

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2015
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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F 000	INITIAL COMMENTS Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/10/15 through 3/11/15. Prairie View Care Center was found not in compliance with the following requirements: F281, F314, and F371.	F 000	<p><i>Addendums noted with an asterisk per 4/9/15 telephone to facility administrator. JAR/SDDH/MF</i></p> <p>The facility states that with respect to:</p> <p>F281</p> <p>1. Employee A was re-educated on manufacture recommendations of Novolog insulin on 3-12-15. Reviewed all residents receiving Novolog insulin and clarified orders with primary care physicans.</p> <p>2. A guideline outlining Novolog Insulin manufacturer recommendations was reviewed with nursing staff on 3-24-2015. A guideline for obtaining insulin orders was developed and all nurses will be educated on 4-3-2015.</p> <p><i>*for timing of insulin with/without food</i></p> <p>3. Director of Nursing or designee will audit all new insulin orders received in the next 3 months. The Director of Nursing or designee will report the results of the review to the QA committee every three months. The reviews will continue until the QA committee advises to discontinue.</p>	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, manufacturer's instructions review, and policy review, the provider failed to ensure the medication short acting insulin had been administered as the manufacturer indicated for one of two sampled residents (14) with insulin administration observations. Findings include: 1. Observation on 3/10/15 at 10:24 a.m. revealed registered nurse (RN) A had administered Novolog insulin to resident 14. After the insulin had been administered the resident left her room and went to the dining room to watch television. That resident did not receive her lunch until 11:34 a.m. Review of the manufacturer NovoLog website accessed on 3/12/15 at 8:30 a.m. revealed the insulin was to have been given within five to ten minutes before a meal.	F 281		4-7-2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kristi Hill</i>	TITLE Acting Admin	(X6) DATE 4-1-15
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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.

DISCLOSED

APR 03 2015

If continuation sheet Page 1 of 16

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F 281	Continued From page 1 Review of the provider's undated Administration of Medications: Subcutaneous injections policy did not reveal when the medication was to have been given in relationship to food or meal intake. Review of the provider's undated Omniview drug information revealed "Inject this medication under the skin as directed by your doctor, usually five to ten minutes before meals." Review of the provider's undated Insulin Products Comparison Chart revealed "Novolog insulin to be administered five to ten minutes before meals." Interview on 3/11/15 at 9:00 a.m. with the interim administrator, the director of nursing, and the Minimum Data Set (MDS) assessment nurse confirmed they would have expected the manufacturer's recommendations to have been followed. They confirmed the Insulin Products Comparison Chart had been present in both medication administration record (MAR) notebooks for nurses to reference when administering insulin.	F 281			
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314			

