

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2015
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NAME OF PROVIDER OR SUPPLIER AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078
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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 000 INITIAL COMMENTS

F 000

Surveyor: 33488
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/14/15 through 9/16/15. Avera Sr James Care Center/Avera Yankton Care Center was found not in compliance with the following requirement:
F441.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

F 441

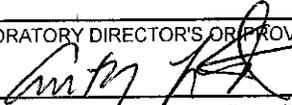
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

- (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

F441
Facility will review/revise as necessary Policy and Procedures about Infection Prevention and Control relevant to cleaning bathrooms, handwashing, and bathing procedures by 10/6/15. An inservices will be conducted for all staff Nursing and Housekeeping staff regarding the above stated Infection Policy & Procedures by 10/14/15. Audits will be conducted on handwashing and glove changes, bathroom cleaning, and bathing procedures, utilizing facility Audit Checklist. Random Audit Checklist will completed weekly for 3 weeks, then monthly for 2 months (Nov./Dec.), then quarterly thereafter. Monitoring will be done by Household Coordinator (RN) or Housekeeping supervisor with results reported to the Director Resident Care Services & Director of Quality who will compile findings and report monthly for the first 3 months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.

10/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR OF SENIOR SERVICES	(X6) DATE 10/14/15
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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.

OCT 08 2015
SDT

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

PRINTED: 09/28/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2015
NAME OF PROVIDER OR SUPPLIER AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078		
(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 1</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, policy review, and procedure review, the provider failed to ensure: *Proper disinfection was done for one of three observed resident whirlpool bathtub (Cabin area) cleanings. *Proper cleaning technique was used for one of three observed resident rooms (River front area). Findings include:</p> <p>1. Observation on 9/15/15 at 11:00 a.m. of certified nursing assistant (CNA) A cleaning the whirlpool bathtub in the Cabin living area after a resident bath revealed: *She was the primary bath aide and had given baths to residents for a few years. *She cleaned the bathtub by scrubbing the surfaces with disinfectant, rinsing it with water, then stated she would wait ten minutes. "That's the way I've always done it" *This surveyor had her check the instructions to clean the bathtub that were located in the bath room. *Those instructions said to scrub the surfaces with disinfectant then wait ten minutes before</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER avera sr james care center/avera yankton care cent		STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078		
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F 441	<p>Continued From page 2</p> <p>rinsing with water. That would ensure germs were killed.</p> <p>*The above procedure would not have adequately disinfected the bathtub.</p> <p>Review of the provider's 10/11/12 Tub Cleaning Procedure instructions revealed:</p> <p>**"Use brush to scrub all interior surfaces with [disinfectant] solution in the tub."</p> <p>**"Allow to remain wet with solution for minimum of 10 min. [minutes]."</p> <p>**"Rinse soapy water away."</p> <p>2. Observation and interview on 9/16/15 at 9:55 a.m. of housekeeper B cleaning a resident's bathroom revealed:</p> <p>*There was fecal matter smeared on the toilet seat and some on the floor in front of the toilet.</p> <p>*She put gloves on and wiped the sink with a clean cloth soaked in a sanitizer solution. After a minute or two she wiped it off with a paper towel.</p> <p>*She used the cloth to clean the toilet surfaces and the inside of the toilet bowl.</p> <p>*She dipped the cloth into the water in the toilet bowl, and then wrung it out.</p> <p>*She sprayed disinfectant on the fecal matter on the floor.</p> <p>*She went to the housekeeping cart and placed the cloth into the used cloth bag.</p> <p>*With those same gloved hands that had cleaned the toilet she proceeded to touch other supplies on her cart.</p> <p>*She removed her gloves and sanitized her hands.</p> <p>*Next she mopped the bathroom floor.</p> <p>-The mop pushed around some pieces of fecal matter.</p> <p>-She mopped those pieces onto the rug of the resident's room. She would then vacuumed them</p>	F 441		

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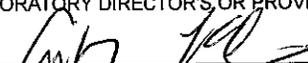
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/16/2015
NAME OF PROVIDER OR SUPPLIER AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078		
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F 441	<p>Continued From page 3</p> <p>up.</p> <p>*When this surveyor asked her why she had not removed her dirty gloves before going to the cart she replied "the carts not sanitary anyway."</p> <p>3. Review of the provider's June 2014 Infection Control in Housekeeping policy revealed: *They were to follow standard precautions when cleaning a bathroom by wearing gloves to protect against the spread of disease. *"Change gloves and clean hands after contact with contaminated items. Do not wear contaminated gloves outside of use area."</p> <p>Interview on 9/16/15 at 11:00 a.m. with the director of nursing (DON) and the housekeeping supervisor revealed: *The DON agreed proper disinfection of the whirlpool tub had not been done. *Both agreed neither proper cleaning technique nor use of gloves had been done when cleaning the above bathroom.</p>	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2015
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NAME OF PROVIDER OR SUPPLIER AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/15/15. Avera Sister James Care Center / Avera Yankton Care Centers (Building 01 Sister James 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 	TITLE EXECUTIVE DIRECTOR OF SENIOR SERVICES	(X6) DATE 10/6/15
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OCT 08 2015

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

ORIGINAL

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2015
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NAME OF PROVIDER OR SUPPLIER AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/15/15. Avera Sister James Care Center / Avera Yankton Care Centers (Building 02 Yankton 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 TITLE (X6) DATE

[Signature] **EXECUTIVE DIRECTOR of SENIOR SERVICES** 10/6/15

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ORIGINAL

PRINTED: 09/29/2015
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10716	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2015
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NAME OF PROVIDER OR SUPPLIER avera sr james care center/avera yan	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 W 11TH STREET YANKTON, SD 57078
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S 000	<p>Initial Comments</p> <p>Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/14/15 through 9/16/15. Avera Sr James Care Center/Avera Yankton Care Center was found in compliance.</p>	S 000		

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

TITLE

(X6) DATE

[Handwritten Signature]

EXECUTIVE DIRECTOR OF SENIOR SERVICES 10/6/15

STATE FORM

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If continuation sheet 1 of 1

