

ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2015
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NAME OF PROVIDER OR SUPPLIER SUNQUEST HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 MICHIGAN AVENUE SW HURON, SD 57350
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F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/14/15 through 12/16/15. SunQuest Healthcare Center was found not in compliance with the following requirements: F164 and F323.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>F164 1.) The facility policy for "Confidentiality of Information" was reviewed by the Administrator and D.O.N. on 01/04/2016. Education for all facility Nurses and Medication aides was conducted by the D.O.N. on 01/05/2016, to ensure they understand the importance of keeping computer screens minimized or tipped shut when they are away from their computers to ensure confidentiality of resident information at all times. Personal education was provided to staff member F on 01/05/2016 and to staff member D on 01/05/2016 to ensure that they understand the importance of keeping computer screens minimized or tipped shut when they are away from their computers to ensure confidentiality of resident information at all times.</p> <p>Audits will be conducted on staff members F & D, resident #10's medical record screen and 5 random</p>	01-29-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruce L. Solem</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1/8/2016</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and policy review, the provider failed to ensure residents' personal information had been kept secured by two of five staff members (D and F) during medication passes in the dining rooms (Independence and Nixon Nook). Findings include:</p> <p>1. Observation on 12/14/15 at 6:00 p.m. revealed registered nurse F had prepared the medications for resident 10 at the medication cart in the Independence dining room. She left the medication cart and went to the resident's table to administer those prepared medications. Her back had been to the medication cart. The electronic medication administration record (eMAR) had been left open for anyone to see. During that time the dining room had numerous residents, staff members, and family members present.</p> <p>Observation on 12/15/15 at 8:00 a.m. revealed a medication cart with the eMAR open in the Nixon Nook dining room. Unlicensed assistive personnel (UAP) D was at a resident's table visiting with her back toward the medication cart. It was three minutes before the UAP realized the surveyor had been standing at the cart. The eMAR with residents' medication could be read during the time the UAP had her back to the medication cart.</p> <p>Interview on 12/15/15 at 4:10 p.m. with the director of nursing confirmed her expectations would be to have the eMAR closed when staff</p>	F 164	<p>residents weekly for 4 weeks then monthly for 3 months to ensure the facility policy on Confidentiality of Resident information with computer usage is carried out appropriately.</p> <p>The D.O.N. /designee will be responsible for overall compliance. The D.O.N./designee will report audit findings at monthly Client Care and C.Q.I. meetings for 4 months.</p>	

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F 164	Continued From page 2 members were not present at the medication cart. Review of the provider's 10/1/15 Medication Administration - General Guidelines policy revealed "Privacy is maintained at all times for all resident information (e.g.[for example], MAR) by closing the MAR book/covering the MAR sheet or computer screen when not in use." Review of the provider's Resident Rights pamphlet given to all residents upon admission revealed "The resident has the right to personal privacy and confidentiality of his or her personal and clinical records."	F 164		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to safely transfer one of four sampled residents (6) during two of five observed transfers with a gait belt (assistive device used to move a person from one place to another) creating a potential for injury. Findings include: 1. Review of resident 6's medical record	F 323	F 323 The facility policy "Safe Lifting And Movement of Residents" was reviewed by the D.O.N., Administrator and Nurse Management team on 01/04/2016 to ensure accuracy. All nursing staff was educated on the Safe Lifting and Movement of Residents policy on 01/05/2016 by the D.O.N. and Physical Therapy Consultant. Personal education was provided by the D.O.N. to staff member A on 01/05/2016, to staff member B on 01/07/2016 to staff member C on 01/07/2016 and staff member D on 01/05/2016 to ensure that they understand the importance of following the facility "Safe Lifting and Movement of Residents" policy. Resident #6 was assessed by therapy on 12/17/2015 and deemed to	01-29-16