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F 314	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Preceptor: 16385 Based on observation, interview, record review, and policy review, the provider failed to ensure skin integrity (normal condition) was maintained for two of three sampled residents (1 and 5) with skin breakdown. Findings include:</p> <p>1. Review of resident 5's medical record revealed he: *Was initially admitted on 4/4/12. *Was re-admitted from the hospital on 1/20/15 with a diagnosis of Influenza A. *Had other diagnoses that included dementia, left side weakness from a cerebral vascular accident (CVA [stroke]), generalized pruritis (itching), and constipation.</p> <p>Review of the 1/20/15 Nursing Admission Assessment revealed he: *Was alert with memory problems. *Did not have anything checked for skin conditions present at that time. *Was not able to ambulate or transfer independently and required limited assistance. *Had been occasionally incontinent (unable to control) of urine. *Was on a scheduled toileting program. *Used liners or briefs for incontinence. *Had a poor appetite.</p> <p>Review of the 1/20/15 Braden Scale Assessment (type of skin assesement) revealed a score of 17 indicating he was at moderate risk for</p>	F 314	<p>F314</p> <p>Resident 5:</p> <p>1.Nursing staff removed the pressure equalization pad from resident 5's wheelchair on 3/11/15 and replaced it with a gel pad cushion. On 3/11/15 residents plan of care was updated indicating he had an open area to his buttocks. Interventions regarding: sore treatment from recent physician visit, toileting and repositioning were also added to the plan of care on 3/11/15.</p> <p>2.A facility policy regarding air filled cushions is implemented and will be effective on 4/3/15. All air filled cushions in use by residents are assessed to ensure they are in compliance with implemented policy. A policy is also implemented indicating the allotted time frame to update a resident's plan of care and who is responsible for these changes. All nursing staff will attend an in-service on 4/3/15 to be</p>	4-7-15
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F 314	<p>Continued From page 3 pressure ulcers (open area to the skin from too much pressure).</p> <p>Review of the 3/6/15 Non-Pressure Skin Condition Report revealed: *A 0.4 centimeter (cm) (unit of measure) by 0.7 cm open sore to his left buttock. -The surrounding skin and wound edges were normal for skin. *A standing order was started to apply Calmoseptine ointment to the area twice a day as needed. *To encourage the resident to lay down in the p.m. *To toilet the resident every two hours. *The physician and family were notified that same day. *Dietary had not been notified. *There were boxes to indicate if the plan of care had been updated, and nothing was checked.</p> <p>Review of the 3/9/15 physician's orders revealed he was seen by his physician that day. The physician ordered to keep the pressure off his buttocks at least two hours in the a.m. and in the p.m.</p> <p>Review of resident 5's current care plan with a last revised date of 3/9/15 revealed: *He had short and long term memory problems. *He had dry itchy skin that was delicate and would tear easily. *"MASD (moisture associated skin damage) to groin." *Interventions for skin included to: -Remind the resident to change positions frequently. -Use a gel pad in his wheelchair. *The resident needed assistance with activities of</p>	F 314	<p>educated on the air filled cushion policy and the updating of resident care plans.</p> <p>3. The DON or designee will monitor compliance with the air filled cushion policy: twice weekly X1 month, once weekly X1 month, twice monthly X1 month, monthly X1 month. DON or designee will monitor compliance with care plans: 3 times weekly X1 month, 2 times weekly X1 month, once weekly X 2 months. DON or designee will report findings of both audits at facilities QA meeting until the QA committee feels it is appropriate to discontinue auditing.</p> <p>Resident 1:</p> <p>1. Nursing staff verifies physician's treatment orders for the community acquired sore to resident #1's left heel on 3/11/15. Facility is in compliance as resident has a duoderm dressing intact. Ensured that all treatments for resident with skin conditions are being carried out and documented appropriately on the MAR.</p>	

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F 314	<p>Continued From page 4 daily living. *He had been continent of bowel and bladder. *Staff would assist him to the toilet as needed. *There had been no mention of: -The open area to his left buttock. -The treatment to the open area. -The physician's orders from 3/9/15 to treat the open. -How often staff would assist him to the toilet and reposition him.</p> <p>Observation on 3/10/15 at 11:30 a.m. revealed resident 5 had been sitting in his wheelchair in the dining room. At 1:35 p.m. that same day he was laying down in his bed. At that same time his wheelchair had been noted to have a cushion in the seat with a black cover. That cushion appeared to have bumps on the surface. Upon further inspection it was a rubber type of air-filled cushion and had a valve to add or remove air. The cushion appeared to have little air in it.</p> <p>Observation and interview on 3/10/15 at 1:40 p.m. with registered nurse (RN) A revealed she did not know what kind of cushion resident 5's wheelchair had been.</p> <p>Interview on 3/10/15 at 2:45 p.m. with the director of nursing (DON) and Minimum Data Set (MDS) assessment nurse revealed they had looked at the cushion. The cushion was called a position equalization pad. When questioned if it was an air-filled type of cushion the DON said it had not been. She referred to the bumps on the cushion as "wavy foam things."</p> <p>Observation and interview on 3/11/15 at 11:00 a.m. of resident 5's transfer from the toilet to his wheelchair with certified nursing assistants (CNA)</p>	F 314	<p>2. Facility is creating a skin integrity performance improvement project to identify residents at risk for skin breakdown, review the treatments currently in place and work together as an interdisciplinary team to ensure all residents are receiving the best preventative care and treatments for their individualized needs. The first meeting is scheduled for 4/9/15. A policy regarding admission skin assessments is implemented and will be effective 4/3/15. This policy indicates that nursing staff is to assess (including measuring) all sores within 24 hours of admission/readmission unless otherwise indicated by physician. As a part of this policy the facility has created a communication form for nursing staff to report to the DON or</p>		

