



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

PRINTED: 11/13/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</b>		
(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 170	Continued From page 1 Saturday by office staff. *The residents' mail was available for delivery on Saturday but was not delivered until Monday morning. *He had been aware mail was to have been delivered to the residents on Saturdays. *He stated "I would want my mail on Saturday too."	F 170			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and interview, the provider failed to ensure a clean and sanitary environment had been maintained for the following: *Caulking around the toilets in 9 of 22 resident bathrooms (rooms A8, A9, A15, A19, A21, B6, B9, B12, and B13). *One of twenty-two resident bathrooms (A21) had a board on the wall with a gouge in it making it an uncleanable surface. *One of twenty-two resident bathrooms (A8) had a strong odor of urine. *Heat registers in one of two hallways (B) had visible gray lint-like debris hanging out of the vents.	F 253	F253 Caulking was repaired in resident bathrooms A8, A9, A15, A19, A21, B6, B9, B12, & B13 on 11/5/15. The board in bathroom A21 was removed and wall repaired. All resident rooms were assessed for caulking and cleanable surfaces by the maintenance manager and DON.  Vent in b hall and the three air conditioners in the dining room were cleaned and lint removed on 11/4/15. All other vents, air conditioners, heat registers were assessed and cleaned as necessary.  Room A8 was cleaned and urine odor subsided. All other rooms were assessed for urine odor and cleaned as necessary.	11/24/15	

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F 253	Continued From page 2 *Three of three heater/air conditioners in the dining room had visible gray lint-like debris hanging out of the vents. Findings include:  1. Walking tour and interview on 11/4/15 at 7:15 a.m. with the maintenance supervisor (MS) confirmed the following: *The caulking around the toilets in the following resident's rooms needed to be repaired or replaced: -A8, A9, A15, A19, A21, B6, B9, B12, and B13. -He stated the caulking had not been on a preventative maintenance plan. *Resident's room A21 bathroom had a board on the wall with a gouge in it making it an uncleanable surface. *Resident's room A8 bathroom had caulking that had been stained, and the room had a strong urine odor.  Walking tour and interview on 11/4/15 at 7:30 a.m. with the housekeeping supervisor confirmed the following: *The heat register at the end of the B hallway had visible one-fourth to one-half inch gray lint-like debris hanging out of the vents. -The housekeepers for the hallway were responsible to maintain the cleanliness of those heat registers. *The three air conditioners in the dining room had one-fourth to one-half inch gray lint-like debris hanging out of the vents. *There was no preventative housekeeping plan for those heat registers or air conditioners.	F 253	Maintenance will add caulking to monthly maintenance checklist. The DON or designee will QA this process monthly for the first quarter and then quarterly thereafter. Findings will be reported to the QAPI committee quarterly by the DON or designee until the committee advises to discontinue.  Housekeeping will add vents, air conditioners and heat registers to weekly cleaning assignment list. Housekeeping and nursing staff will monitor facility wide for urine odor. The DON or designee will QA this process weekly for the first quarter and then quarterly thereafter. Findings will be reported to the QAPI committee by the DON or designee quarterly until the committee advises to discontinue.		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274			

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F 274	<p>Continued From page 3</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review and interview, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessments for two of six sampled residents (1 and 4). Findings include:</p> <p>1. Review of resident 1's medical record revealed MDS assessments had been completed on the following dates: *5/9/15, a quarterly assessment. *7/27/15, an annual assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following activities of daily living (ADLs; assistance with bathing, dressing, eating, and grooming) areas were coded as follows: *Bed mobility (movement in bed): -5/9/15 he needed limited assistance of one person.</p>	F 274	<p>274</p> <p>The MDS coordinator will submit significant correction assessments for resident 1 and 4 by November 25 to accurately reflect their significant change in status and update care plans accordingly. The MDS coordinator, along with nursing staff will receive education on this topic on 11/25/15 by the administrator, who is an RN with 15+ years of MDS experience.</p> <p>The administrator or designee will review the most recent MDS assessments for all resident by 12/24/15 to determine if any other significant changes were missed. The administrator or designee will QA 8 resident MDS assessments monthly for one quarter to further evaluate proper coding by the MDS coordinator. The administrator or designee will report findings to the QAPI committee quarterly until the QA committee advises to discontinue.</p>	12/24/15	