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F 323	<p>Continued From page 3 revealed: *Her diagnoses included Alzheimer's (memory) disease. *She did not walk and required extensive staff assistance with her activities of daily living (ADL; dressing, toileting, hygiene, bathing, eating, and transferring). *Her 5/21/15, 8/26/15, and 11/7/15 Fall Risk Assessments revealed: -She was disoriented (not aware of self, person, or place) at all times. -She was chair bound and unable to walk or move around. -She was unable to perform walking and balance functions. *She had worked with physical therapy in January and February 2015. Those notes revealed: -She had started with therapy on 1/23/15 after nursing noted she was bearing little to no weight on her legs during transfers. -On 2/6/15 she completed therapy, and they recommended she could continue sit-to-stand transfers, pivot transfers, and walking only short distances of five feet or less. *On 8/24/15 she was screened by therapy. That note stated: -"Resident has not had a significant change in the past year. Skilled therapies not appropriate at this time." -For transfers she needed extensive assistance of two staff.</p> <p>Observation and interview on 12/14/15 at 5:15 p.m. with certified nursing assistants (CNA) A and B during resident 6's transfer from her wheelchair to the toilet and back revealed: *They applied the gait belt around her waist. *Then they grabbed onto the gait belt and assisted her to stand up from the wheelchair.</p>	F 323	<p>require the use of a full hoyer lift to assist with her transfers. All other residents in the facility that are care planned to transfer with a gait belt will be assessed by 01/29/2016 to ensure their care plan includes the safest transfer method.</p> <p>Audits will be conducted on staff members A, B, C and D, resident #6 and 5 random residents weekly for 4 weeks and monthly for 3 months to ensure residents are being transferred in the safest manner possible. Audits will be conducted by the D.O.N./Designee who will also be responsible for overall compliance. Audit finding 5 will be reported at monthly Client Care and C.Q.I. meetings for 4 months.</p>		

