted the high school to see if students would help with activities. *She stated she was burned out as no one would help the department. Review of the 5/27/15 activities meeting minutes revealed "Activities will be getting no one to replace person who leave here. ___ [administrator] has made it clear! ___ is gone	F 248		

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F 248	Continued From page 18 also because she is taking CNA [certified nurse assistant] training. She will be the only one that can come back and work in activities." Interview on 9/23/15 at 11:00 a.m. with the social services designee (SSD) revealed: *She had a letter from the Department of Health that stated she was a QAC (qualified activity coordinator). *She had been appointed by the administrator as the activities director in June 2014. *She had no signed documentation from the administrator to confirm the above. *She supervised the activities supervisor. *The activities department had monthly meetings to discuss employee schedules and the group activities. Review of the undated and unsigned delegation of authority policy revealed: *The administrator may delegate the authority of implementing our policies and procedures and of supervising department to responsible personnel. *Such delegation is made in writing, signed, and dated by both the designated employee and the administrator. Review of a 6/23/14 dated change of notice signed by the administrator for human resources revealed the following note for the SSD: "Added activities director position $3.00 per hour. Only until she is not longer the Activities Director." Surveyor: 29162 Interview on 9/22/15 at 9:45 a.m. with resident 5 revealed she spent a lot of time in her room and did not participate in group activities very much. She could not tolerate being up very long. She stated she would have enjoyed having some one-on-one activities in her room.	F 248		

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F 248	Continued From page 19 Interview on 9/23/15 at 1:30 p.m. with the activity supervisor revealed: *She had not attended the training to become a qualified activity coordinator (QAC). *She reported to the SSD as the SSD was a QAC. *During the July 2015 resident council meeting an outing to the lake had been discussed. *The residents had wanted to go to the lake for an outing this summer. *The administrator had approved the outing. *The SSD/QAC had said they should wait until next year. Interview on 9/23/15 at 4:20 p.m. with the SSD/QAC revealed: *She had decided it was too late in the summer for the outing to the lake that had been requested by the resident council. *She was aware the residents had talked about the outing in the July 2015 meeting with the activity director. *It would have taken at least two to three weeks to arrange that outing, because she had to obtain transportation, park access, fishing licenses, and notify the game warden. *She could not get the outing to the lake arranged until the summer of 2016. Surveyor: 20031 Interview on 9/23/14 at 4:30 p.m. with resident 15 revealed he attended very few activities. He stated most of them were for women. He stated no one from activities had ever come to his room or any other resident's room to talk, offer magazines or activity books, music, or ask them about themselves. He revealed he liked to do word search puzzles in his room, but might enjoy	F 248		

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F 248	Continued From page 20 other things if they were of interest to him. Review of the 11/12/14 signed activity supervisor job description revealed the activity supervisor reported to the administrator. Review of the undated and unsigned activity services policy revealed: *"Resident shall have the right to choose the types of activities and social events in which they wish to participate. *When special situation arise and extra money is required, the Activity/Director/Coordinator confers with the Administrator regarding funding options (e.g. fund raising event, etc.). *The Activity Director /Coordinator meets with the Dietary supervisor prior to the beginning of each month to discuss the Activity programs that will require food. -Food item may include birthday cakes, snacks, beverages, special event meals, outdoor barbecues, etc. *Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interests of each resident and include, as a minimum: -Weather permitting, at least one activity a monthly is held away from the facility. -Weather permitting, outdoor activities are held on a regular basis. -At least two group activities per day are offered on Saturday, Sunday, and holidays. *Other facility staff, volunteers, visitors, residents, and family members may also provide the activities. *Scheduled activities are posted on the resident bulletin board. And provided individually to resident who cannot access the bulletin board (e.g. visually impaired residents).	F 248		

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F 248	Continued From page 21 *Individualized and group activities are provided that appeal to men and women as well as those of various age groups. *The Activity director/Coordinator shall at least: -Monitor and evaluate the resident's responses to activities and revise the approaches as appropriate. -Develop, implement, supervise, and evaluate the activity programs. *Individual activities will be provided for those resident who situation or condition prevents participation in other types of activities, and for those resident who do not wish to attend group activities. Resident who are able to maintain an independent program will have supplies available to them. -It is recommended that resident on a full room visit program received, at a minimum, there room visits per week. *Residents who choose not to attend group activities will maintain an independent program."	F 248		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on interview, observation, and testing, the provider failed to maintain a desirable hot water temperature in 6 of 6 residents' rooms for 11 of 43 residents in the north hall. Findings include:	F 252	All rooms on the north wing will be tested for temperature daily for one week by the Maintenance Supervisor, then weekly for three weeks and monthly for 2 more months. It will be logged in the PMP book with results sent to Safety and QAPI committees. Maintenance supervisor will review or contractors will be contacted to review the boiler heating system to ensure that circulating pumps, zone valves, and thermostats or any other mechanical failure of the boiler heating system are in proper working order to ensure appropriate warming temperature for residents care needs. Maintenance supervisor will report water temps to QAPI committee monthly or until committee recommends discontinuation.	11/12/15 RL 11-3-15