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F 274	<p>Continued From page 4</p> <p>-7/27/15 he needed extensive assistance of one person.</p> <p>*Locomotion (ability to get around in facility):</p> <p>-5/9/15 he needed extensive assistance of one person.</p> <p>-7/27/15 he needed total assistance of one person.</p> <p>*Dressing:</p> <p>-5/9/15 he needed extensive assistance of one person.</p> <p>-7/27/15 he needed total assistance of one person.</p> <p>*Bowel continence (ability to hold stool until toileted).</p> <p>-5/9/15 he was frequently incontinent (not able to hold stool).</p> <p>-7/27/15 he was always incontinent.</p> <p>Interview on 11/3/15 at 3:30 p.m. with the MDS coordinator confirmed a significant change in condition MDS should have been completed for resident 1 on 7/27/15 when his ADL assistance needs had changed.</p> <p>Surveyor: 26632</p> <p>2. Review of resident 4's medical record revealed MDS assessments had been completed on the following dates:</p> <p>*7/16/15, a quarterly assessment.</p> <p>*10/3/15, a quarterly assessment.</p> <p>Review of the above MDS assessments for the resident revealed the following areas were coded as follows:</p> <p>*Signs and symptoms of delirium (disorganized thinking or an altered level of consciousness [mental awareness]).</p> <p>-7/16/15: He had no indicators of delirium noted.</p> <p>-10/3/15: He had indicators of delirium including</p>	F 274		

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F 274	<p>Continued From page 5</p> <p>inattention, disorganized thinking, and altered level of consciousness noted. Those behaviors were constant.</p> <p>*He had no evidence of an acute change in mental status documented for the MDS assessment.</p> <p>*Mood assessment: -7/16/15: He had little interest or pleasure in doing things on more than half of the days and felt tired or had little energy on several days. That indicated a minimal risk of depression. -10/3/15: He had little interest or pleasure in doing things, had trouble falling or staying asleep or was sleeping too much, felt tired or had little energy, and had trouble concentrating on things nearly every day. He had a poor appetite nearly half of the days. He had a moderate risk of depression.</p> <p>*His ADL areas were coded as follows: *Bed mobility (movement in bed): -7/16/15: He needed no assistance. -10/3/15: He needed set-up assistance of one person. *Locomotion (ability to get around in facility): -7/16/15: He needed minimal assistance of one person. -10/3/15: He needed total assistance of one person one or two times. *Dressing: -7/16/15: He needed minimal assistance of one person. -10/3/15: He needed total assistance of one person. *Weight: 10/3/15: He had a significant weight loss of eight pounds in the last month.</p> <p>Interview on 11/3/15 at 12:45 p.m. with the MDS assessment coordinator confirmed a significant</p>	F 274		

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F 274	Continued From page 6 change in condition MDS should have been completed for resident 4 on 10/3/15 when his mental status and ADL assistance needs had changed. She stated the care plan team had discussed resident 4 but had decided to wait and see if he improved. She agreed he had not improved and a significant change MDS assessment should have been completed.	F 274		
F 280 SS=F	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Surveyor: 36413  Surveyor: 26632	F 280	F280 Resident 1,2,3,4,5,6, and 9 care plans were reviewed in entirety by the DON on 11/17/15 to ensure each residents care plans were individualized, comprehensive, up to date, with updated target goal dates, and reflecting their current needs.  All active resident's comprehensive care plans will be evaluated by the DON or designee to ensure care plans are individualized, comprehensive, up to date, with updated target goal dates, and reflecting their current needs.  The MDS coordinator and nursing staff will receive education on this area by the DON, information to include the MDS coordinator will be responsible for coordinating and monitoring the implementation of the care plan, to include target dates.	12/24/15

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F 280	Continued From page 7  Surveyor: 32572  Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure care plans had been reviewed and revised to reflect the individual needs for seven of nine sampled residents (1, 2, 3, 4, 5, 6, and 9). Findings include:  1. Review of resident 1's care plan revealed: *He had been admitted on 5/14/10. *Focus areas had initiation dates from 2013, 2014, and 2015. *All of the goal target (complete by) dates had been 6/9/15. *That target date had lapsed and had not been updated.  2. Review of resident 2's care plan revealed: *He had been admitted on 12/23/12. *Focus areas had initiation dates from 2013 and 2014. *All of the goal target dates had been 5/26/15. *That target date had lapsed and had not been updated.  Surveyor 36413 3. Review of resident 3's care plan revealed: *She had been admitted on 7/7/06. *Focus areas had initiation date from 2013. *All of the goal target dates had been 3/10/15. *The target dates had lapsed or run out.  Surveyor: 26632 4. Review of resident 4's care plan revealed: *He had been admitted on 4/29/15. *Focus areas with initiation dates of 5/6/15 or	F 280	The DON or designee will review this process at weekly interdisciplinary care plan meetings for the first quarter, to ensure that all care plans are individualized, comprehensive, up to date, with updated target goal dates, and reflecting their current needs. After the first quarter this process will be completed monthly. The Don or designee will report to the QAPI committee at quarterly meetings until the committee advises to discontinue.		

