

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/12/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AURORA BRULE NURSING HOME INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383</b>
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F 000	<p><i>Addendums noted with an asterisk per 9/10/15 telephone to facility administrator. NS/S000H/JJ</i></p> <p>Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/10/15 through 8/12/15. Aurora Brule Nursing Home Inc was found not in compliance with the following requirements: F166, F281, F323, F431, and F441.</p>	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waving the foregoing statement, the facility states that with respect to:	
F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview, record review, and policy manual review, the provider failed to inform residents of resolutions to grievances brought up in the resident council meetings from February 2015 through July 2015. Findings include:</p> <p>1. Review of the resident council minutes from February 2015 through July 2015 revealed the following resident grievances had been documented: *On 2/16/15 "Residents asked for their dirty clothes to be picked up and their beds to be made everyday. Some residents felt that between 8:00 p.m. and 10:30 p.m. that call lights were not being answered as efficiently as they are throughout the day." *On 6/11/15 "The residents did have a request to</p>	F 166	<p>Resident council minutes for the months of February 2015 and June 2015 were reviewed to ensure prompt efforts by the facility to resolve any grievances the residents may have, including those with respect to the behavior of other residents.</p> <p>All resident council minutes for the 2015 year <del>was</del> reviewed to ensure prompt efforts by the facility to resolve any grievances the residents may have, including those with respect to the behavior of other residents.</p> <p>The Administrator and Activity Director reviewed and revised as necessary the policies and procedures of the activity department to ensure that there was a documented process and follow through to show prompt efforts by the facility to resolve any grievances the residents may have, including those with respect to the behavior of other residents.</p>	10/1/15

*and ongoing Council meeting minutes were and will be NS/S000H/JJ*

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>8-28-15</b>
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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 166	<p>Continued From page 1</p> <p>play dart toss, chip toss, Plinko, and spin the wheel more frequently and to do less fishing." *There had been no documentation regarding the resolutions to the above concerns.</p> <p>Confidential interview on 8/11/15 at 1:30 p.m. with a group of residents who requested to be unidentified revealed: *One resident stated they were not picking up his dirty clothes everyday. -Staff would see them and leave them in his room. -He wanted his dirty clothes to be picked up everyday. *Several residents felt the call lights were not being answered in a timely manner in the evenings after supper. *They had recalled talking about the call lights in a resident council meeting. *They had not been informed of what had been done to fix the above problems.</p> <p>Interview on 8/12/15 at 8:20 a.m. with the activity director and the director of nursing (DON) revealed: *The activity director had notified the DON of the call light concern but had not documented it. *The DON had re-educated the certified nursing assistants about answering the call lights in a timely manner. -She had not conducted audits to see if the call light problem had improved. *They had not gone back to the residents to verify the problems had gotten better. *The activity director read the past months minutes for approval during the current months resident council meetings. *She agreed there was no documentation of grievance resolutions.</p>	F 166	<p>The Activity Director or designee will audit resident council minutes monthly for three months and will follow up with the residents at the monthly resident council meetings to ensure prompt efforts by the facility to resolve any grievances the residents may have, including those with respect to the behavior of other residents.</p> <p>The Activity Director or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p>	

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F 166	Continued From page 2	F 166			
F 281 SS=D	<p>Review of the provider's undated resident policy manual revealed: *Grievances could be oral or in writing. *If grievances had not been resolved in five days they should have been passed on to the administrator. *If the problem had not been resolved within ten days then the grievance should have been registered with the governing board. *There was nothing in the manual regarding addressing the resolution with the residents.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on record review, interview, and policy review, the provider failed to obtain a physician's order and to have complete documentation for treatment of a wound for one of one sampled resident (5). Findings include:</p> <p>1. Review of resident 5's medical record revealed: *A weekly pressure ulcer record with the following documentation: -An onset date (when the wound was found) of 6/23/15. -A stage II ulcer (a shallow open wound) on the top of her coccyx (tailbone). -The ulcer measured two centimeters (cm) by two cm.</p>	F 281	<p>Resident 5's medical record was reviewed to make certain a physician order for wound dressing had been obtained as well as complete documentation for the treatment of Resident 5's wound to ensure the services provided or arranged by the facility met professional standards of care.</p> <p>for all other residents with wounds, their medical records were reviewed to make certain physician orders for wound dressing were obtained as well as complete documentation for the treatment of wounds to ensure the services provided or arranged by the facility are meeting professional standards of care.</p> <p><i>* Education was provided to all nursing staff regarding wound care on 8/21/15. NS/SOOH/JJ</i></p>	10/1/15	

