

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

ORIGINAL

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

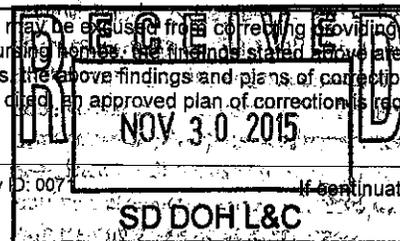
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580	
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F 000	INITIAL COMMENTS Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/2/15 through 11/5/15. Winner Regional Healthcare Center was found not in compliance with the following requirements: F221, F248, F280, and F514.	F 000	*Addendums noted with an asterisk per 12/14/15 per telephone with facility administrator. SW/SDDOH/EL	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on record review, observation, interview, and policy review, the provider failed to complete ongoing restraint assessments for three of three sampled residents (7, 9, and 12) with restraints. Findings include: 1. Review of resident 7, 9, and 12's medical records revealed: *Resident 7 used two half handrails for positioning when in bed. *Resident 9 used two quarter bedrails for positioning when in bed and a self releasing seat belt when he was in his wheelchair. *Resident 12 used a chest harness when he was in his wheelchair. *No restraint assessments had been completed for those residents in 2015.	F 221	F-221 1. A physical restraint assessment completed for resident's 7, 9, and 12 as of November 24, 2015. Director of Nursing has verified physician orders for #7 bed rails used for positioning, #9 bed rails for positioning and quick releasing seat belt in wheelchair for November 23, 2015. All other residents with restraints will be assessed by December 3, 2015. 2. The Director of Nursing and DOO reviewed policy November 23, 2015 and no changes were made. Staff will be educated on the existing policy and importance of documentation on November 30. Return demonstration of restraint assessment will be completed by all licensed nursing personal staff by December 3, 2015. All residents with restraints will be assessed upon admission, quarterly, annually and with significant change with MDS's. The assessments will be performed by nursing, MDS nurse, therapy and physicians. 3. Director of Nursing or designee will audit five (5) random residents charts for restraint assessment monthly for three (3) months then quarterly based on MDS calendar and further	12.03.2015

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting (provided 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 221	Continued From page 1 Random observations on 11/2/15 at 4:45 p.m. through 11/5/15 at 4:40 p.m. revealed the above restraints were being used for the above residents. Interview on 11/3/15 at 4:50 p.m. and on 11/4/15 at 12:00 noon with the director of nursing (DON) revealed she: *Confirmed no restraint assessments were found in resident 7, 9, or 12's medical records for 2015. *Would have expected the assessments to have been completed quarterly. *Stated they were not being completed. *Confirmed they were not following their physical restraints and restrictive devices policy and protocol. Review of the provider's revised July 2012 Restraints-Physical policy revealed the continued use of a restraint was to have been evaluated quarterly. Review of the provider's August 2012 Restraint/Restrictive Device Protocol revealed the continued use of a restraint or protective device was to have been evaluated at least quarterly to determine their continued need.	F 221	audits will be determined by the Quality Assurance team at quarterly Council meeting March 2016. The Director of Nursing or designee will report to Quality Council March 2016 and upon discretion of quality team will move forward.		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	F248 Care Plans, tasks and Point, Click, Care have been reviewed to ensure Residents #3 and #4 have had the Activity Interview for Daily and Activity Preferences initial interview and preference assessment completed as November 23, 2015 to ensure their desired quality of life. All other residents in the Special Care Unit will be assessed using the Activity Interview for Daily and Activity Preferences by December 3, 2015.	12.03.2015	