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F 314	<p>Continued From page 5</p> <p>C and D and RN E revealed:</p> <ul style="list-style-type: none"> *An open area to his left buttock. -Approximately the size of a pencil eraser. *The surrounding skin on his left and right buttocks was noted to be purplish in color. *CNA C stated therapy or restorative would implement the type of cushion a resident would use. She was unsure how long the resident had been using the current cushion. <p>Observation on 3/11/15 at 12:15 p.m. revealed resident 5's cushion in the wheelchair remained the same as the above observation on 3/10/15.</p> <p>Interview on 3/11/15 at 11:00 a.m. with the DON revealed:</p> <ul style="list-style-type: none"> *The MDS nurse primarily updated care plans on everyone. Those updates would have been completed within one to two days. *The certified nursing assistants would have looked at the care plan for information about each resident. *She confirmed resident 5's care plan had not mentioned: <ul style="list-style-type: none"> -The open area to his left buttock. -How often staff should have assisted him to the toilet. -That he was incontinent. -How often staff should have assisted him with repositioning. -The physician's orders for treatment to the open area or to keep pressure off his buttocks at least two hours in the AM and PM. -The current air-filled cushion that was in place to his wheelchair. *She agreed the cushion had been an air-filled type of cushion and would potentially cause more harm to the resident's skin if it was not aired up properly. 	F 314	<p>designee if medications or supplies do not arrive from the pharmacy in a timely matter. All nursing staff will attend an in-service on 4/3/15 for education on the above policies.</p> <p>3. The DON or designee will oversee the skin integrity performance improvement project. The DON or designee will also monitor the timeliness of skin assessments with each admission or readmission to facility X3 months. DON will report findings of this audit at facility QA meeting and will continue to monitor until QA committee feels it is appropriate to discontinue auditing.</p>	
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quaternary assessment