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F 280	<p>Continued From page 8 5/12/15. *All the goal dates had been 8/4/15 that had lapsed.</p> <p>Surveyor: 32572 5. Review of resident 5's care plan revealed: *He had been admitted on 1/7/14. *Focus areas with various initiation dates 2015. *All of the goal dates had been 4/21/15 that had lapsed.</p> <p>Surveyor: 36413 6. Review of resident 6's care plan revealed: *She had been admitted 10/1/11. *Focused areas had initiation dates from 2013. *All of the goal target (complete by) dates had been 1/6/15. *The target dates had lapsed or run out.</p> <p>Surveyor:32572 7. Review of resident 9's care plan revealed: *He had been admitted on 1/9/13. *Focus areas with various initiation dates in 2013. *All of the goal dates had been 6/30/15 that had lapsed.</p> <p>Interview on 11/4/15 at 7:50 a.m. with the assistant director of nursing confirmed care plans were to: *Reflect the current status of the residents. *Have been updated as the resident's conditions changed. *Goal dates had passed, and the care plans were not current for the above residents.</p> <p>Interview on 11/4/15 at 8:20 a.m. with the Minimum Data Set assessment nurse confirmed: *She was responsible for updating the care plans into the computer quarterly.</p>	F 280		

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F 280	Continued From page 9 *She expected the nurses to keep the care plans current and to have been changed as needed. *The goal dates for the above residents had passed. *She agreed the above residents care plans were not current.  Review of the provider's revised 3/2015 Care Plan policy revealed: *"Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." *"A staff person will be designated to be the Care Plan Coordinator and will be responsible for coordinating and monitoring the implementation of the care plan." *"A qualified team of persons will review care plans at least quarterly [capitalized]."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, record review, and manufacturer's instructions review, the provider failed to ensure services met professional standards of quality according to accepted standards of clinical practice for: *One of one sampled resident (3) with a fall without follow-up to a physician's response. *One of one unlicensed assistive personnel (UAP) (A) during the administration of an inhaled	F 281	F 281 All RNs and LPNs including LPN E, D, & B, will receive education on 11/25/15 by the DON regarding the correct procedures for follow up with providers after a resident sustains an injury. Providers will be called on all resident injuries and policy will be updated by the DON to reflect this.  The DON or designee will QA this process weekly for the first quarter and then monthly thereafter. All residents with falls or injuries will be assessed by the DON or designee to assure there	12/24/15

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F 281	<p>Continued From page 10 medication to one of one observed resident (11). Findings include:</p> <p>1. Random observations on 11/2/15, 11/3/15 and 11/4/15 of resident 3 revealed the left side of her face had a laceration above her eyebrow with steri-strips (special tape to hold a cut together). She had bruising on her forehead and her left cheek.</p> <p>Review of resident 3's medical record revealed: *On 10/22/15 at 7:20 p.m. resident 3 fell when trying to get a cup off the floor. She hit her forehead on the left side above her eyebrow. Licensed practical nurse (LPN) E cleansed the cut and steri-strips were applied. *On 10/23/15 a fax was sent by LPN E to the certified nurse practitioner (CNP) reporting resident 3 had fallen out of her wheelchair while seated near the nurses desk. She had been trying to get her cup off the floor. *On 10/26/15 at 12:30 p.m. LPN B talked to the provider about swelling to resident 3's nose and face. A CT scan (series of X-ray images taken from different angles and uses a computer process to create more detail than a plain X-ray) was ordered and done later that afternoon. A report from that CT scan indicated there was "No bony fracture. Scalp hematoma (localized collection of blood within an injured tissue area)." *On 10/28/15 at 12:55p.m. LPN B recorded she had been notified resident 3 was requiring help with eating and had stopped feeding herself. *On 10/28/15 at 1:13p.m. LPN D received an order from CNP to make an appointment about post fall follow-up for resident 3. *On 10/29/15 at 12:55p.m. resident 3 was taken to scheduled appointment with the CNP. She returned with orders for the use of alternation ice</p>	F 281	<p>was proper provider notification and follow up. Findings will be reported to the QAPI committee by the DON or designee at quarterly meetings until the committee advises to discontinue.</p> <p>All RNs, LPNs, and UAP's will receive education on proper administration of inhaled medications, including UAP A. Each Nurse and UAP will complete a competency on proper administration of inhaled medications directed by the DON.</p> <p>The DON or designee will observe 3 medication passes weekly for the first quarter, then monthly to monitor for compliance and accuracy of medication administration. The DON or designee will report findings to the QAPI committee at quarterly meetings until the committee advises to discontinue.</p>	