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F 248	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to make available meaningful individualized activities for two of two sampled residents (3 and 4) in the memory care unit. Findings include:</p> <p>1. Random observations on 11/3/15 from 10:00 a.m. through 5:30 p.m. and on 11/4/15 from 8:30 a.m. through 11:00 a.m. of resident 3 in the memory care unit revealed: *She was either having a snack, eating meals, or receiving care such as her bath. *The TV in the dining area was on to random TV shows. No music was played at any time. *She was given a haircut in the dining area. *No other activities took place.</p> <p>Review of resident 3's medical record revealed: *An admission date of 10/9/14. *Her BIMS (brief interview for mental status) showed severe mental impairment. *Her family rated listening to music as very important to her.</p> <p>Review of resident 3's 6/5/15 activities area of her care plan revealed: **Resident will attend and participate in sing-alongs and respond to music being played." **Arts and Crafts." **Baking." **Gardening." **Puzzles/Simple Word Games." **Working with Bird Houses/watching birds." **10/7/14 encourage [resident] to participate in games and group activities as she chooses."</p>	F 248	<p>2. Residents in the general care area will be assessed upon admission, quarterly, annually and with significant change with the DMDS schedule. The Activity Director and Director of Nursing reviewed the Special Care Unit Activities policy November 24,2015. Activities are to be charged in Point, Click, Care as they are completed. Staff will be educated on the existing policy and the importance of documentation on November 30, 2015.</p> <p>3. Audits will be performed on all residents of the Special Care Unit on a weekly basis by the Activity Director or designee and 2 residents randomly selected from each of the wings on the main floor until 21.31.2015. Audits will then be completed monthly for three months then quarterly. Continued audits will be determined by the Quality Assurance team during March, 2016 meeting. To ensure compliance, a yearly audit for compliance will be completed by the Activity Director of designee.</p> <p>4. This deficiency will be completed by December 3, 2015.</p>	

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F 248	Continued From page 3 Review of resident 3's October 2015 activity documentation report revealed: *Activities occurred eleven out of thirty-one days. *Those activities were exercise, resident council meetings, birthday party, cards, church, current events, mail, reminisce, social, and a sing-along. 2. Random observations on 11/3/15 from 10:00 a.m. through 5:30 p.m. and on 11/4/15 from 8:30 a.m. through 11:00 a.m. of resident 4 in the memory care unit revealed: *He was either seated at the dining table, sitting in an easy chair, or receiving care such as his bath. Those easy chairs were placed in a row and facing residents' rooms. *He had small objects in the chair next to him to work with. *He was given a hair cut in the living area as he sat in an easy chair. *No other activities took place. Review of resident 4's medical record revealed: *An admission date of 4/13/15. *His BIMS showed severe mental impairment with behaviors such as wandering and some aggression. *His family rated doing his favorite activities and animals as very important to him. Music was somewhat important. Review of resident 4's 4/23/15 activities area of his care plan revealed: **"Activities announced during meal times and overhead." **"Assist to activities." **"Calendars posted in rooms/by nurses desk/in newsletter." (Resident is severely impaired mentally.)	F 248			

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F 248	<p>Continued From page 4</p> <p>*"Remind of activities being offered." *"Arts and Crafts." *"Baking." *"Puzzles/Simple Word Games." *"Working with Bird Houses/watching birds."</p> <p>Review of resident 4's October 2015 activity documentation report revealed: *Activities occurred nine out of thirty-one days. *Those activities were exercise, resident council meetings, bible study, birthday party, current events, church, game night, mail, reminisce, and sing-alongs.</p> <p>Neither of the above resident's care plan was individualized for activities to meet their interests. There were no meaningful activities for those residents in the memory care unit.</p> <p>Review of the provider's October 2015 activity calendar revealed a statement at the bottom that read "Activities in the SCU [memory care unit] are limited to 15-20 minute increments due to attention span and the need for activities to be Modified to each individual."</p> <p>Interview on 11/4/15 at 10:55 a.m. with the activities director regarding activities in the memory care unit revealed she: *Had been in her position for at least a year. *Had not finished activities training but was in the process of doing so. *Stated activities done with residents in the memory care unit were: "nail care, singing, arts and crafts, social hour with a snack, and exercises in the afternoon." *"CNAs (certified nursing assistants) do all the activities." *Was unaware activities had not been done.</p>	F 248			

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F 248	Continued From page 5 *Agreed it was her responsibility to oversee activities in the memory care unit. *Was unsure what individualized and meaningful activities for memory care residents would be. Interview on 11/4/15 at 2:10 p.m. with the director of nursing regarding residents 3 and 4 revealed she agreed individualized and meaningful activities had not happened. Review of the provider's March 2012 LTC (long term care) Activities policy revealed: **A variety of activities shall be offered based on the comprehensive assessment, care plan, and resident or family input. They will be designed to meet each individual's interests, choices, needs, previous lifestyles, and daily schedules." **Activities shall be offered at a variety of times throughout the entire day including morning, afternoon, and some evenings and week-ends." **Assistance shall be provided to residents during activities."	F 248		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be 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,	F 280	F-280 1. Care plans have been reviewed and updated for residents 1 and 5 as of November 23, 2015. Review of all other residents' care plans by MDS nurse, dietary, social services and activities by December 25, 2015. 2. The Director of Nursing and DOO reviewed policy November 23, 2015 and no changes were made. Staff will be educated on the existing policy and importance of accurate updates on November 30, 2015. All other residents' care plans will be initiated within seven (7) days of admission, reviewed and updated quarterly, annually and with significant change with MDS's. The review will be completed by MDS nurse, Social Service, Activities and Dietary.	12.25.2015