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F 252	Continued From page 22 1. Resident group meeting on 9/22/15 at 10:30 a.m. revealed two of eleven residents (who asked to be unidentified) who resided in the old part of the north hall in two different rooms revealed: *The hot water took forever to even get warm in their bathrooms. *They had told maintenance and the nurses about the problem. *They did not like to wash their face and perform other personal hygiene with "luke warm" water. Observation and testing on 9/22/15 from 11:20 a.m. to 11:40 a.m. in the old part of the facility revealed: *Testing with a calibrated thermometer of the bathroom hot water temperatures revealed: -After running the hot water for five minutes the temperatures ranged from 85.3 degrees Fahrenheit (F) to 88.2 F. Interview with one of the above two residents revealed she would: *Turn on the hot water when she entered the bathroom. *Use the toilet and then wash her hands in the cool running water. *Continue to let the water run to brush her teeth. *Continue to let the water run to wash her face. *"Hated to use the water as it didn't feel good to wash her hands or face with the luke warm water." Interview on that same day at 11:45 a.m. with housekeeper F revealed his housekeeping closet had hot water. Testing of that hot water in the soiled linen room of the new part of the building revealed it would reach 118 F. in less than thirty seconds.	F 252		

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F 252	Continued From page 23 Interview on 9/23/15 at 10:30 a.m. with the maintenance supervisor revealed: *He was not aware the hot water temperature in the north hall was only warm to touch. *He stated the hot water for the north hall came from a holding tank and the outside gauge read 105 F. to 110 F. *He stated he had not checked the hot water temperatures in the bathrooms of the north hall. Interview on 9/23/15 at 4:20 p.m. with the SSD revealed she: *Was aware the hot water "was not hot" in the old part of the building on the north hall. *Had told maintenance at least twice in the last few months about the hot water. *Had thought it had been taken care of. But had not checked on the situation to see if had been resolved. *Had not kept a grievance file for concerns from residents or resident council. Review of the national plumbing code revealed tempered water (a mixture of hot and cold) ranged from 90 F to 105 F.	F 252	*The maintenance supervisor will audit residents as part of the process of determining what option is needed with the date 11/12/15. KW/SDDOH/EL	
F 256 SS=E	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on record review, interview, observation, and policy review, the provider failed to meet 32	F 256	The maintenance supervisor will research the lighting options to help resurrect the lighting concern by residents on west hall. Once a viable and cost effective option is decided upon, then this option will be initiated. The Maintenance Supervisor will audit all residents as part of the process of determining a viable and cost effective option for the lighting concern. Once the option is installed, the maintenance supervisor will audit resident's feedback once per week for one month then once per month for two more months to ensure adequate and comfortable lighting levels.	11/12/15 RK 11-3-15

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F 256	Continued From page 24 of 43 residents' needs in the west hall. An additional light was not installed over the mirrors in the bathrooms for residents' hygiene and grooming. Findings include: 1. Review of the resident council meeting minutes revealed: *5/26/15: Old Business: -"None." New Business: -___ mentioned it would be nice to have lamps over the residents' mirrors, so they could see themselves better. *9/2/15: Old Business: -Residents still do not have light over their mirrors. Maintenance was asked if they could be installed several months ago. They said they would check to see and get back to the resident council. The resident group meeting on 9/22/15 at 10:30 a.m. with eighteen residents (Six who were active participants and asked to be unidentified) revealed the residents on the west wing still had no lights over their sinks. They had brought the concern to council at least two times. Observation on that same day at 2:55 p.m. revealed there were ceiling lights in all the bathrooms on the west hall. But there were no lights directly over the mirror above the sinks in those bathrooms. Interview on that same day at 3:00 p.m. with resident 9 the president of the resident council revealed: *She thought the council had not been very active. No one voiced concerns or wants at the resident council as nothing got done.	F 256		

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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 256	Continued From page 25 *Many of the concerns addressed had never been acted on or answered by the particular person in charge of the area or the department. Interview on 9/23/15 at 1:30 p.m. with the activity director revealed: *She was the staff designee for the resident council and attended all the meetings. *She reported to the social service designee (SSD). Interview on 9/23/15 at 4:20 p.m. with the SSD revealed she: *Had not attended any recent resident council meetings. She had attended a few meetings a while ago but had been unsure when that was. *Was not aware of any concerns from the resident council. *Had told the activity director to "get back to the department if there had been a concern" from resident council. *Had not kept a grievance file for concerns from residents or resident council. Review of the undated, unsigned, homelike environment policy revealed: *"Residents are provided with a safe, clean, comfortable, and homelike environment. *These characteristics include: -Comfortable (minimum glare) yet adequate (suitable to the task) lighting. -Comfortable and adequate lighting is provided in all areas of the facility."	F 256		
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	F 280		11/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435090		09/23/2015