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F 281	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>-A duoderm dressing had been applied.</li> <li>-The physician, family, and dietary department had been notified of the ulcer on 6/23/15.</li> <li>-On 7/9/15 there was no change to the ulcer.</li> <li>-There was no further documentation on that record after 7/9/15.</li> <li>*There was no documentation regarding the coccyx ulcer in the nursing notes on 6/23/15.</li> <li>*There was no physician's order for a dressing to have been applied to the ulcer.</li> </ul> <p>Interview on 8/12/15 at 10:43 a.m. with the director of nursing (DON) revealed there was no further documentation in resident 5's medical record regarding her wound. The only documentation was on the 6/23/15 weekly pressure ulcer record.</p> <p>Interview on 8/12/15 at 10:55 a.m. with registered nurse (RN) C and the DON revealed:</p> <ul style="list-style-type: none"> <li>*RN C verified the 6/23/15 weekly pressure ulcer record was for resident 5.</li> <li>-She had completed the wound pressure ulcer record on 6/23/15 when the wound was found.</li> <li>-She usually would have documented about the wound and notifications in the nursing notes.</li> <li>-She had needed a physician's order to apply a duoderm (wound dressing), but she had not done that.</li> <li>-Would usually have written the wound information and the ordered treatment of the wound on resident 5's treatment administration record.</li> <li>-The ulcer had been healed.</li> <li>-There was no documentation that the wound was healed on the weekly pressure ulcer record.</li> <li>*The DON agreed:</li> <li>-The above statements by RN C would have been the procedure she would have expected to</li> </ul>	F 281	<p>The Administrator, Medical Director, and Director of Nursing reviewed and revised, as necessary, the wound care policies and procedures to make certain they included obtaining a physicians order for the dressing of wounds as well as complete documentation and assessments to ensure the services provided or arranged by the facility are meeting professional standards of care.</p> <p>The Director of Nursing or designee will audit the medical records for all residents receiving wound care treatment twice a month for two months and once a month for one more month to make certain physician orders for wound dressings are obtained as well as complete documentation and assessment to ensure the services provided or arranged by the facility are meeting professional standards of care.</p> <p>The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p>	

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F 281	Continued From page 4 have been completed by a nurse on all wounds. -They had not followed their policy and procedure for the above resident's wound.  Review of the provider's February 2014 Pressure Ulcer Prevention and Wound Care Policy and Procedure revealed: **Residents who have a pressure ulcer will have assessment completed weekly and as needed due to changes, by a Licensed Nurse." **"Assessment will be recorded on the Weekly Pressure Ulcer Record." **"This will be noted on the resident's TAR [treatment administration record] that this assessment is to be completed." **"Each Pressure Ulcer will have its own Weekly Pressure Ulcer Record sheet." **"Dressing changes and treatments will be carried out by the Licensed Nurse according to the Physician Orders."  Review of the provider's 7/28/14 Transcription of Physician Orders Policy and Procedure revealed the "TAR must be updated regularly in accordance to changed [changes] with [the] resident's medication, treatment and patterns of use."	F 281			
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.	F 323	Resident 8's medical record was reviewed and to make certain that an assessment of the safety of the side rail had been completed to ensure that resident 8's environment remained free of accident hazards as is possible.	10/1/15	

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F 323	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and measurements, the provider failed to assess half side rails for safety and entrapment (getting caught in) prior to utilizing them on the bed for one of one sampled resident (8) documented as having a half side rail. Findings include:</p> <p>1. Review of resident 8's 5/26/15 Minimum Data Set (MDS) assessment revealed she used bed rails daily.</p> <p>Review of resident 8's medical record revealed: *A 7/1/15 physician's order for "1/2 [half] side rails on outside of bed per resident request for security and to aid in repositioning." *Assessment for use of the half side rail had been completed on 11/24/14, 2/22/15, and 5/26/15. *There had been no assessment for the safety of the side rail.</p> <p>Interview on 8/12/15 at 3:35 p.m. with the director of nursing revealed they had not completed assessments for the safety of the side rails on resident 8's bed. She was the only resident in the building with the half side rails. They had no policy on completing safety assessments on the side rails.</p> <p>Observation, measurement review, and interview on 8/12/15 at 4:00 p.m. with resident 8 in her room revealed: *The resident stated the staff put the side rail up when she was in bed. *The side rail was metal and had five spaces between the bars.</p>	F 323	<p>All other residents' utilizing side rails, <i>*were reviewed NS/saach/JJ</i> to make certain that assessments of the safety of the side rails had been completed to ensure that those resident environments remained free of accident hazards as is possible.</p> <p>The Administrator, Medical Director, and Director of Nursing reviewed and revised, as necessary, the policies and procedures regarding the use of side rails so that they included the completion of assessments on the safety of the side rails to ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>The Director of Nursing or designee will audit once a month for three months all medical records for residents using a side rail to make certain that proper safety assessments have been completed on those side rails to ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p>		