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F 280	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to review and revise 2 of 13 sampled residents' (1 and 5) care plans to reflect their current health conditions. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *A 3/17/14 admission date. *She was independent with transfers and ambulation (ability to move from place to place). *A fracture of the left hip had occurred on 8/4/15 after a fall in her room. -The resident and her family declined to have the hip surgically repaired. -She returned to the nursing home from the hospital on 8/10/15. *Physical and occupational therapy worked with her until those services ended on 9/16/15. -She was discharged to restorative therapy. -She remained unable to bear weight on her left leg.</p> <p>Review of resident 1's 9/11/15 Minimum Data Set (MDS) assessment revealed she: *Required the extensive assistance of at least two people to transfer, get dressed, and use the</p>	F 280	<p>3. The Director of Nursing or designee will audit five (5) residents monthly for three (3) months, then quarterly based on the MDS calendar and further audits will be determined by the Quality Assurance team at quarterly council meeting March, 2016. The Director of Nursing or designee will report to Quality Council March, 2016 and upon discretion of quality team will move forward.</p> <p>4. This deficiency will be completed by December 23, 2015.</p>		

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F 280	<p>Continued From page 7 bathroom.</p> <p>*Was unable to walk in her room or the corridor.</p> <p>Review if resident 1's undated and current care plan revealed she:</p> <p>*Required the limited assistance of one staff person with her grooming, dressing, toileting, and oral care.</p> <p>*Would take herself to the bathroom.</p> <p>*Was able to walk in her room safely and used the wheelchair for longer distances.</p> <p>Review of resident 1's 11/2/15 certified nursing assistant (CNA) quick reference care guide revealed:</p> <p>*She used a Hoyer lift (mechanical equipment using a sling to lift resident from one place to another) for transfers, toileting, and activities of daily living.</p> <p>*A Broda (wheelchair that tilts and reclines) chair was used to move her from one area to another.</p> <p>Interview on 11/4/15 at 5:10 p.m. with the director of nursing regarding resident 1's care plan revealed:</p> <p>*The resident required a higher level of care than what the care plan reflected.</p> <p>*She acknowledged it had not been updated to reflect the resident's current needs following her hip fracture.</p> <p>Interview on 11/5/15 at 8:55 a.m. with CNA G regarding resident 1 revealed:</p> <p>*She was not able to walk on her own.</p> <p>*The Hoyer lift was used with two staff assisting her.</p> <p>*The quick reference guide was used with each resident, and it was frequently updated.</p> <p>*If a CNA had any additional concerns they would</p>	F 280			

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F 280	<p>Continued From page 8 use their walkie-talkies to request nurse assistance.</p> <p>Surveyor: 35121 2. Observation on 11/3/15 at 3:54 p.m. of CNAs A and H doing care with resident 5 revealed: *A Hoyer lift was used to transfer him from his bed to his wheelchair. *The lift was operated by both of the above CNAs. *The resident was dependent (relied on help from others) on staff for transfers and wheelchair mobility.</p> <p>Review of resident 5's medical record revealed: *He had fallen on 10/2/15 while being lifted with a mechanical easy lift (device that lifts a person from a sitting to a standing position). *A Hoyer lift with the assistance of two staff members had been used since that fall.</p> <p>Review of resident 5's undated and current care plan revealed he was to have been: *Assisted only as necessary. *Lifted with a mechanical "easy" lift with the assistance of one staff member. *Able to bring himself to the dining room via his wheelchair for meals. *Instructed to lock the wheels on his wheelchair before rising.</p> <p>Interview on 11/5/15 at 8:45 a.m. with the MDS registered nurse (RN) regarding resident 5's care plan and her responsibilities revealed: *Resident 5: -Needed assistance with his wheelchair. -Did not stand on his own. *The MDS RN stated she: -Was responsible for updating the care plans.</p>	F 280			