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F 280	Continued From page 26 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. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure care plans had been updated to reflect current residents' needs for one of ten sampled residents (3) and one of one random sampled resident (12). Findings include: 1. Review of resident 12's 7/2/15 care plan revealed: *A focus area "At risk for recurrent diarrhea r/t [related to] infection, c diff [clostridium difficile-infection of the bowel]. At risk for spreading it to other residents." *A goal of "Will have no episodes of diarrhea. Will not spread to other residents and have no signs of dehydration if she does."	F 280	2015: F 280 The Care Plan for residents 12 was updated to reflect that resident had no restrictions and as a result could use the whirlpool bath. Staff education was provided for the bath aide and communication to other caregivers as well. All residents are potentially affected. MDS Coordinator or designee will audit care plans to reflect current conditions and updated care requirements. Audits will be completed weekly X4 then monthly thereafter. MDS Coordinator will report to QAPI Committee for review and recommendations. 2. Resident ~~12~~ #3's care plan was updated to reflect current condition and mobility/activity guidelines by PT/OT for Restorative Therapy and Nursing Staff. All residents are potentially affected. MDS Coordinator or designee will audit Physician orders for Restorative therapy or updated mobility orders. Care plans will be updated at that time for any changes that are ordered. Audits will be completed weekly X4 then monthly thereafter. MDS Coordinator will report to monthly QAPI Committee for further review and recommendations.	RK 11-3-15

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F 280	Continued From page 27 *Interventions that included: "Use shower when bathing, do not use tub due to cleaning process. Unable to use appropriate cleaner in tub." Interview on 9/25/15 at 11:05 a.m. with resident 12 revealed she would like a whirlpool bath, but was unable to due to her bowel infection. Review of resident 12's medical record revealed she had a negative C-Diff test on 6/16/15. Interview on 9/25/15 at 11:30 a.m. with certified nursing assistant C revealed: *She was the bathing aide. *She had been told resident 12 could only have a shower due to her having C-Diff. Interview on 9/25/15 at 1:00 p.m. with the Minimum Data Set (MDS) assessment coordinator revealed: *She was aware resident 12 had not had C. Diff for approximately three months. *She had thought she had communicated that resident 12 could have a whirlpool bath if she wanted. *She agreed she had not removed the focus area, goal, and interventions from resident 12's care plan. Surveyor: 23059 2. Review of resident 3's 6/2/15 nurses notes revealed she had fallen and broken her clavicle (collarbone). She had received physical therapy after that time until 8/21/15. Review of an 8/28/15	F 280	Resident #3's care plan was updated to reflect current condition which includes Restorative Therapy goals and gait training. MDS Coordinator or designee will audit all care plans for accuracy and to reflect current medical, psychological, mental health and nursing care needs. Audits will be completed on all care plans weekly X4, monthly X3 months. MDS Coordinator or designee will report findings to QAPI committee for further review and recommendations.	RK 11-3-15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 28 physician's order revealed an order for restorative therapy five days per week for upper and lower extremity strengthening exercises. She also was have gait (walking) exercises with a front wheeled walker one time a day every Monday, Tuesday, Wednesday, Thursday, and Friday. Review of her revised 9/14/15 care plan revealed there was no focus area, goal, or interventions related to her fractured clavicle. There was no mention of the need for restorative therapy five days per week. Review of that same care plan revealed she had a focus area of limited physical mobility, and she used a wheelchair. There was no mention of the use of a front wheeled walker, and she needed to walk one time a day five days a week. 3. Interview on 9/23/15 at 2:30 p.m. with the MDS assessment coordinator revealed she was responsible for updating the care plans. She stated she had not been notified of the physician's order for restorative care and gait training for resident 3. She confirmed that information should have been added to the care plan. She stated she had forgotten to remove resident 12's intervention regarding only using the shower due to her past history of C-Diff. Review of the provider's revised November 2010 Care Planning - Interdisciplinary Team policy revealed: *The care plan should have included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs developed for each resident. *Assessments of residents were ongoing and care plans were to have been revised as information about the resident and the resident's	F 280		

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F 280	Continued From page 29 condition changed.	F 280		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	PPE will be audited for availability throughout the facility monthly X3 by Laundry/Housekeeping Supervisor or designee. Audits will include proper PPE being available to all staff for the job they are doing. L/Hsp Supervisor or designee will report to QAPI committee meetings monthly for review and recommendations until committee deems otherwise.	11/12/15 RL 11-3-15