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F 314	<p>Continued From page 6</p> <p>*Therapy or restorative would have decided which cushion the resident needed.</p> <p>Interview on 3/11/15 at 12:50 p.m. with restorative aide B revealed she would be the one who aired up the cushion. She did not have a specific schedule to check the air in the cushion. She mentioned they had other resident's using air-filled cushions as well.</p> <p>Review of the providers 10/1/13 Care Plans - Comprehensive policy revealed: *2. The comprehensive care plan is based on a thorough assessment...Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change." *3. Each resident's comprehensive care plan is designed to:" - "a. Incorporate identified problem areas;" - "b. Incorporate risk factors associated with identified problems;" - "f. Identify the professional services that are responsible for each element of care;" - "g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels;" - "i. Reflect currently recognized standards of practice for problem areas and conditions."</p> <p>Surveyor: 32355 2. Review of resident 1's medical record revealed: *An admission date of 2/11/15. *Diagnoses of right hip fracture (broken bone) with repair, dementia (forgetfulness), and a stage I pressure ulcer (red, intact [unbroken] skin, over a bony prominence [bone]) to the left heel.</p>	F 314		
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F 314	<p>Continued From page 7</p> <p>*He had acquired the stage I pressure ulcer on his left heel during his stay at the hospital.</p> <p>*He had been dependent upon staff to assist him with all of his mobility needs (transferring from place to place and moving in bed) and ADL needs.</p> <p>Review of resident 1's 2/11/15 Braden Scale Assessment revealed a score of 13. That score indicated the resident was at moderate risk for developing pressure ulcers.</p> <p>Review of resident 1's 2/11/15 physician's admission orders revealed: *He had a wound to the left heel with an optifoam dressing (medicated type of dressing) applied on 2/11/15 by the hospital staff. *That dressing was to have been changed every three days and as needed (PRN).</p> <p>Review of resident 1's weekly pressure ulcer record revealed: *The response to treatment/comments were: -2/11/15 "There is a medicated patch to heel that is intact. I do not have another patch to replace so did not measure at this time." -2/21/15 "Has 0.6 x (by) 1 centimeter (cm) light brown area with skin intact. Duoderm (protective dressing) on to be changed every 3 days and PRN until healed. Protective boots in place." *No documentation to support the wound had been assessed by the nursing staff prior to 2/21/15.</p> <p>Review of resident 1's 2/11/15 admission head-to-toe physical assessment revealed no documentation to support any abnormal skin problems were assessed. The comments documented were to "See skin assessment."</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>Review of resident 1's bath schedule from 2/13/15 through 3/6/15 revealed he had: *An admit bath on 2/13/15 with no skin issues documented. *A bath on 2/15/15 with documentation of a dressing that was intact to his left heel. *No documentation to support any further skin assessments had been done on his bath days.</p> <p>Review of resident 1's February 2015 medication administration record (MAR) revealed: *He had an order for an optifoam dressing to be applied to his left heel and changed every three days with a start date of 2/11/15. *No staff initials or documentation supported that dressing had been observed to be in place, removed, re-applied, or discontinued from the time of admission on 2/11/15 through 2/28/15. *On 2/22/15 a hand written order stated "Duoderm to left heel pressure sore. Change every 3 days and PRN until healed." *No documentation to support the resident's left heel had a treatment or protective dressing in place until 2/22/15.</p> <p>Review of resident 1's physician's order revealed: *The resident had been assessed by his primary physician on 2/13/15. *The physician had signed his admission orders on 2/13/15. *On 2/13/15 the provider was to have continued with the optifoam dressing to his left heel. *On 2/26/15 the provider faxed a concern to his primary physician. The concern had stated "Resident has 0.6 x 1 cm pressure sore to left heel that he had upon admission. Area is dry with skin intact, light brown in color. Standing order wrote for Duoderm to area change every 3 days</p>	F 314		