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F 280	Continued From page 9 -Had not updated resident 5's care plan to reflect his current needs. -Had not followed their policy for updating their care plans. Review of the provider's January 2012 Care Plans policy revealed: *"The care plan is developed from the resident assessment (MDS) [Minimum Data Set] and in coordination with the attending physician's regimen of care." *"The care plan is reviewed as necessary, but at least quarterly." *"Care plans are revised as changes in the resident's condition dictates." *"Daily care and documentation must be consistent with the resident's care plan."	F 280		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 29354	F 514	F514 1. A fall risk assessment completed for residents 2, 5, and 10 as of November 24, 2015. All residents will have fall risk assessment by December 15, 2015. 2. The Director of Nursing and DOO reviewed policy November 24, 2015 and no changes were made. Staff will be educated on the existing policy and importance of fall risk assessments November 30, 2015. All other residents will have the fall risk assessment completed upon admission, quarterly, annually and with significant change with MD's. The updates will be completed by the MDS nurse. 3. Director of Nursing or designee will be performed on five (5) residents monthly for three (3) months; then quarterly based on MDS calendar and further audits will be determined by the quality Assurance Team at quarterly council meeting March, 2016. The Director of Nursing or designee will report to	12.15.2015

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F 514	<p>Continued From page 10</p> <p>Based on record review, interview, and policy review, the provider failed to have completed fall risk assessments for three of three sampled residents (2, 5, and 10) with falls. Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 2's medical record revealed she had two falls from March 2015 through November 5, 2015. One of the falls resulted in a major injury. There was no documentation fall risk assessments had been completed for any falls. 2. Review of resident 10's medical record revealed she had four falls from July 2015 through November 5, 2015. There was no documentation fall risk assessments had been completed for any falls. <p>Surveyor 35121</p> <ol style="list-style-type: none"> 3. Review of resident 5's medical record revealed he had fallen on 10/2/15. There was no documentation a risk for falls assessment had been completed for any falls. 4. Interview on 11/4/15 at 2:50 p.m. with the DON regarding risk for falls assessments for the above residents revealed they were not: *Being completed quarterly. *Following their falls policy. <p>Interview on 11/5/15 at 8:15 a.m. with the Minimum Data Set (MDS) registered nurse (RN) revealed: *She had not completed any fall risk assessments on residents 2 and 10. *They used to complete fall risk assessments on residents a long time ago but had stopped. *She felt they should be completing fall risk assessments on all residents.</p>	F 514	<p>Quality council March, 2016 and upon discretion of quality team will move forward.</p> <p>4. Deficiency will be completed by December 15, 2015.</p>	

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: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/05/2015
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580		
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F 514	Continued From page 11 Interview on 11/5/15 at 8:40 a.m. with the director of nursing (DON) revealed: *Her expectations were for fall risk assessments to be completed on all residents. *They were looking at implementing a fall risk management meeting. Surveyor: 35121 Review of the provider's revised October 1999 Falls policy revealed a Risk for Falls Assessment for all residents was to have been reviewed 30 days after admission and quarterly thereafter.	F 514			

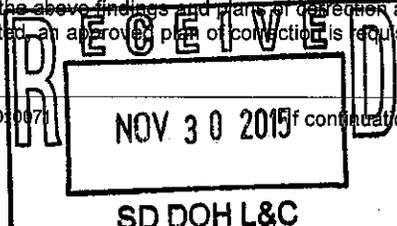
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2015
NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580	
(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: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/4/15. Winner Regional 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 deficiency identified at K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 12/3/15 per telephone with facility administrator. LF/SDDO/H/EL	
K 062 SS=C	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: 32334 Based on observation and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with the National Fire Protection Association (NFPA) 25 (corroded sprinkler heads found in the kitchen and 300 wing tub room). Findings include: 1. Observation at 11:25 a.m. on 11/4/15 in the dietary kitchen revealed two quick response sprinkler heads near the commercial kitchen hood. Those two sprinkler heads had extensive	K 062	Upon notification of the deficiency, *LF/SDDO/H/EL Maintenance Supervisor [redacted] performed a visual inspection of the Dietary heads in question. A greenish discoloration was observed on the sprinkler head as well as obvious rusting on the chrome escutcheon. A phone conversation with Building Sprinkler, Inc. (Sioux Falls, SD - 605-334-1880) did confirm this to be corrosion. A visual inspection in the 300 tub room did not reveal that same greenish tint but the rusting of the chrome escutcheon is present. CORRECTIVE ACTION - Building Sprinkler, Inc. has been instructed to inspect and/or replace any of the other 16 heads in the kitchen which also includes the dishwashing room. Completion date will be prior to December 25, 2015. Building Sprinkler, Inc. will replace the 2 sprinkler heads in the 300 tub room. They have also been instructed to inspect and/or	12.23.2015