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F 441	Continued From page 30 This REQUIREMENT is not met as evidenced by: Surveyor: 20031 Based on random observation, interview, and policy review, the provider failed to ensure protective or sanitary conditions were maintained and available for: *Proper personal protective equipment (PPE) for laundry staff. *A toilet riser in one of one resident room (44). *One of fifteen sampled resident's (9) wheelchair. *Two of three soiled linen canvas bags in the soiled linen holding room and one of one soiled linen bag in the main dining room. *One of one vinyl back cushion for the tub chair in one of one whirlpool room. *Five of six electric razors in the cupboard above the hand washing sink in the bathing room alcove. Findings include: 1. Random observations from 9/21/15 through 9/23/15 revealed: a. A thin cloth cover jacket was noticed on a hook in the laundry room. Interview with the laundry and housekeeping supervisor revealed that cloth jacket was used for sorting soiled laundry. She stated they would wash the jacket once a week. She stated when they sorted soiled linen they did not have: *A long non-absorbent apron to wear over their clothes. *Long rubber gloves that extended up their arms. *Protective eye wear. *Masks. *Interview at the time of the observation with the	F 441	F441 page 31 of 36 Proper PPE for laundry staff include masks, googles, face shields, and long gloves have been found. Ordered long apron on 10-07-2015. Will use PPE every time when doing laundry for infection control. Housekeeping/Laundry Supervisor will monitor that PPE are worn while sorting laundry, for one week. Then have the Administrator sign off. Then will be submitted to safety, infection control and QAPI for further review. 5.Tape to the toilet riser in room #44 has been removed. 7.Bubble wrap was removed to resident 9's wheel chair. Arms were replaced with padded Velcro wrap and the leg was replaced with Velcro sheep skin. 8.DON designee will conduct monthly audits on all equipment and wheelchairs in the facility. F441 page 32 of 36 Soiled linen canvas bags in sorting room, and dining room. Ordered sorting bins, and bags on 10-1-2015. Bins will arrive on 10-12-2015, and bags on 10-22-2015. Housekeeping/Laundry Supervisor will monitor that mew items are being used for one week, and brought to the Administrator to sign off on. Then will be submitted to safety, infection control, and QAPI for further review. Sorting bins and laundry bags will be monitored monthly X3 and results of audit reported to monthly QAPI committee by L/Hsp Supervisor or designee until committee deems otherwise. RJC 11-3-15	

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F 441	Continued From page 31 laundry aide revealed the staff on the floor did not wash out residents' clothing, bed linen, or bed pads that were heavily soiled. She stated they had to be very careful at times when they sorted the soiled linen, so it did not splash and spill. b. The arms on the toilet riser in resident room 44's bathroom had been wrapped with colored tape. Interview at the time of the above observation with the physical therapy (PT) aide confirmed that finding. She stated PT would use colored tape on residents' adaptive equipment, so the residents would know where to place their hands or feet. c. Resident 9's wheelchair had layers of bubble wrap wound around the left arm and left leg. The bubble wrap had been secured with layers of tape. That tape and bubble wrap were discolored and soiled. *Interview at the time of the above observation with resident 9 confirmed the bubble wrap on her wheelchair. She stated the bubble wrap on the left arm was there as the arm rests were too high and made her shoulders hurt. She stated they had found a lower arm rest or pad for the right arm. But they could not find another arm rest or pad for the left arm. The bubble wrap was in place on her left leg of her wheelchair as it rubbed her leg and made it sore. She revealed her daughter had placed the bubble wrap on the left arm and leg of her chair. d. Two in-use soiled linen canvas bags in the soiled linen holding room were torn, had holes the size of softballs and foot balls, and were thread bare. The soiled linen bag in the main dining room was very threadbare. You could see the colors and stripes of the soiled clothing protectors in that bag. *Interview at the time of the above observation with the housekeeping and laundry supervisor	F 441	F 441 Maintenance ordered a new back rest with Penner Supply to replace the old one on 10-8-15. Maintenance will install when it comes in and report on completion date to administrator to sign off on it. Will report outcome to safety and QAPI upon completion. F441 1. All residents residing within the facility have the potential to be affected. 2.Electric razors are to be cleaned every Sunday by the HS CNAs. 3. The DON designee will complete audits on electric razors weekly x 4, then monthly. A minimum of three residents will be reviewed per audit. 4.The DON will bring the results of the written audits to the facility QAPI committee monthly for review and recommendations. Monthly equipment audits will be completed by night shift CNA's. Repairs and/or replacement needs will be reported to DON and/or Maintenance Supervisor. DON or designee will report results of audits to QAPI committee monthly. RK 11-3-15	