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F 323	<p>Continued From page 4</p> <ul style="list-style-type: none"> *The resident's knees remained bent when she was standing. *As she was standing the gait belt slid up around her chest. That had caused the CNAs hands and arms that were on the gait belt to appear to put pressure underneath her arms and shoulders. *The CNAs moved her to the toilet. *Once she was on the toilet they had to manually lift her with each CNA having one hand on the gait belt and the other under each of her legs to get her in the proper position on the seat. *She did not appear to have fully participated or held up her own weight during the transfer. *CNA A stated: <ul style="list-style-type: none"> -She sometimes stood better and took steps. -Sometimes she was weaker and did not stand up well. -If she was standing okay they would have transferred her with two staff assistance and the gait belt. -Sometimes they used the Hoyer (sling type of equipment to move a resident from one place to another) lift when she was not standing well. *During her transfer from the toilet to the wheelchair: <ul style="list-style-type: none"> -The gait belt slid up her chest again causing the CNAs to appear to put pressure underneath her arms and shoulders. -Her knees remained bent when she was standing and moving. -She did not appear to have fully held up her own weight during the transfer. -Once she was in the wheelchair they had to manually lift as they did onto the toilet to get her into the proper position in the wheelchair seat. *Following the above transfers the CNAs: <ul style="list-style-type: none"> -Agreed they had performed the transfers with the resident bearing little to none of her own weight. -Confirmed the gait belt had slid up which could 	F 323		
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F 323	<p>Continued From page 5</p> <p>have caused injury to the resident's arms or shoulders.</p> <p>-Stated this week her transfers had been worse, and they should have let the nurse know.</p> <p>-Stated the nurse would have had therapy evaluate the resident's transfers for safety.</p> <p>-Thought maybe they should have used the Hoyer lift for her transfers since she was not transferring as well lately.</p> <p>Interview on 12/14/15 at 6:00 p.m. with registered nurse/resident care coordinator E regarding resident 6 and her transfers revealed:</p> <p>*If she was sleepy, tired, or not participating well in the transfer the CNAs should have used the Hoyer lift for her safety.</p> <p>*Some days she was able to stand and transfer well and some days were not as good.</p> <p>*If she was not transferring well they could have asked therapy to evaluate her.</p> <p>*Therapy had worked with her in the past on safe transfers.</p> <p>*She stated they were a "no lift" facility indicating the staff should not have manually lifted the residents during transfers.</p> <p>*She agreed there was a potential for injury to the resident if she was not standing or transferring well with a gait belt.</p> <p>Observation and interview on 12/15/15 at 10:50 a.m. with CNAs C and D during resident 6's transfer from her bed to her wheelchair revealed:</p> <p>*They assisted the resident to sit up at the edge of the bed and applied a gait belt around her waist.</p> <p>*Then stood her up using the gait belt and moved her into her wheelchair.</p> <p>*The resident's knees remained bent during the standing and moving.</p>	F 323		
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F 323	<p>Continued From page 6</p> <p>*She did not appear to have fully held up her own weight during the transfer.</p> <p>*They had to manually lift her with each CNA having one hand on the gait belt and the other under each of her legs to move her into the proper position in the wheelchair seat.</p> <p>*They stated:</p> <p>- "Some days she doesn't stand as well."</p> <p>- The above transfer was normal for her.</p> <p>- They could have used the Hoyer lift to transfer her as needed, but they hardly ever used it.</p> <p>*They agreed there was a risk of injury to the resident during a transfer if she was not participating or holding up her own weight.</p> <p>Review of resident 6's November 2015 care plan revealed:</p> <p>*She had a diagnosis of Alzheimer's, impaired balance, and impaired mobility.</p> <p>*She required extensive to total assistance of one or two staff with ADLs and extensive assistance of two staff and a gait belt for transfers.</p> <p>*They could have used the Hoyer lift as needed.</p> <p>- There was no mention of when specifically they would have used the Hoyer lift.</p> <p>Interview on 12/15/15 at 3:00 p.m. with the director of nursing regarding resident 6 and her transfers revealed:</p> <p>*She agreed there was a potential for injury to the resident:</p> <p>- If she was not standing or holding up her own weight during gait belt transfers.</p> <p>- When the gait belt slid up causing staff to put pressure underneath her arm or shoulders.</p> <p>*They were a "limited" lift facility meaning they could have assisted residents who did not hold up all of their own weight during transfers.</p> <p>*They preferred to keep their residents using their</p>	F 323			

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F 323	Continued From page 7 own strength to move for as long as able, but it might have been time to change resident 6 to Hoyer lift transfers for her safety. *Therapy had not evaluated resident 6's transfer status since August 2015; she might have declined since that time. Review of the provider's 12/17/13 Safe Lifting and Movement of Residents policy revealed: **"Manual lifting of residents shall be eliminated when feasible." **"Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan." **"Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary."	F 323			

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/17/15. SunQuest Healthcare Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K018, K047, K056, and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to furnish one randomly observed lit exit sign (basement boiler room) to ensure the path of egress to exits were identified. Findings include: 1. Observation at 11:00 a.m. on 12/17/15 revealed the secondary exit (stairs) for the basement boiler room led to the corridor system by the Rushmore dining room. No exit sign was visible to indicate the path of egress for the second required exit in the basement. The	K 047	An exit sign that is lit at all times was installed in the basement to indicate the path of egress for the second exit in the basement. This lit exit sign was added to the monthly preventative maintenance log which includes all facility exit signs so they can be checked monthly to ensure they are in proper working condition. The Plant Operations Supervisor will be responsible for overall compliance and will conduct audits on monthly preventative maintenance checks for facility lit exit signs to monthly Safety and C.Q.I. meetings for 6 months.	01-07-16