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F 281	<p>Continued From page 11</p> <p>and heat and scheduled Tylenol three times daily for one week.</p> <p>*On 10/29/15 a written response from the CNP about the 10/23/15 fax was also received and indicated, "I was never called about this patient [resident] injury. I was in the ER [emergency room] on call Thursday through Monday am at [another facility name]. I was finally notified on Monday of the following week. I can be reached at any time by cell phone. Also patient should have been CT'd [had a CT scan completed]after fall and examined by a provider if any thought of fracture."</p> <p>Interview on 11/4/15 at 11:30 a.m. with the assistant director of nursing confirmed there had been a lack of nursing follow up after the resident's fall.</p> <p>Review of the provider's 4/2010 Accident and Incident Reporting policy revealed no directions for physican notification or follow up.</p> <p>Surveyor: 26632</p> <p>2. Observation on 11/3/15 at 8:07 a.m. of resident 11 in the dining room eating breakfast revealed:</p> <p>*UAP A brought his Symbicort inhaler (medication for asthma) to his table.</p> <p>*He had just taken a bite of food and stated his mouth was full.</p> <p>*He took the pills she had brought, and then she said "Here's your inhaler."</p> <p>*UAP A had not waited until he had swallowed all of his food.</p> <p>*She held the inhaler up to his mouth and activated it two times in a row.</p> <p>*Aerosolized medication could be seen in the air above his mouth.</p> <p>*She had not:</p>	F 281		

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F 281	Continued From page 12 -Asked him to take a deep breath -Waited at least one minute between the activations. -Asked him to rinse his mouth out after using the inhaler.  Interview on 11/3/15 at 1:00 p.m. with the director of nursing and the administrator confirmed UAP A had not administered the inhaler correctly to resident 11.  Review of the manufacturer's guidelines for the use of Symbicort revealed: *The resident should breathe in deeply and hold the medication for ten seconds or more. *The second dose could then have been administered. *The resident should have been instructed to rinse their mouth with water after the two puffs.  Review of a UAP inservice by the administrator/RN revealed "Inhalers: our job to instruct in proper use." and "If steroid neb [nebulizer] or inhaler is used must offer to have resident rinse their mouth afterwards."	F 281			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced	F 309	F309 All residents will be evaluated for weight loss or gain, including resident 3 and 9. All residents with a 5% change in weight will be assessed by the DON to determine if RD has evaluated them and if recommendations are being followed by dietary department and nursing staff. If not evaluated by the RD, the DON will notify the DM, who	12/24/15	

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F 309	<p>Continued From page 13</p> <p>by: Surveyor: 26632</p> <p>Surveyor: 36413</p> <p>Surveyor: 32572</p> <p>Based on observation, interview, policy review, and record review, the provider failed to ensure residents were provided the necessary care and services for the following:</p> <p>*One of nine sampled residents (9) who had frequent falls.</p> <p>*One of nine sampled residents (3) with weight loss.</p> <p>*Identify and implement preventive measures for one of nine sampled residents (4) at high risk for pressure ulcers.</p> <p>*Following of physician's orders for one of nine sampled residents (4) for the prevention of pressure ulcers.</p> <p>Findings include:</p> <p>Surveyor: 36413 Surveyor: 26632</p> <p>1. Observation on 11/3/15 of resident 3 revealed she had slept until 11:30 a.m. and had missed breakfast.</p> <p>Interview on 11/3/15 at 10:30 a.m. with CNA F revealed: *"Snack cart went by her room as I was getting her dressed." *"Charting on morning intake should not say refused because she never refuses."</p> <p>Review of resident 3's intake records revealed: *The October 2015 records showed twenty-five of twenty-nine charted breakfasts were sleeping or refused.</p>	F 309	<p>will notify RD to evaluate resident. Also will ensure providers have been made aware of weight changes in all residents. If not, provider will be notified by the DON and any orders received will be implemented by the DON or designee. Resident 3 will be woken up in the morning and given the opportunity to attend breakfast or continue to sleep. Resident 3's orders will be updated to reflect snacks up to 6 times a day. All resident's current meal and snack consumption orders will be reviewed by the DM to ensure accuracy and appropriate follow thru.</p> <p>The Dietary Manager will QA resident weights weekly to evaluate for 5% change in weight. The DM will also review meal intake charting and snack consumption charting for accuracy and appropriateness. Residents identified with weight changes will be reviewed for appropriate follow through with diet and snack consumptions. These processes will be QA'd weekly for the first quarter and then monthly thereafter by the DM. The DM will communicate weight changes and meal/snack consumption to the DON and RD. The DON or designee will be responsible for notifying the</p>		