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F 441	Continued From page 32 confirmed those findings. She stated she was aware of the condition of the bags but could not find any to fit the rolling metal carrier. Interview with the laundry aide also confirmed the above observations. She stated those bags had been in poor condition for years, and they just kept trying to patch them when they needed to be thrown away. e. The vinyl cushion on the back of the tub chair for the whirlpool was visibly cracked and pitted. The cracks and pitted areas exposed the padding beneath the vinyl. *Interview at the time of the above observation with the maintenance supervisor confirmed that condition. He stated he had replaced the seat of the chair about two weeks ago. He had noted the back rest needed to be replaced too but had not told the DON so she could order one. f. Five electric razors were stored in the cabinet above the hand washing sink in the bathing alcove. Opening those razors revealed small piles the size of marbles of whiskers and skin debris that fell out on the floor. Interview at the time of the above observation with certified nurse assistant (CNA) B confirmed those findings. She stated the night time CNAs were to clean and disinfect the razors every Sunday night. She confirmed it appeared the razors had not been cleaned for some time. g. Interview on 9/23/15 at 4:00 p.m. with the DON revealed: *She was not aware the laundry staff did not have appropriate PPE. *She was aware PT used tape to identify placement for hands and feet. She had not considered the tape was uncleanable on toilet risers in shared bathrooms. *She was aware:	F 441	e. Whirlpool tub chair back vinyl cushion will be replaced. All whirlpool tub chair cushions will be audited to ensure no cracking or pitting. Maintenance supervisor will audit whirlpool tub chair cushions once per month for three months to ensure no cracking or pitting. Maintenance supervisor will report audit findings at monthly QAPI for review and recommendations. Re-education on proper cleaning of electric razors was provided at October 13th CNA meeting by DON. Charge nurses were provided re-education on October 16th Nurses meeting by DON. DON or designee will monitor electric razor cleaning weekly X4, monthly X3. DON will report results of audit to monthly QAPI meetings for review and recommendations.	RK 11-3-15 RK 11-3-15

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F 441	Continued From page 33 -Resident 9's wheelchair had bubble wrap on the arm and on the leg. -Resident 9's daughter had placed the bubble wrap on the chair. -Therapy had been trying to locate another armrest or pad for the left arm. -The bubble wrap was not a cleanable surface. *Was not aware of the condition of the soiled laundry bags. *Was aware the tub chair seat cushion had been replaced. But was not aware the back cushion needed to be replaced. *Was not aware the CNAs had not been cleaning the electric razors. Review of the undated and unsigned infection control and environment policies revealed: *"Personal protective equipment appropriate to specific task requirements is available at all times. *Employees required to perform tasks that may involve exposure to blood/body fluids will be provided appropriate protective clothing and equipment. Such as: -Gowns/aprons/lab coats (disposable, cloth, and and/or plastic). -Gloves (sterile, non-sterile heavy-duty and/or puncture resistant). -Masks. -Eyewear (goggles and/or face shields). *Soiled laundry/bedding shall be handled in a manner that prevent gross microbial contamination of the air and person handling the linen. *Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment. *Environmental services and nursing staff will place and transport contaminated laundry that is	F 441		

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F 441	Continued From page 34 wet enough to potentially leak or soak through the bag or container in double bags, or leak-proof bags or containers."	F 441		
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. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to have accurate documentation for one of six sampled resident's (1) code status. Findings include: 1. Review of resident 1's medical record revealed: *No documentation of his code status on the outside of his record. *A DNR (Do Not Resuscitate, no life saving measures) identifier on the red divider inside his record. *The Request Concerning Life-Prolonging Procedures form had been checked yes for CPR	F 514	F514 1.All residents residing within the facility have the potential to be affected. 2.DNR identifier on red divider inside resident 1's record was removed. 3. In red clear pocket in the resident's record the newly signed form dated 10-9-15, indicating "Yes I want to be resuscitated" is present. 4.DON designee will audit charts monthly comparing : A.The red divider on each chart with B.The Physician's order in the e-chart C.With the signed code status sheet in the red plastic protector in the resident's physical chart to ensure consistency. 5.The DON will bring the results of the written audits to the facility QAPI committee monthly for review and recommendations. DON or designee will monitor 10 charts monthly.	11/12/15 RIC 11-3-15

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F 514	Continued From page 35 (cardiopulmonary resuscitation, attempting to save the persons life). That form had been signed on 11/3/14 by a staff nurse and the physician on 11/4/14. *The Five Counties Nursing Home Do Not Resuscitate Request/Order form box that stated "Yes I want to be resuscitated" had been checked, initialed, and signed by the resident. That form had also been signed by a staff nurse and the physician on 4/21/15. *The 9/18/15 signed physician orders stated, CODE II NO CPR OR VENT (ventilator- machine to breath for individual)." *The 4/21/15 signed physician orders stated CODE II NO CPR OR VENT. *The September 2015 medication administration record had not had any documentation in the Advanced Directive space. *The Care Conference Summary dated 7/9/15 stated the resident had a "DNR" (do not start CPR) status. Interview on 9/23/15 at 10:50 a.m. with the director of nurses revealed the resident's documented code status had been conflicting throughout his medical record.	F 514		

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

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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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 9/22/15. Five Counties Nursing Home (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 9/24/15 upon correction of the deficiencies 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 deficiencies identified at K022, K046, K052, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 10/17/15 per telephone with facility interim-administrator. LF/SDDOH/EL	*[redacted] LF/SDDOH/EL 11/12/15
K 022 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chad Abel
TITLE: Administrator
(X6) DATE: 10/16/15

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.