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F 323	Continued From page 6 *The spaces measured from left to right eight inches, four inches, seven and three-quarters inches, four inches, and 8 inches. *Those spaces were large enough for a resident's head or limb to be entrapped.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	The medication fridge in the medication room was observed to ensure that refrigeration temperatures were maintained appropriately for medication storage.  All other medication fridges were reviewed to ensure that refrigeration temperatures were maintained appropriately for medication storage.  The Administrator, Pharmacist, and the Director of Nursing reviewed and revised, as necessary, the policies and procedures regarding medication refrigeration so that they included the proper maintenance procedure to ensure that refrigeration temperatures are being maintained appropriately for medication storage.  Education on the newly reviewed and revised medication refrigeration policies and procedures was provided to all staff responsible for logging and maintaining medication refrigeration temperatures.	10/1/15

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F 431	<p>Continued From page 7 be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, record review, interview, and policy review, the provider failed to ensure proper temperatures (between 36 to 46 degrees Fahrenheit [F]) were maintained for one of one refrigerator containing medications. Findings include:</p> <p>1. Observation on 8/12/15 at 9:40 a.m. in the medication room of the medication refrigerator revealed: *The thermometer inside of the door read 64 degrees F. *The thermometer on the top shelf read 52 degrees F. *There were various medications in the refrigerator for resident use including insulins, suppositories, Tuberculosis (a bacterial disease) testing solution, and emergency injectable medications.</p> <p>Review of the June, July, and August 2015 refrigerator temperature charts revealed temperatures with no documentation of action taken for the following out of range readings: *June 16, 48 degrees F. *July 1, 25, and 30 respectively were 48 F, 55 F, and 47 F. *August 5, 8, 9, and 10 respectively were 48 F, 48 F, 50 F, and 52 F.</p> <p>Interview on 8/12/15 at 9:50 a.m., 10:25 a.m., and 4:10 p.m. with the director of nursing regarding</p>	F 431	<p>The Director of Nursing or designee will audit the medication refrigeration temperature log once a week for one month and monthly for two more months to ensure that refrigeration temperatures are being maintained appropriately for medication storage.</p> <p>The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.</p>	

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F 431	<p>Continued From page 8</p> <p>medication refrigerator temperatures that had been out of the proper range revealed she:</p> <p>*Would have expected the nurse to:</p> <ul style="list-style-type: none"> <li>-Turn the temperature dial on the refrigerator up higher.</li> <li>-Recheck the temperature later.</li> <li>-Report it to her or maintenance.</li> <li>-Call the pharmacy to report the high temperature.</li> </ul> <p>*Agreed they did not follow their policy for monitoring medication refrigerator temperatures.</p> <p>Interview on 8/12/15 at 10:18 a.m. with pharmacist F regarding medication refrigerator temperatures that had been out of the proper ranged revealed:</p> <p>*He stated the above temperature readings were too high.</p> <p>*He would have expected the facility to call the pharmacy for instruction on what medications were safe to use and what medications would need to be replaced.</p> <p>*There was no record of the facility calling the pharmacy on any of those days listed above.</p> <p>Review of the provider's December 2014 Medication Fridge Policy revealed:</p> <p>***The refrigerator temperature is to be checked daily on both shifts."</p> <p>***The temperature must be between 36 and 46 degrees F."</p> <p>***Readings outside this range should be documented with actions documented/initialed."</p> <p>***Must call the Director of Nursing, the designee, or the maintenance director is [if] problem is not resolved."</p>	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 9  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	The disinfecting of the glucometer was observed to ensure that the manufacturer's instructions were being followed as to help prevent the development and transmission of disease and infection for residents 12 & 13 and all other residents with glucometer usage.  The Administrator, Medical Director, and interdisciplinary team reviewed and revised, as necessary, the policies and procedures regarding glucometer cleaning and disinfecting so that they included the manufacturer's instructions on disinfecting as to help prevent the development and transmission of disease and infection.  Education on the newly reviewed and revised glucometer cleaning policies and procedures was provided to all staff responsible for the disinfecting and cleaning of glucometers.  The Director of Nursing or designee will audit once a week for three months the process of disinfecting glucometers to ensure that the manufacturer's instructions are being followed as to help prevent the development and transmission of disease and infection.  The Director of Nursing or designee will present the findings of the audits at the monthly QAPI meetings with further follow up as recommended by the committee.	10/1/15