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F 309	<p>Continued From page 14</p> <p>*On 11/1/15 she had eaten 100% of her breakfast, 100% of her lunch, and 25% of her supper.</p> <p>*On 11/2/15 she had eaten 25% of her breakfast, 0% of her lunch, and 100% of her supper.</p> <p>*On 11/3/2015 she refused breakfast, had eaten 25% of her lunch, and 50% of her supper.</p> <p>*She had not received a morning snack on 11/3/15.</p> <p>Review of resident 3's monthly weights revealed: *1/15/15: 110 pounds (lb). *3/5/15: 105.5 lb. *4/27/15: 100 lb. *6/15/15: 96.5 lb. *7/16/15: 93 lb. *8/27/15: 86 lb. *9/10/15: 82.5 lb. *10/5/15: 78 lb.</p> <p>There were no weights recorded for February or May 2015.</p> <p>Review of resident 3's 10/8/15 physician's orders revealed "Please encourage high fat/carb [carbohydrate] foods, small frequent meals and snacks 6x [times] per day. Continue to monitor weight."</p> <p>Surveyor: 26632 2a. Observation of resident 4 revealed: *On 11/2/15 from 1:00 p.m. through 5:10 p.m. he had been sitting in his recliner in his room with a gel cushion (help relieve pressure to skin) in it. He was brought to the dining room and seated in a regular chair for the evening meal. His gel cushion was still on his recliner. *On 11/3/15 from 8:00 a.m. through 11:50 a.m. he was seated in the dining room for breakfast without the gel cushion in his dining room chair.</p>	F 309	<p>appropriate provider of weight changes and follow thru with provider orders. The DM or designee will report findings to the QAPI committee quarterly until the committee advises to discontinue.</p> <p>On 11/4/15 a gel cushion was placed on resident 4's chair in the dining room. This gel cushion will remain in the dining room and a separate cushion will remain in his wheelchair. Resident 4's care plan will be reviewed and dates of when interventions were put in place will be added by the MDS coordinator. All resident care plans will be reviewed by the DON or designee to ensure proper repositioning and pressure reducing devices are used as appropriate.</p> <p>The DON or designee will QA this process monthly for the first quarter and then quarterly thereafter. Findings will be reported to the QAPI committee quarterly until the committee advises to discontinue.</p> <p>All residents with falls will be evaluated for trending patterns, including resident 9 by the DON or designee. Interventions will be evaluated to determine appropriateness and thoroughness in reducing resident falls. All</p>		

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F 309	<p>Continued From page 15</p> <p>-He was then seated in a recliner in the television room without his gel cushion from 8:55 a.m. until 11:50 a.m. when he was moved to the dining room. He did not have his gel cushion in his dining room chair.</p> <p>-He was then moved to his room and was seated in his recliner with the gel cushion from 1:00 p.m. to 5:00 p.m. when he was brought to the dining room for supper. He did not have his gel cushion in his dining room chair.</p> <p>Review of resident 4's medical record revealed: *He had been admitted on 4/29/15. *He had a small reddened area on his coccyx (tailbone). *On 8/3/15 he had a stage two pressure ulcer (open area or outer layer of skin missing from pressure and frequently over a bony area) to his coccyx.</p> <p>Review of resident 4's 5/6/15 care plan revealed: *Focus area: "The resident was admitted with a red area to his coccyx." *Goal of: "The resident will have intact skin, free of redness, blisters or discoloration." *Interventions that included: -"The resident needs limited assist of 1 to turn/reposition at least every 2 hours, more often as need or requested." -"Pressure reducing mattress, gel cushion to w/c [wheelchair]." Those interventions were handwritten for his weight loss focus area. There was no date when those interventions had been added.</p> <p>Review of resident 4's 8/11/15 physician's orders revealed "Apply pressure relieving mattress to bed. Pt. [patient/resident] needs to have a gel pad cushion in all chairs."</p>	F 309	<p>interventions will have start dates.</p> <p>Resident 9 will receive a speech therapy evaluation and recommendations will be ordered and implemented by the DON. This process will be QA'd by the DON or designee weekly for the first quarter and then monthly thereafter. Findings will be reported to the QAPI committee quarterly by the DON or designee until the committee advises to discontinue.</p> <p>Education will be provided to all staff responsible for providing care to residents on 11/25/15 by the DON.</p>	

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F 309	Continued From page 16  Review of resident 4's October 2015 treatment administration record revealed "8/11/15 Information QW [every week] Gel Cushion to w/c [wheelchair], DR [dining room] chair, & [and] recliner. Check Q [every] Sunday."  Interview on 11/4/15 at 7:45 a.m. with licensed practical nurse B revealed she was not aware resident 4 should have had his gel cushion in any chair he sat in. She agreed he was at risk of getting a pressure ulcer. She stated he had a cushioned dressing on his coccyx also for prevention of a pressure ulcer.  Interview on 11/4/15 at 8:00 am. with certified nursing assistant C revealed she was not aware resident 4 should have had his gel cushion in any chair he sat in.  Review of the provider's revised 7/25/12 Pressure Sores: Skin Assessment and Prevention policy revealed: *All residents would be repositioned as noted in their plan of care. *Any resident at risk would be placed on a pressure-reducing device. *Chair-bound residents would have a pressure reducing pad in the wheelchair.  Surveyor: 32572 3. Review of resident 9's medical record revealed he had fallen on the following dates: *5/25/15 at 8:45 a.m. out of his wheelchair reaching for something. *6/18/15 at 6:45 p.m. in his bathroom. *7/3/15 at 6:15 p.m. in his bathroom. *7/7/15 at 4:00 p.m. in his bathroom. *7/10/15 at 8:25 a.m. in his bathroom.	F 309		