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OCT 16 2015
SD DOH L&C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435090		09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE COUNTIES NURSING HOME	405 6TH AVENUE WEST LEMMON, SD 57638

(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 022	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to provide exit signs with continuous illumination in one randomly observed exit sign that had lamps burned out (into north office foyer). Findings include: 1. Observation at 11:45 a.m. on 9/22/15 revealed an exit sign into the north office foyer. That exit sign was equipped with light bulbs to illuminate the exit sign. The bulbs providing the illumination were burnt out and did not provide the necessary illumination. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated that exit sign was on a preventative maintenance checklist and indicated it was working properly the last time it had been checked.	K 022	K 022 Bulb was changed same day 9-22-2015. Threshold has been met. Administrator will sign off on this. Maintenance has this already on it's PMP log.	
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: 32334 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches for one randomly observed smoke barrier located on the first floor of the original building (between the original building and the 1962 addition). Findings include:	K 028		F * [redacted] LF/SDDO H/EL

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LEMMON, SD 57638

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K 028	Continued From page 2	K 028		
	1. Observation at 10:30 a.m. on 9/22/15 revealed the cross-corridor doors between the original building and the 1962 addition were only 30 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report dated 7/29/14 revealed those doors were the original doors.			* [redacted] LF/SDDOH/KL
	The building meets the FSES. Please mark an "F" in the completion date column.			
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD	K 032		
	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2			F
	This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. The basement had only one means of egress. Findings include:			
	1. Observation at 9:45 a.m. on 9/22/15 revealed the basement was not provided with two means of egress. One exit stairwell was the only means of egress from the basement. Review of the previous survey dated 7/29/14 confirmed that finding.			
	The building meets the FSES. Please mark an			

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K 032	Continued From page 3 "F" in the completion date column.	K 032		
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain a minimum clear space of 22 inches between the swing of the door and the newel post in one of three stairwells (southwest stair enclosure). Findings include: 1. Observation at 9:50 a.m. on 9/22/15 and record review of the previous survey report dated 7/29/14 revealed the first floor door swung into the southwest stair enclosure. That door in the open position restricted the egress to 17 inches measuring from the latch side of the door leaf to the stair newel post. The building meets FSES. Please mark an "F" in the completion date column.	K 034		F
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to provide proper illumination of the means	K 046	K 046 Maintenance will replace, single outside lights with dual bulb lamps. *and ensure these lamps are tied to emergency power Maintenance will report completion date to safety, and QAPI. Administrator will sign off on this when completed. Maintenance will start a PMP on exterior lights daily for one week, one year for 3 weeks, then monthly for one year. With results given to safety and QAPI quarterly.	11/12/15 LF/SDDOH/EL

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K 046	Continued From page 4 of egress for the exit discharge at eight of eight exits from the facility (all marked exits from the building). Findings include: 1. Observation at 10:15 a.m. on 9/22/15 revealed exit discharge from the west wing. Exit discharge lighting on the exterior of that exit was provided by a single bulb lighting fixture. Additional fixtures were provided in the area to provide lighting in the event the single bulb fixtures were to fail. Interview with the maintenance supervisor at the time of the above observation confirmed that condition. Further interview revealed he was unsure if those lights were tied into the type II essential electrical system powered by the on-site backup generator. Exit discharge is classified as a means of egress and shall be provided with emergency lighting. He indicated he was unaware of that requirement and further indicated those lights were not on a preventative maintenance checklist to ensure lighting was maintained. That condition was also found at seven other exit discharge locations from the facility.	K 046		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K 052 Maintenance did find sheet (copy enclosed). Administrator will sign off since it was done on 10-21-14. I have called simplex to schedule next yearly inspection (due soon). Administrator will sign off on this and results will be submitted to safety, and QAPI.	11/12/15

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K 052	Continued From page 5	K 052		
	This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic fire alarm system was inspected annually. The last annual inspection report available was dated September 2012. Findings include: 1. Review of the provider's fire alarm system inspection reports revealed the last annual inspection report available for review was dated September 2012. Interview with the maintenance supervisor at the time of the review confirmed that finding. He indicated he believed Simplex Grinnell had completed annual inspections annually after that time but was unable to locate the inspection reports. He was unsure if an annual inspection had been completed in the last year. Review of the preventative maintenance checklist revealed there might have been a mix up with the annual fire sprinkler inspection required and the annual fire alarm inspection required. It appeared the sprinkler system inspection was contracted, but the fire alarm system had been missed.			
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		11/12/15

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K 144	Continued From page 6	K 144		
	This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observations, testing, and interview, the provider failed to maintain, inspect, and test the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (emergency lighting testing, generator battery testing, and annual load bank testing). Findings include:			
	1. Observation at 10:45 a.m. on 9/22/15 revealed an on-site backup generator for the type II essential electrical service. That diesel powered generator was provided with maintenance free batteries for running the ignition, annunciator panel, and other electrical systems on the generator. Those batteries were installed in the last year as indicated by the maintenance supervisor. Maintenance free batteries are not permitted as they do not allow the required weekly specific gravity testing. Interview with the maintenance supervisor revealed he was unaware of that requirement. He indicated he would have installed non-maintenance free batteries had he known about the requirement.		K 144-1 Batteries will be changed out to be able to test them (internally). Completed work will be signed off by administrator and will be reported to safety and QAPI as to completion.	
	2. Observation at the above time revealed a backup battery pack emergency light in the on-site generator shed. That light is required to be in place in the event the generator does not start or the transfer switch fails to transfer power. Testing of the light at the above time revealed one of the two bulbs in that fixture was not working.		K 144-2 Replaced bulb 9-24-2015. Maintenance has this on its PMP, sheets attached. Administrator will sign off on completed work and report will be given to safety and QAPI on completion of work.	