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

Laurie L. Solom

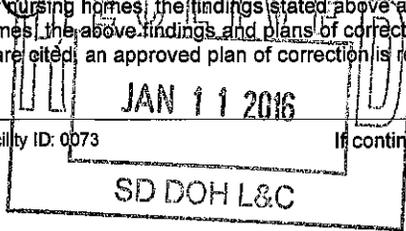
TITLE

Administrata

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K 047	Continued From page 1 primary exit (stairs) from the basement boiler room leading to the exterior of the building was furnished with a lit exit sign. Interview with the maintenance supervisor at the time of the observation confirmed that finding.	K 047		
K 062 SS=F	The deficiency affected one of numerous requirements for marking the paths of egress. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review, observation, and interview, the provider failed to verify the required maintenance of the sprinkler system (five year internal inspection) had been performed. Findings include: 1. Review of the provider's sprinkler maintenance records on 12/17/15 revealed no documentation the required five year internal obstruction inspection of the sprinkler system had been performed in accordance with NFPA 25. Observation at 10:45 a.m. on 12/17/15 revealed there was not a tag on the fire sprinkler risers indicating a five year obstruction inspection had been performed. Interview with the administrator at 3:10 p.m. on 12/17/15 revealed she was under the impression	K 062	K062. A 5 year Internal Obstruction Inspection was conducted on the facility's sprinkler system on 12/30/2015. A notice was posted at each Sprinkler Riser in the facility to denote when the 5 year inspection took place and when the next inspection is due. The Plant Operations Supervisor is responsible for overall compliance to ensure 5 year Sprinkler Inspections are completed timely. Inspection due dates will be reported at Safety and C.Q.I. meetings in January and July each year by the Plant Operations Supervisor to ensure compliance.	12-30-15

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K 062	Continued From page 2 that the inspection requirement was not being enforced for the NFPA 25 five year maintenance items. The deficiency affected one of numerous requirements for fire sprinkler system maintenance.	K 062		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435020	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 12/17/2015
NAME OF PROVIDER OR SUPPLIER SUNQUEST HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1345 MICHIGAN AVENUE SW HURON, SD	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
K 056	<p>Continued From Page 1</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches which are electrically connected to the building fire alarm system 19.3.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, interview, and document review, the provider failed to meet the minimum construction standards of the 2000 Life Safety Code (LSC). The building was not provided with a complete automatic sprinkler system in accordance with NFPA 13 (boiler room/kitchen/laundry). Findings include:</p> <p>1. Observation at 10:30 a.m. on 12/17/15 revealed two sprinkler risers in the boiler room were domestic sprinkler installations. The sprinkler risers also did not have hydraulic information signs. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated those risers fed the kitchen and laundry area sprinklers. Document review of the annual sprinkler system inspections performed on 8/27/15 by the contractor revealed those systems were noted as being domestic-fed systems.</p> <p>Sprinkler systems for nursing facilities must be in accordance with the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), 2000 edition and NFPA 13, Installation of Sprinkler Systems, 1999 edition. The system was not in compliance with the Centers for Medicare and Medicaid Services (CMS) requirements at 42 CFR 483.70(a)(8) (see attachment).</p> <p>Interview with the administrator at 3:00 p.m. on 12/17/15 revealed she was unaware the building was not in compliance with automatic fire sprinkler system installations.</p> <p>The deficiency affected one of numerous requirements for providing complete automatic fire sprinkler systems in healthcare facilities.</p> <p>01/04/16 On 12-30-2015 a technician from Building Sprinkler, Inc. was in the facility and determined that the Facility's sprinkler system was installed by their company in 1986 and it is a Pipe Schedule Design system. Building Sprinkler, Inc. did supply the facility with a sign which was placed near the sprinkler riser in the basement to denote it is a Pipe Schedule Design System.</p>		

ORIGINAL

PRINTED: 12/30/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10633	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/17/2015
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NAME OF PROVIDER OR SUPPLIER SUNQUEST HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1345 MICHIGAN AVE SW HURON, SD 57350
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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	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/14/15 through 12/17/15. SunQuest Healthcare Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/14/15 through 12/17/15. SunQuest Healthcare Center was found in compliance.	S 000		

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

TITLE

(X6) DATE

STATE FORM

6899

RCPM11

If continuation sheet 1 of 1

Lauren L. Lem

Administrative

1/8/2016