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F 309	<p>Continued From page 17</p> <p>*7/24/15 at 6:30 p.m. in his bathroom. *9/6/15 at 9:45 a.m. in his room. *9/18/15 at 5:15 p.m. in his bathroom. *10/17/15 at 11:30 a.m. in his bathroom. Seven of the above nine falls had occurred in his bathroom while he was self-transferring to or from the toilet.</p> <p>Review of resident 9's 11/26/13 revised care plan revealed: *Focus area: "The resident has an ADL [activities of daily living; bathing, showering, toileting, eating] self-care performance deficit [problems] r/t [related to] limited ROM [range of motion; moving of the arms and legs], impaired balance, decreased safety AEB [as evidenced by] requiring some set up help and supervision to limited assist of one with some ADLs." *Goal was: "The resident will maintain current level of function in ADLs without decline in present status through the review date of 6/30/15." *Interventions for: -"Toilet use: The resident requires limited assist of one staff with toileting." -"Transfer: The resident is independent with transfers some of the time, but may require set-up help." The only change in interventions on the care plan was "Uses two [up arrow] one-quarter side rails for repositioning - assess quarterly." There had not been a change in the plan of care to prevent falls since the revision on 3/16/15. *Focus area of: "The resident is at risk for injury r/t falls due to ambulates with a fww [front wheeled walker] for balance and has a h/o [history of] fall prior to admission." -It then listed the dates of the falls and if any injury had occurred or not.</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>*Goal of: "The resident will be free of injurious [hand-written above] falls through review date of 6/30/15.</p> <p>*Interventions of:                      -"Anticipate and meet the resident's needs."                      -Hand written in without a date stated:                      --"Weight sensitive bed alarm and to w/c [wheelchair]."                      --"Personal alarm."                      -"Resident was moved to a closer room to the nurse's station on 10/7/14."                      Review of the care plan and nursing documentation revealed the resident had never been put on a toileting program to anticipate his needs and prevent the falls.</p> <p>b. Review of resident 9's medical record revealed the following weights from January 2015 to October 2015 :                      *1/5/15: 145.5 pounds (lb).                      *2/5/15: 142 lb.                      *3/5/15: 143 lb.                      *4/6/15: 137 lb.                      *5/4/15: 141 lb.                      *6/8/15: 135 lb.                      *7/6/15: 135.5 lb.                      *8/6/15: 137 lb.                      *9/7/15: 134 lb.                      *10/5/15: 134 lb.</p> <p>Review of resident 9's medical record revealed:                      *Nurses notes from 5/10/15 through 11/4/2015 revealed choking episodes had occurred on 6/21/15 and 8/17/15.                      *A physician ordered EGD (esophagogastroduodenoscopy, specialized test to look at the throat and into the stomach) for a persistent cough and discomfort in the esophagus (tube from mouth to stomach). The</p>	F 309		

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F 309	<p>Continued From page 19</p> <p>results of the EGD were negative for swallowing abnormalities.</p> <p>Review of resident 9's 3/16/15 care plan revealed:</p> <p>*Focus area: "The resident has nutritional problem or potential nutritional problem due to about an 8 1/2% [eight and one-half percent] weight loss in 180 days with a weight of 155 on 2/3/15."</p> <p>-It then listed weights that went from 154 lb on 4/24/14 to 138 lb on 8/10/15..</p> <p>*Goal: "The resident will maintain adequate nutritional status as evidenced by maintaining weight within plus or minus 5# [pounds] of current weight of 155# and show no s/sx [signs or symptoms] of malnutrition, and consuming at least 75-100% of meals daily through next care plan review date of 6/30/15."</p> <p>*Interventions:</p> <p>-"Monitoring/document/report PRN [as needed] any s/sx of dysphagia [difficulty swallowing]: pocketing [holding food in cheek area], choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals."</p> <p>-"Provide, serve diet as ordered. Liberalized ground meat diet and monitor intake and record q [every] meal."</p> <p>-"RD [registered dietician] to evaluate and make diet change recommendations PRN."</p> <p>-Hand written in was "5/17/15 Encourage fluids." There had not been any other change in interventions to prevent weight loss even from the RD.</p> <p>There had not been a request for a speech therapy (ST) referral for swallowing difficulties.</p> <p>c. Interview on 11/4/15 at 7:50 a.m. with the</p>	F 309		