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K 144	Continued From page 7 Interview with the maintenance supervisor at the above time of the observation and testing confirmed that condition. He indicated that light was on the preventive maintenance checklist and was working properly the last time it had been checked. 3. Interview with the maintenance supervisor at the above time in regards to the annual load bank test revealed he was not aware of the requirement to conduct an annual load bank test. Deiseal generators that are not loaded to 30% of the nameplate power rating are required to be provided with a two hour load bank that ensures the generator is still operating as intended. He indicated he was unsure if the generator was loaded to 30% of the 125 kilowatt nameplate rating of that generator. He indicated he would have an electrician come by and determine the electrical load on the generator.	K 144	K 144-3 Stocks electric will find out, when 30% load is generated. Required voltage is generated. Maintenance will send results to safety, and QAPI. Administrator will sign off on work completed. Maintenance will log it in yearly PMP book and report findings to safety, and QAPI.	

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

ORIGINAL

PRINTED: 09/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	435090		09/22/2015

NAME OF PROVIDER OR SUPPLIER: FIVE COUNTIES NURSING HOME

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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 9/22/15. Five Counties Nursing Home (building 02) 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 deficiencies identified at K046, K052, K067, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 10/17/15 per telephone with facility interim-administrator. LF/SDDOH/EL	* [redacted] LF/SDDOH/EL
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to provide proper illumination of the means of egress for the exit discharge at eight of eight exits from the facility (all marked exits from the building). Findings include: 1. Observation at 10:15 a.m. on 9/22/15 revealed exit discharge from the west wing. Exit discharge lighting on the exterior of that exit was provided by a single bulb lighting fixture. Additional fixtures were provided in the area to provide lighting in the event the single bulb fixtures were to fail. Interview with the maintenance supervisor at the	K 046	K 046 Maintenance will replace, single outside lights with dual bulb lamps. * and ensure lamps are tied to emergency power. LF/SDDOH/EL Maintenance will report completion date to safety, and QAPI. Administrator will sign off on this when completed. Maintenance will start a PMP on exterior lights daily for one week, one year for 3 weeks, then monthly for one year. With results given to safety and QAPI quarterly.	11/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chad Abel — TITLE: Administrator — (X6) DATE: 10/16/15

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.

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K 046	Continued From page 1 time of the above observation confirmed that condition. Further interview revealed he was unsure if those lights were tied into the type II essential electrical system powered by the on-site backup generator. Exit discharge is classified as a means of egress and shall be provided with emergency lighting. He indicated he was unaware of that requirement and further indicated those lights were not on a preventative maintenance checklist to ensure lighting was maintained. That condition was also found at seven other exit discharge locations from the facility.	K 046		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on record review and interview, the provider failed to ensure the automatic fire alarm system was inspected annually. The last annual inspection report available was dated September 2012. Findings include:	K 052	K 052 Maintenance did find sheet (copy enclosed). Administrator will sign off since it was done on 10-21-14. I have called simplex to schedule next yearly inspection (due soon). Administrator will sign off on this and results will be submitted to safety, and QAPI.	11/12/15

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K 052	Continued From page 2 1. Review of the provider's fire alarm system inspection reports revealed the last annual inspection report available for review was dated September 2012. Interview with the maintenance supervisor at the time of the review confirmed that finding. He indicated he believed Simplex Grinnell had completed annual inspections annually after that time but was unable to locate the inspection reports. He was unsure if an annual inspection had been completed in the last year. Review of the preventative maintenance checklist revealed there might have been a mix up with the annual fire sprinkler inspection required and the annual fire alarm inspection required. It appeared the sprinkler system inspection was contracted, but the fire alarm system had been missed.	K 052		
K 067 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to install automatic shutdown of the west wing air handling system upon activation of the building fire alarm signaling system. Findings include: 1. Observation at 2:15 p.m. on 9/22/15 during a	K 067	K 067 Maintenance set an appointment with Stocks to check system. I will report findings to safety and QAPI. Completion time will be logged and signed off by administrator.	11/12/15

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K 067	Continued From page 3 fire drill revealed a central air handling system that did not shut down upon activation of the building fire alarm signaling system. That air handling system was installed with original construction in 2002. That air handler should have been provided with automatic shutdown upon activation of the fire alarm system. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He indicated he was not aware of the requirement for the fan to shut down.	K 067		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observations, testing, and interview, the provider failed to maintain, inspect, and test the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (emergency lighting testing, generator battery testing, and annual load bank testing). Findings include: 1. Observation at 10:45 a.m. on 9/22/15 revealed an on-site backup generator for the type II	K 144	K 144-1 Batteries will be changed out to be able to test them (internally). Completed work will be signed off by administrator and will be reported to safety and QAPI as to completion. K 144-2 Replaced bulb 9-24-2015. Maintenance has this on its PMP, sheets attached. Administrator will sign off on completed work and report will be given to safety and QAPI on completion of work. K 144-3 Stocks electric will find out, when 30% load is generated. Required voltage is generated. Maintenance will send results to safety, and QAPI. Administrator will sign off on work completed. Maintenance will log it in yearly PMP book and report findings to safety, and QAPI.	11/12/15