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

TITLE

(X6) DATE

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 WINNER REGIONAL HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 805 E 8TH ST WINNER, SD 57580		
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K 062	<p>Continued From page 1</p> <p>corrosion build-up due to the high humidity from cooking. Corrosion build-up on sprinkler heads has the potential to impair the functionality of the sprinkler head. That issue was also found in the 300 wing tub room due to the high humidity environment in that room.</p> <p>Interview with the maintenance supervisor at the time of the above observations confirmed that condition. He indicated he was aware the tub room sprinkler head was corroded. He indicated he had planned on having the sprinkler service vendor replace that head during the next annual inspection.</p>	K 062	<p>replace 2 more heads in the tub room of the secured unit.</p> <p>QUALITY ASSURANCE – The standard heads, usually installed as a result of bid letting, will be upgraded to the nickel plated sprinkler heads. These heads are recommended for areas of higher humidity and are more resistant to corrosion.</p> <p>In addition, sprinkler head inspection will be added to the monthly safety walk-through form. This survey is then reviewed at the monthly Safety meeting with deficiencies then being returned to the proper department for correction.</p> <p>Building Sprinkler, Inc. will continue to do annual inspections, typically in March.</p>		

ORIGINAL

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10713	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2015
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NAME OF PROVIDER OR SUPPLIER WINNER REGIONAL HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 805 EAST 8TH ST WINNER, SD 57580
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S 000	Compliance/Noncompliance Statement Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 11/2/15 through 11/5/15. Winner Regional Healthcare Center was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	S206 1. Temporary agency staff, A, B, C, D, and E will complete personal training utilizing Sanford Learn programs by December 20, 2015. All other temporary staff not meeting education requirements will receive necessary training by December 20, 2015. 2. Director of Nursing and Education Nurse will develop policy for continued education for all temporary staff utilizing Sanford Learn prior to any resident contact. Programs and training to include: Fire prevention and response, Emergency procedures and preparedness, Infection Control and prevention, Accident prevention and safety procedures, proper use of restraints, resident rights, confidentiality of resident information, incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms, care for residents with unique needs, dining assistance (nutritional risks and hydration needs), and abuse neglect, misappropriation of resident property and funds and mistreatment. Education to staff completed November 30, 2015. Staffing Scheduler will monitor.	12.20.2015

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

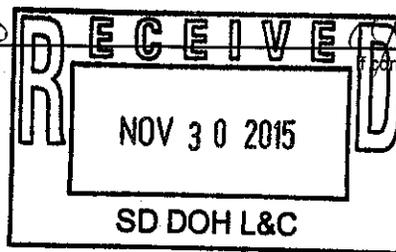
TITLE

(X6) DATE

STATE FORM

6899

CEO
UQWU11



11/15/15
Continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10713	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2015
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S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29354 Based on interview and personnel file review, the provider failed to have an ongoing orientation education program for five of five sampled temporary (temp) agency staff (A, B, C, D, and E). Findings include:</p> <p>1. Review of the personnel files for temp agency staff A, B, C, D, and E revealed they had not received any training upon having been hired or ongoing education for the following required topics: *Accident prevention and safety procedures. *Patient and resident rights. *Incidents and diseases subject to mandatory reporting or the facility's reporting mechanisms. *Dining assistance, nutritional risks, and hydration (fluid) needs of residents.</p> <p>Interview on 11/4/15 at 1:30 p.m. with the director of nursing revealed: *The temp agency staff had not received the above training upon being hired or ongoing. *She confirmed: -She was not sure if the temp agencies had provided the above training for their staff. -There was not any documentation in the above personnel files regarding the required training. -There was not a temp agency policy. -They did not have an in-service training policy.</p>	S 206	<p>3. Director of Nursing or designee will monitor current education temporary staff has and provide education on any missing educational requirements monthly for three (3) months and then quarterly. Further audits will be determined by the Quality Assurance team at quarterly council meeting March, 2016. The Director of nursing or designee will report to quality council March, 2016 and upon decision of quality team will move forward.</p>	