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

PRINTED: 08/24/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/12/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>AURORA BRULE NURSING HOME INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383</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 441	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121</p> <p>Based on observation, interview, policy review, and manufacturer's instructions, the provider failed to ensure disinfection of a glucometer (equipment used to measure blood sugar level) after use for two of two residents (12 and 13) who required blood sugar testing. Findings include:</p> <p>1. Observation on 8/11/15 at 11:15 a.m. of registered nurse (RN) B revealed after she had used the glucometer on resident 12 she: *Wiped the outside of the glucometer with a germicidal disposable cloth for three seconds. *Immediately placed the glucometer in a plastic container in the medication cart drawer.</p> <p>Observation on 8/11/15 at 5:27 p.m. of RN B revealed after she had used the glucometer on resident 13 she: *Wiped the outside of the glucometer with a germicidal disposable cloth for ten seconds. *Immediately placed the glucometer in a plastic container in the medication cart drawer.</p> <p>Interview on 8/11/15 at 5:32 p.m. with RN B revealed she did not know how long the glucometer was to be wet from the germicidal wipe to be effectively disinfected.</p> <p>Interview on 8/12/15 at 10:43 a.m. with the director of nursing and the infection control nurse regarding the disinfection of the glucometer revealed they agreed staff had not followed their policy for cleaning glucometers.</p> <p>Review of the provider's March 2014 Glucometer Cleaning Policy revealed after glucometer testing</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>AURORA BRULE NURSING HOME INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383</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 441	Continued From page 11 the nurse was to: *"Use the disinfectant wipe to clean all external parts of the glucometer." *"Leave surface wet per wipes protocol." *Place the clean glucometer "on another paper towel which is new and clean."  Review of the PDI Super Sani-cloth germicidal disposable wipes that had been used in the above observations revealed the disinfection instructions the nurse was to follow were: *"Unfold a clean wipe and thoroughly wet surface." *"Allow treated surface to remain wet for a full two (2) minutes." *"Use additional wipe(s) if needed to assure continuous two (2) minute wet contact time."	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/11/2015</b>
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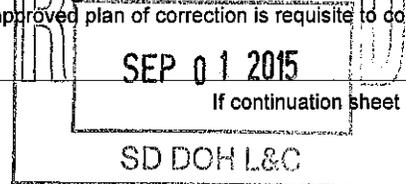
NAME OF PROVIDER OR SUPPLIER  <b>AURORA BRULE NURSING HOME INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383</b>
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K 000	INITIAL COMMENTS  Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/11/15. Aurora Brule Nursing Home Inc. 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 K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waving the foregoing statement, the facility states that with respect to:	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the type II emergency electrical service (EES) conformed to requirements set forth in National Fire Protection Agency (NFPA) 99 Standard for Health Care Facilities at one of one emergency system (emergency electric panel). Findings include:  1. Observation at 1:10 p.m. on 8/11/15 revealed an emergency panel in the boiler room. Further observation of the circuits tied to that panel revealed a circuit that was dedicated to the lawn irrigation system. Only circuits that are considered essential for the protection of life and	K 147	The emergency panel in the boiler room was observed to ensure only circuits that are considered essential for the protection of life and safety and effective operation of the institution shall be tied to the emergency electrical service.  All other emergency panels were observed to ensure only circuits that are considered essential for the protection of life and safety and effective operation of the institution shall be tied to the emergency electrical service.	10/11/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator 8-28-15</b>	(X6) DATE
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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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NAME OF PROVIDER OR SUPPLIER  <b>AURORA BRULE NURSING HOME INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383</b>		
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K 147	Continued From page 1 safety and effective operation of the institution shall be tied to the EES. Lawn irrigation would not be considered essential for the protection of life and safety.  Interview with the maintenance supervisor at the time of the observation confirmed that condition. He indicated he was unaware of the requirements for the EES system.	K 147	The Maintenance Director contacted an electrician to have the circuit that was dedicated to the lawn irrigation system removed from the emergency panel in the boiler room to the nearest available utility powered panel so that only circuits that are considered essential for the protection of life and safety and effective operation of the institution are tied to the emergency electrical service.  The Maintenance Director will audit on all emergency panels within the facility once per month for three months to ensure that only circuits that are considered essential for the protection of life and safety and effective operation of the institution shall be tied to the emergency electrical service.  The Maintenance Director will present the findings of the audit at the monthly QAPI meetings with further follow up as recommended by the committee.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10709</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/12/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AURORA BRULE NURSING HOME INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>408 S JOHNSTON ST WHITE LAKE, SD 57383</b>
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S 000	Initial Comments  Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/10/15 through 8/12/15. Aurora Brule Nursing Home Inc was found not in compliance with the following requirement: S236.	S 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waving the foregoing statement, the facility states that with respect to:	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Tuberculin screening requirements for healthcare workers or residents are as follows:  (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 35625 Based on employee file review, interview, and policy review, the provider failed to ensure: *Three of five sampled employees (A, D, and E)	S 236	Employee A, D, and E's files were reviewed to ensure that a two-step method of Mantoux skin test was completed properly within 14 days of employment or that any two documented Mantoux skin tests were completed within a 12 month period prior to the date of employment.  All other employee files were reviewed to ensure that a two-step method of Mantoux skin testing was completed properly within 14 days of employment or that any two documented Mantoux skin tests were completed within a 12 month period prior to the date of employment.  The Administrator, Business Office Manager, and interdisciplinary team reviewed and revised, as necessary, the policies and procedures regarding new hire Mantoux skin testing so that they included the timeliness of the two-step Mantoux skin test within 14 days of hire or that proper documentation of Mantoux skin test completed within a 12 month period prior to hire were obtained.	10/1/15