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F 309	Continued From page 20 assistant director of nursing (ADON) confirmed care plans were to: *Reflect the current status of the residents. *Have been updated as the resident's conditions changed. *Goal dates had passed and the care plan was not current for resident 9. *A toileting program would have been a good intervention to anticipate the needs for resident 9.  Interview on 11/4/15 at 8:20 a.m. with the Minimum Data Set (MDS) assessment nurse confirmed: *She was responsible for updating the care plans into the computer quarterly. *She expected the nurses to keep the care plans current and changed as needed. *She was unable to find documentation that resident 9 had an ST referral. *The care plan for resident 9 had not been current.  Review of the provider's March 2014 Care Plan policy revealed: **Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." **"A staff person will be designated to be the Care Plan Coordinator and will be responsible for coordinating and monitoring the implementation of the care plan." **"A qualified team of persons will review care plans at least quarterly [capitalized]."	F 309		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency	F 425		

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F 425	<p>Continued From page 21</p> <p>drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, review of manufacturer's recommended guidelines, and policy review, the provider failed to ensure: *Three of eight insulin (diabetic medication) vials (container) had not been used beyond expiration dates. *Insulin had been administered according to the manufacturer's guidelines for one of five insulin administration observations. *Glucometers (device for measuring blood sugar) had been disinfected according to policy for five of five observations on sampled residents (7, 12, 14, 15, and 16). Findings include:</p>	F 425	<p>F425</p> <p>Education will be provided to all nurses including LPN D on 11/25/15 regarding the correct administration of insulins and expiration dates. All opened vials will have an open date and an expiration date written on the vial. Night nurses will be instructed to monitor all open vials for expiration dates nightly. The DON or designee will QA this process weekly for the first quarter and then monthly thereafter. Findings will be reported to the QAPI committee quarterly until QAPI committee advises to discontinue.</p> <p>Resident 13's medication administration record will be updated to reflect the appropriate time schedule per the Novolog Insulin Manufacturer's Guidelines. All residents receiving insulin injections MAR's will be reviewed for appropriate time schedules. Changes will be made as necessary. All nurses will be educated on proper insulin administration times on 11/25/15, including LPN B. This process will be QA'd weekly by the DON or designee for the first quarter and monthly thereafter. Findings will be reported to the QAPI committee</p>	12/24/15

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</b>	
(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 425	<p>Continued From page 22</p> <p>1. Random observations on 11/2/15 throughout the day revealed: *Three of eight insulin vials stored for residents in the medication refrigerator had been opened on 10/2/15. -Those insulin vials were: Levemir, Novolog and Lantus.</p> <p>Interview on 11/2/15 at 4:43 p.m. with licensed practical nurse (LPN) D revealed "Insulin is good for twenty-eight days, but we usually let them go for thirty days."</p> <p>Observation and interview on 11/3/15 during the morning medication pass with LPN B revealed: *She had attempted to administer expired Levemir insulin to resident 13. -She confirmed a new vial of insulin had been ordered, received, and available for use. *A sign on the medication refrigerator in the medication room stated to dispose of insulin after twenty-eight days of opening vial.</p> <p>Review of the manufacturer's recommended guidelines for Levemir insulin revealed: *"Keep in refrigerator or at room temperature below 86 degrees Fahrenheit for up to twenty-eight days in use." *"Throw away an opened vial after twenty-eight days of use, even if there is insulin left in the vial."</p> <p>2. Observation on 11/3/15 and review of resident 13's medication administration record revealed Novolog insulin had been administered at 4:40 p.m. and her supper meal was served to her at 5:40 p.m.</p> <p>Review of the manufacturer's recommended guidelines revealed "Do not inject Novolog if you</p>	F 425	<p>quarterly until the QAPI committee advises to discontinue.</p> <p>All nurses will receive education regarding proper disinfection of glucometer between resident use. A competency will be performed by all nurses. This process will be QA'd by the DON or designee weekly for the first quarter and then quarterly thereafter. Findings will be reported to the QAPI committee quarterly until the QAPI committee advises to discontinue.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</b>		
(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 425	<p>Continued From page 23 do not plan to eat right after injection."</p> <p>Review of the provider's July 2002 Insulin Administration Timing policy did not reveal a statement regarding timing of administration of insulin related to the meals. *LPN B had not administered the Novolog (short acting) insulin to resident 13 per manufacturer's recommended guidelines.</p> <p>3. Random observations on 11/2/15 through 11/3/15 revealed: *LPN D had performed glucometer testing for five residents (7, 12, 14, 15, and 16). *LPN D had not disinfected that glucometer between residents testing for all five observations.</p> <p>Review of the provider's Glucometer Cleaning policy dated July 2012 review revealed: *"Glucometers for use on more than one resident/patient will be cleaned after each use. -Clean glucometer with a disposable Clorox germicidal wipe."</p> <p>Interview on 11/4/15 at 11:30 a.m. with the assistant director of nursing confirmed the above findings.</p>	F 425			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</b>	
(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 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/03/15. Bennett County Hospital and Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 11/04/15 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 K038, K047, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 12/07/15 per telephone with facility administrator. CH/SDDO/H/EL	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and document review, the	K 033		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Erdal Martin* TITLE: *Administrator* (X6) DATE: *11/23/15*

