

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
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NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383
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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	<p><i>*Addendums noted with an asterisk per 8/18/16 per telephone with facility administrator. DHBDOHTEL</i></p> <p>Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/25/16 through 7/27/16. Aurora Brule Nursing Home Inc was found not in compliance with the following requirements: F159 and F226.</p>	F 000	<p>F000 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:</p>	
F 159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of</p>	F 159	<p>F159 All resident money has been put into the resident trust account, which will be interest bearing. Any withdrawals will be taken from the facilities petty cash fund, or by using a resident trust fund check. Subsequently the residents individual amount in our QuickBooks system will be lowered by that amount as well as the resident trust fund account. Quarterly statements of the resident's individual amounts will be printed out from our QuickBooks system and delivered to each resident.</p> <p>The Administrator, Business Office Manager, and Social Service Designee have worked to alter the admission policy agreement forms to reflect the correct information regarding personal fund handling while residing in our facility.</p> <p>Education of our policies and laws regarding residents funds has been passed on to the Administrator, Business Office Manager, and our Billing Specialist.</p> <p>The Administrator or designee will audit these changes weekly for 4 weeks and monthly for 2 more months by checking on deposit slips, the</p>	9/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joe Moran</i>	TITLE Administrator	(X6) DATE 8-10-16
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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 AURORA BRULE NURSING HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383
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F 159	<p>Continued From page 1</p> <p>resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, record review, admission agreement review, and policy review, the provider failed to ensure one of one residents' trust fund, was in an interest bearing financial account. Findings include:</p> <p>1. Interview, record review, and policy review on 7/27/16 from 1:00 p.m. to 1:15 p.m. with the administrator revealed: *He believed the residents' trust fund had been in an interest bearing account as required. *He found the account was not interest bearing and had not been since 5/9/14. *There was one of two randomly reviewed residents (12) with more than \$50 in his trust fund account. *Four other residents had funds in the resident trust fund account. The total amounts these</p>	F 159	<p>F159 continued</p> <p>resident fund bank account, the individual accounts in QuickBooks, and verifying quarterly statements have been sent out. In addition those that receive Medicaid benefits will be notified when their account reaches \$200 less than the SSI resource limit for one person. 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2016
NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383		
(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 159	Continued From page 2 residents had in their accounts was requested of the administrator on 7/27/16 at 1:00 p.m., but not received before the end of the survey. Review of the undated provider's Resident Policy Manual in the Personal Funds section revealed: **"We prefer not to handle any resident funds." **"By law we can hold onto \$50 for Medicaid residents and \$100 for Medicare residents. Any additional funds would have to be put into a resident trust account." Review of the undated Admission Agreement in the Resident Funds section revealed: *If the resident chose to have the facility manage their finances the funds would be kept in accordance with government regulations and were to have been disbursed from a Resident Trust Account. *Accurate records were to have been kept. *A resident was limited to leaving a maximum of \$50 in a personal resident account in the nursing home. *The business office was to have been sending a quarterly statement of resident funds. Who this was to have been sent to was not identified. *All personal funds were to have been given to the resident, their family, or to the estate as required by state law or regulation in the event of the resident's discharge or death.	F 159			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	<i>DH/SDOHHEL</i> → *including the incident with resident 13 F226 All incident reports have been reviewed by the Director of Nursing to ensure questions such as, "was there a possibility of abuse" was not answered with "unknown", but has an absolute. All policies and procedures involving neglect, abuse, mistreatment, and misappropriation of resident property have been examined and revised if needed. It is the policy of Aurora Brule Nursing Home inc. for a staff member who witnesses or finds any incident to complete an incident report. This is given to the charge nurse on duty and later the final	9/15/16	

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F 226	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180</p> <p>Surveyor: 37545 Based on record review, interview, and policy review, the provider failed to ensure one of five sampled residents (13) incident investigations was thoroughly completed. Findings include:</p> <p>1. Review of resident 13's 3/3/16 Required Healthcare Facility Event reporting document revealed the form was completed as follows: *The type of event being reported was answered "Unsure." *The event to have been investigated was "Physical harm/injury." -The resident had a skin tear. *A brief explanation of the event included "CNA [certified nursing assistant], noted dry blood on the bed when getting resident up for the day, RN [registered nurse] assessed note a 1 x 4 cm [centimeter] skin tear to lef [as written] leg-upper calf, RN cleansed, was able to roll skin together, applied steri strips and a non adhesive dressing. Family, physician, and DON [director of nursing] aware." *They answered if abuse/neglect was substantiated "Unknown." *They answered if a resident was suspected of abuse/neglect was it a willful act "Unknown." *There was no documentation to support the cause of the skin tear nor had they ruled out suspicion of abuse or neglect. *There was no investigation completed.</p> <p>Interview on 7/27/16 at 10:36 a.m. with the DON</p>	F 226	<p>f226 continued investigation will be done by the Director of Nursing. All investigations will have relevant employee schedules, interviews, and additional information if applicable stapled to the incident report. All state notifications will be sent by the Director of Nursing or designee within 24 hours while serious injury will be reported within 2 hours.</p> <p>The Administrator, Director of Nursing, Nurses, and Nurse Aides are aware of policies and procedures regarding the investigating and submitting of incidents witnessed or found.</p> <p>The Director of Nursing will audit this system weekly for 4 weeks and monthly for 2 more months to ensure all reports are being filled out, the state is notified if applicable, and that proper paperwork and information is being included in the report.</p> <p>The Director of Nursing 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2016
NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383		
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F 226	<p>Continued From page 4</p> <p>and review of the above event reporting form confirmed the investigation had not been thoroughly completed or documented.</p> <p>Interview on 7/27/16 at 1:10 p.m. with the administrator and review of the event reporting form revealed: *He confirmed the investigation had not been thoroughly completed. -There were a lot of blanks on the form. *There was no other documented information on that incident.</p> <p>Review of the provider's 7/15/13 Abuse Policy and Procedure revealed *"The facility will identify and investigate all suspicions or allegations of abuse (such as suspicious bruising of residents, neglect or misappropriation of resident property); reviewing the occurrence, patterns and trends that may constitute abuse. This information will be used to determine the direction of the investigation. *Investigation to include exact timeline of events, interviews, and statements with all staff scheduled during time of incident. *Investigation timeline, interviews, statements, copies of schedules, and investigation checklist will be kept with incident report."</p>	F 226			

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

ORIGINAL

PRINTED: 08/03/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2016
NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME INC			STREET ADDRESS, CITY, STATE, ZIP CODE 408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383	
(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	<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 7/26/16. Aurora Brule Nursing Home Inc 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Joe Dawson **Administrator** **8-10-16**

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SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/27/2016
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NAME OF PROVIDER OR SUPPLIER AURORA BRULE NURSING HOME INC	STREET ADDRESS, CITY, STATE, ZIP CODE 408 S JOHNSTON ST WHITE LAKE, SD 57383
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S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/25/16 through 7/27/16. Aurora Brule Nursing Home Inc was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/25/16 through 7/27/16. Aurora Brule Nursing Home Inc was found in compliance.	S 000		

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

Joe Hanson

TITLE

Administrative 8-10-16

(X6) DATE