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K 144	Continued From page 4 essential electrical service. That diesel powered generator was provided with maintenance free batteries for running the ignition, annunciator panel, and other electrical systems on the generator. Those batteries were installed in the last year as indicated by the maintenance supervisor. Maintenance free batteries are not permitted as they do not allow the required weekly specific gravity testing. Interview with the maintenance supervisor revealed he was unaware of that requirement. He indicated he would have installed non-maintenance free batteries had he known about the requirement. 2. Observation at the above time revealed a backup battery pack emergency light in the on-site generator shed. That light is required to be in place in the event the generator does not start or the transfer switch fails to transfer power. Testing of the light at the above time revealed one of the two bulbs in that fixture was not working. Interview with the maintenance supervisor at the above time of the observation and testing confirmed that condition. He indicated that light was on the preventive maintenance checklist and was working properly the last time it had been checked. 3. Interview with the maintenance supervisor at the above time in regards to the annual load bank test revealed he was not aware of the requirement to conduct an annual load bank test. Deiseal generators that are not loaded to 30% of the nameplate power rating are required to be provided with a two hour load bank that ensures the generator is still operating as intended. He indicated he was unsure if the generator was loaded to 30% of the 125 kilowatt nameplate rating of that generator. He indicated he would	K 144		

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K 144	Continued From page 5 have an electrician come by and determine the electrical load on the generator.	K 144		

ORIGINAL

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FORM APPROVED

South Dakota Department of Health

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	10641		09/23/2015

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STREET ADDRESS, CITY, STATE, ZIP CODE: 405 6TH AVENUE W, LEMMON, SD 57638

(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) COMPLETE DATE
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 9/21/15 through 9/23/15. Five Counties Nursing Home was found not in compliance with the following requirements: S153 and S156.	S 000		11/12/15
S 153	44:04:02:10 PLUMBING Facility plumbing systems must be designed and installed in accordance with SDCL 36-25-15 and 36-25-15.1. Plumbing must be sized, installed, and maintained to carry required quantities of water to required locations throughout the facility. Plumbing may not constitute a source of contamination of food equipment or utensils or create an unsanitary condition or nuisance. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to install a vacuum breaker on the hand-held hose at one randomly observed location (beauty salon). Findings include: 1. Observation at 1:35 p.m. on 9/22/15 revealed a beauty salon on the second floor. A new hair wash station had recently been installed. That hair wash station was equipped with a hand held hose. That hand held hose was not equipped with a vacuum break. A vacuum break shall be provided on all plumbing hose extensions to ensure the potential for contamination of the potable water system is minimized.	S 153	S 153 Maintenance will install back flor valve in beauty shop. Head wash sink won't contaminate potable water. Administrator will sign off on work upon completion. Will submit to safety and QAPI upon completion. All other hand held hoses will be audited by the Maintenance Supervisor to ensure back flow valves are in place to prevent water contamination. Maintenance Supervisor will report audit findings to monthly Safety Meeting and QAPI committee when back flow installation is completed. The Maintenance supervisor will audit hand held hoses once per month for three months to ensure back flow valves are in place and functioning properly.	11/12/15 RK 11-3-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chad Abel — TITLE: Administrator — (X6) DATE: 10/16/15

STATE FORM 6899 U5UB11 If continuation sheet 1 of 2

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10641		09/23/2015

NAME OF PROVIDER OR SUPPLIER: FIVE COUNTIES NURSING HOME

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S 153	Continued From page 1 Interview with the maintenance supervisor at the time of the observation confirmed that condition. He indicated he had not noticed the sink hand held hose was not provided with a vacuum break.	S 153		
S 156	44:04:02:12 VENTILATION Electrically powered exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to maintain exhaust fan ventilation in one randomly observed location (janitor's closet near nurses station). Findings include: 1. Observation and testing at 11:30 a.m. on 9/22/15 revealed a janitor's closet across from the nurses station. A musty odor was apparent in that room. A tissue was used to test the exhaust ventilation. The exhaust ventilation was not able to pull the tissue against the exhaust grille in the ceiling indicating the exhaust ventilation was not working properly. Interview with the maintenance staff person at the time of the observation and testing confirmed that finding. He indicated a monthly maintenance was used to check exhaust fans.	S 156	S156 Maintenance will have Stocks Electric check exhaust fan for proper exhaust fan ventilation. When results are finished administrator will sign off. Finished results will be submitted to safety and QAPI for further review.	11/12/15