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</b>	
(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 033	Continued From page 1 provider failed to maintain a protected path of egress from the basement to the exterior of the building. The single basement stairway discharged onto the main level and was not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include:  1. Observation at 1:13 p.m. on 11/03/15 revealed a basement stair enclosure discharged onto the main level corridor system. A continuous one hour enclosure was not provided to the exterior of the building. Review of the previous life safety code survey conducted on 9/17/14 confirmed that finding.	K 033		<b>F</b>
K 069 SS=C	The building meets the FSES. Please mark an "F" in the completion date column. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to maintain a connection for the kitchen range hood extinguishing system to the building fire alarm system in accordance with National Fire Protection Association 96. Findings include:  1. Record review at 1:33 p.m. on 11/03/15 of the range hood extinguishing system inspection reports dated 1/13/15 and 7/06/15 revealed there was no documentation showing the range hood's system activated the building fire alarm system. Review of the building fire alarm annual	K 069	K069 Maintenance Supervisor will contact system inspection company and arrange service inspection to assure range hood extinguishing system is connected to building fire alarm system and obtain proper documentation of this from system inspection company. Maintenance Supervisor will provide documentation to the Administrator for inclusion in the next quarterly QAPI committee report. This indicator will then be monitored annually by the administrator for compliance.	<i>12/24/15</i>

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NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551</b>	
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K 069	<p>Continued From page 2</p> <p>inspection dated 6/23/15 at 1:43 p.m. on 11/03/15 revealed there was no documentation showing the range hood's system activated the building fire alarm system. The activation of the range hood fire suppression system must activate the building fire alarm system.</p> <p>Interview with the maintenance supervisor at the time of the record review revealed he was unaware if the suppression system activated the building fire alarm system.</p> <p>This deficiency could potentially affect all forty-two residents of the facility.</p>	K 069		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  43A075	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 11/3/2015
NAME OF PROVIDER OR SUPPLIER  BENNETT COUNTY HOSPITAL AND NURSING HON	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD		

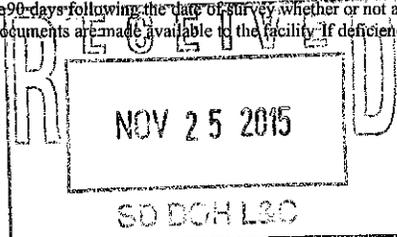
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 038	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p style="text-align: right;">* CH/SDDOT/EL</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure the door at one randomly observed location (west exit door for the resident dining room) was readily accessible at all times. Findings include:</p> <p>1. Observation at 12:33 p.m. on 11/03/15 revealed the west exit door for the resident dining room was obstructed with a table and two chairs with residents occupying that space. The residents and chairs were directly in front of that marked exit door. Interview with the maintenance supervisor at the time of the observation confirmed the finding. He indicated the floor could be marked to show an area to be kept clear. The table and chairs were relocated during the survey.</p> <p>The deficiency had the potential to affect all residents in the dining room area in an emergency situation.</p>
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K 047	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> <p style="text-align: right;">*CH/SDDOT/EL</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain exit lighting for two (west exit door from the resident dining room and corridor exit sign south of the nursing station) of numerous exit signs. Findings include:</p> <p>1. Observation beginning at 12:33 p.m. on 11/03/15 revealed the west exit door from the resident dining room had one of two incandescent lamps not functioning for the fixture. Further observation of the lighted exit sign in the corridor south of the nursing station revealed the same condition existed. Interview with the maintenance supervisor at the time of the observations confirmed those conditions.</p>
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Any deficiency statement ending with an asterisk(\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>43A075</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE: <b>11/3/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENNETT COUNTY HOSPITAL AND NURSING HOM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>K 047</b>	Continued From Page 1 The deficiency affected two locations required to be provided with a marked and identifiable path of egress		

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10646	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  11/04/2015
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NAME OF PROVIDER OR SUPPLIER  BENNETT COUNTY HOSPITAL AND NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551
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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) COMPLETE DATE
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/02/15 through 11/04/15. Bennett County Hospital and Nursing Home was found in compliance.</p>	S 000		

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

*Ethel Martin*

TITLE

*Administrative*

(X6) DATE

11/23/15

STATE FORM C

6899

If continuation sheet 1 of 1