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

TITLE

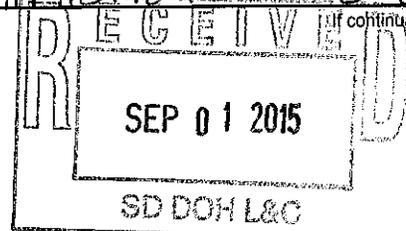
(X6) DATE

STATE FORM

6889

PZ3511

Administrator 8-28-15



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10709</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/12/2015</b>
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S 236	<p>Continued From page 1</p> <p>had documentation present in their file upon inspection to prove the two-step tuberculin (TB) screening had been completed within fourteen days of employment. *One of five sampled employees (A) received the TB screening within fourteen days of employment. Findings include:</p> <ol style="list-style-type: none"> <li>Review of employee A's file revealed: *She had been hired on 6/12/15. *The first step of the TB screening was started on 6/16/15, and the results were read on 6/18/15. *There was no documentation the second step of the TB screening had been started.</li> <li>Review of employee E's file revealed: *She had been hired on 7/22/15. *There was no documentation a two-step TB screening had been completed.</li> <li>Review of employee D's file revealed: *She had been hired on 7/27/15. *The first step of the TB screening was started on 7/27/15, and the results were read on 7/31/15. *There was no documentation the second step of the TB screening had been started.</li> <li>Interview on 8/12/15 at 3:30 p.m. with the director of nursing (DON) regarding the above TB screenings revealed: *Employee A did not have a two-step TB screening completed at the facility. -The first step was completed on 6/16/15, and the results read on 6/18/15. -A second step had not been given. -The employee had told the DON she had recent TB screening but had not gotten them that information. -Prior to the conclusion of the survey a May 2014</li> </ol>	S 236	<p>Education on the newly reviewed and revised new hire Mantoux skin testing policies and procedures was provided to all staff responsible for obtaining the necessary documentation and performing the new hire Mantoux skin test.</p> <p>The Administrator or designee will audit all new hire files once a month for 3 months and to ensure that two-step Mantoux skin tests are performed within 14 days of hire or that proper documentation of Mantoux skin tests were completed within a 12 month period prior to hire are obtained.</p> <p>The Administrator or designee will present the findings of the audit at the monthly QAPI meetings with further follow-up as recommended by the committee.</p>	
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South Dakota Department of Health

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S 236	<p>Continued From page 2</p> <p>TB screening was given to the surveyors with the DON acknowledging the time-frame was greater than twelve months.</p> <p>*Employee E had a two-step TB screening completed and documentation was submitted upon request.</p> <p>-No explanation was given as to why that information was not in the employee file.</p> <p>*Employee D did not have a two-step TB screening completed at the facility.</p> <p>-The first step was started on 7/29/15 with the results read on 7/31/15.</p> <p>-Results were faxed to the facility indicating the employee had a TB screening completed within the previous twelve months.</p> <p>*She acknowledged the information needed to be current in the employee's file.</p> <p>Review of the provider's February 2014 TB Policy and Procedure revealed:</p> <p>*"Each new employee or resident will receive the two-step method of Mantoux skin test [screening test for TB] within 14 days of starting employment.</p> <p>*If documentation of a one-step Mantoux in the past 12 months is provided, then one single dose will be given and this will be considered a two-step method."</p>	S 236		