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F 314	<p>Continued From page 9 and PRN." That request was approved by the physician on 2/26/15. *No documentation to support: -The physician had been aware of a treatment change to his left heel prior to 2/26/15.</p> <p>Review of resident 1's 2/24/15 Minimum Data Set admission progress note revealed "Resident has a document pressure ulcer to left heel. Ulcer not measured at this time as dressing is intact. Ulcer not staged at this time."</p> <p>Review of resident 1's 2/24/15 Comprehensive Area Assessment documentation revealed: *He had been at high risk of obtaining pressure ulcers. *The risk factors identified were: -"Requires staff assistance to move sufficiently to relieve pressure over any one site." -"Confined to a bed or chair all or most of the time." -"Potential for friction and shearing (rubbing against a surface) when moved by sliding rather than lifting." *He had a pressure ulcer to his left heel. **"Dressing in place on heel and no measurements available. Site is un-staged at this time."</p> <p>Review of resident 1's nursing progress notes from 2/11/15 through 2/24/15 revealed no documentation to support the wound had been assessed for worsening or healing conditions, and was free from signs and symptoms of infection.</p> <p>Interview on 3/12/15 at 11:10 a.m. with the DON revealed: *The staff should have removed the optifoam</p>	F 314		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 314	<p>Continued From page 10</p> <p>dressing and assessed resident 1's left heel upon admission on 2/11/15.</p> <p>*An assessment of the resident's left heel should have been done no later than day three after his admission. That had been due to the orders for the dressing to be changed every three days.</p> <p>*She was not able to locate any documentation to support the wound had been assessed prior to 2/21/15.</p> <p>Review of the provider's undated Attention Nurses procedure revealed:</p> <p>**"Please fill out Skin Assessment forms when you see new skin issues. Please include a description and what happened."</p> <p>**"Fax the doctor regarding these issues."</p> <p>**"Please make sure treatment is getting done as ordered (creams, duoderms,)."</p> <p>**"These cannot be monitored if we do not know about them."</p> <p>Review of the provider's 12/12/11 Pressure Ulcer Prevention policy revealed:</p> <p>*Purpose "To promote health intact skin, and prevent breakdown."</p> <p>*Policy "All residents will have a skin risk assessment performed on admission, readmission with each RAI (resident assessment intervention) assessment, and with any significant change in status."</p> <p>*Policy "Resident's that are identified as 'at risk' will have interventions initiated to reduce the risk of skin breakdown."</p> <p>*Procedure:</p> <p>- "Promote optimum mobility and activity to prevent skin breakdown."</p> <p>- "Bath aid will keep a daily log of all skin concerns and present them to the charge nurse at the end of the shift. Charge nurse is then responsible to</p>	F 314		
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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: 435118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2015
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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F 314	<p>Continued From page 11 follow up on any and all concerns." *Interventions: -"Implement a turning schedule, changing position at least every 2 hours (this does not mean in bed only). Position changes can be made in chairs and with toileting." -"Limit sitting time to no longer than two hours at a time, whether in bed, chair or wheelchair." -"Place a pressure reduction device on the bed and or wheelchair." -"Inspect area at least once a day." Review of the provider's 12/13/11 Treatment Protocol for wounds revealed: *Purpose "To maintain and improve skin integrity." *Foundation for treating pressure ulcers: -Relieve pressure. -Treat appropriately and consistently. **Families and physicians will be updated with any changes."</p>	F 314		
F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p>	F 371	<p>The facility states that with respect to: F 371</p> <p>1. On March 12th-Dietary Manager provided re-education to employee F and G regarding food temps and procedures to use to reach proper food temps. The</p>	4-7-15

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F 371	<p>Continued From page 12</p> <p>Based on observation, record review, interview, guideline review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> * Maintain proper sanitizing after washing hands by one of two observed cooks (F). *Test all foods for safe and appropriate temperatures prior to being served to residents for two of two meal observations by two of two cooks (F and G). <p>Findings include:</p> <ol style="list-style-type: none"> 1. Random observations on 3/10/15 from 2:30 p.m. through 5:10 p.m. of cook F washing her hands during a meal preparation revealed: <ul style="list-style-type: none"> *She had washed her hands several times. *Five times she had been observed turning the water faucet handle off without the use of a paper towel. *She was not observed re-washing or sanitizing her hands during those observations. 2. Review of the menu for 3/10/15 revealed: <ul style="list-style-type: none"> *For dinner the following foods were to be prepared and served: <ul style="list-style-type: none"> -Lasagna. -Wax beans. -Coleslaw. -Sliced bread with margarine. *For supper the following foods were to be prepared and served: <ul style="list-style-type: none"> -Creamed turkey on biscuit. -Deviled egg. -Peas. -Mandarin oranges. <p>Observation on 3/10/15 from 11:25 a.m. through 11:40 a.m. of three plates located in the serving area of the kitchen revealed:</p> <ul style="list-style-type: none"> *They had been sitting on the counter and were 	F 371	<p>Dietary Manger provided education to employee F regarding proper hand washing on March 12th.</p> <ol style="list-style-type: none"> 2. The Dietary Manager provided re-education to the All Staff regarding food temperatures, procedure to temp foods, and handwashing on March 24th. A guideline was created identifying the procedure to use when reheating items. This new guideline has been implemented into the new staff orientation program. A hand washing posters will be placed by dietary sanitation sink. 3. The Dietary Manager or designee will audit food temps 4 times per week for one month then 2 times per week for one month then twice monthly. The Dietary Manager or designee will audit hand washing 2 times per week for one month then 1 time per week for one month then twice monthly. The Dietary Manager or designee will report the results of the review to the QA committee every three months. The reviews will continue until the QA committee advises to discontinue. 	
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 371	<p>Continued From page 13 covered with plastic. *There had been three different types of blended foods on each plate. *At 11:30 a.m. cook G: -Placed one of those plates inside a microwave. -Turned the microwave on to heat the food prior to serving. -Had left the plastic on the food during the heating process. *At 11:32 a.m. cook G: -Removed the above plate from the microwave and opened a portion of the plastic. A large amount of steam was released from the plastic as it was opened. -Gave the plate to an unidentified staff member to serve a resident. -Had not been observed checking the temperature of the food after re-heating it in the microwave and prior to being served. *At 11:40 a.m. cook G was observed doing the same process above with another plate of blended foods.</p> <p>Observation and testing on 3/10/15 from 11:25 a.m. through 12:10 p.m. of prepared foods located in the steam table revealed: *Cook G had checked the temperatures of the foods listed on the dinner menu. *At 11:50 a.m. through 12:10 p.m. cook G: -Removed tinfoil from three food wells located in the steam table. Inside of those food wells was pork chops, mashed potatoes, and mixed vegetables. -Had been observed serving the above foods to residents five times. -Had not been observed checking the temperature of those three foods prior to them being served to residents.</p>	F 371		
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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F 371	<p>Continued From page 14</p> <p>Observation on 3/10/15 from 5:30 p.m. through 5:50 p.m. of a plastic rectangular bucket located inside a portion of the steam table revealed: *Blended creamed turkey covered with plastic. *Cook F: -Removed the plastic and served the blended food three times. -Had re-heated the food in the microwave all three times. -Had not been observed checking the temperature of the food prior to it being served to residents.</p> <p>Interview on 3/11/15 at 9:50 a.m. with the certified dietary manager revealed: *Cook F should have used a paper towel to turn off the water faucet handle after washing her hands. *The temperature of all foods were to have been checked prior to being served to the residents. *She had no audits to support the cooks were randomly observed and monitored during the serving process of meals.</p> <p>Review of the provider's February 2015 Food Temperature log revealed: *On 2/10/15: -The lasagna, waxed beans, and coleslaw were the only foods documented as being checked for the proper temperature prior to being served by cook G. -The creamed turkey, peas, and fruit were the only foods documented as being checked for the proper temperature prior to being served by cook F.</p> <p>Review of the provider's undated Handwashing policy for the dietary department revealed "Consider using a paper towel to turn off the</p>	F 371		
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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F 371	<p>Continued From page 15 faucet."</p> <p>Review of the provider's undated Hand Hygiene Competency Criterion checklist revealed "Turn faucet off using a dry paper towel to touch the handle, protecting your clean hands from the contaminated handle."</p> <p>Review of the provider's undated Guidelines for Serving of Meals revealed no procedure in place for checking the temperatures of all foods prior to being served.</p>	F 371		
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SOUTH FIRST AVENUE POST OFFICE BOX 68 WOONSOCKET, SD 57385
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/10/15. Prairie View Care Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kristi Lee</i>	TITLE <i>Acting Admin</i>	(X6) DATE <i>4-1-15</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.

DISCLOSED

APR 03 2015

If continuation sheet Page 1 of 1

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10714	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2015
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NAME OF PROVIDER OR SUPPLIER PRAIRIE VIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 S 1ST AVE WOONSOCKET, SD 57385
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S 000	<p>Initial Comments</p> <p>Surveyor: 32572 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/10/15 through 3/11/15. Prairie View Care Center was found in compliance.</p>	S 000		

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

Husti lg

TITLE

Acting Admin

(X6) DATE

STATE FORM

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