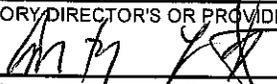


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2016
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NAME OF PROVIDER OR SUPPLIER AVERA SR JAMES CARE CENTER/AVERA YANKTON CARE CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 2111 WEST 11TH STREET YANKTON, SD 57078
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F 000	INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/1/16 through 8/3/16. Avera Sr James Care Center/Avera Yankton Care Center was found not in compliance with the following requirements: F281, F283, F325, F431, and F441.	F 000	*Addendums noted with an asterisk per 9/12/16 per telephone with facility DON and Executive director. JT/SDDOH/EL	
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: 33488 Based on record review, interview, and policy review, the provider failed to appropriately document, follow professional standards, nursing scope of practice, and their policy, ensuring nursing staff were notifying the physician for pronouncement of death for two of two sampled residents (26 and 27) who had died. Findings include: 1. Review of the medical record documentation for resident 26 revealed: *She was found by nursing staff on 2/17/16 at 3:45 a.m. to have no respirations, no heart beat, and her pupils were fixed. *At 3:50 a.m. the family was "notified of resident's death." *At 5:50 a.m. the funeral home was notified. *At 6:24 a.m. the physician was notified, and the body was released to the funeral home at 6:30	F 281	F281 Facility will review/revise as necessary Procedures about Death of a Resident relevant to notification of the physician for pronouncement of death by 8/30/16 before other notifications. An in-service will be conducted for all Teamleaders regarding the above stated procedure by 8/31/16. Audits will be completed on 100% of Residents who pass away due to death, facility will use an Audit Checklist to be completed weekly for 4 weeks, then monthly for 3 months (Oct/Nov/Dec.), then quarterly x2 thereafter. Monitoring will be done by Household Coordinator (RN) supervisor with results reported to the Director of Quality who will compile findings and report monthly for the first 4 months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations.	9/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR of Senior Services	(X6) DATE 8/22/16
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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.

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

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FORM APPROVED
OMB NO. 0938-0391

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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 281	<p>Continued From page 1</p> <p>a.m.</p> <p>*There was no "Death SOC" documentation filled out in the medical record for that resident.</p> <p>2. Review of the medical record documentation for resident 27 revealed: *She was found by nursing staff on 6/21/16 at 12:50 p.m. to have no respirations, no pulse, and fixed pupils. *At "12:45 p.m." the next of kin was notified. *At 1:00 p.m. the physician and funeral home were both notified. *There was no "Death SOC" documentation filled out in the medical record for that resident.</p> <p>3. Interview on 8/3/16 at 2:30 p.m. with the director of nursing regarding resident 26 and 27's death documentation revealed she was unaware nurses were not following the appropriate procedure outlined in the facility's policy.</p> <p>4. Review of the provider's undated Death policy revealed: *The licensed nurse was not to have stated the resident had died. "You cannot make a pronouncement of death- only a physician is allowed to do that." *Notify the following: -The physician. -The family "(if not present)." -Pastoral care. -Funeral home. **"Add a document Death SOC (includes Death record and Death Determination by MD) in the interventions." **"Death Determination by MD to be completed after physician notification and response."</p> <p>Review of Patricia A. Potter et al., Fundamentals</p>	F 281		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	Continued From page 2 of Nursing, 8th Ed., St Louis, MO, 2013, page 724, revealed documentation of end of life includes the name of the health care provider who certified death. Review of South Dakota Codified Law 34-25-18 and 34-25-18.1 revealed: *The signing of the death certificate is a medical act by a physician, physician's assistant, or nurse practitioner. ***Since the Legislature did not provide that the act was delegable to anyone else the South Dakota Board of Nursing did not believe a licensed nurse could officially pronounce death."	F 281		
F 283 SS=D	483.20(I)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review and interview, the provider failed to have an appropriate recapitulation (summary statement) that included a review of the resident's stay for one of one sampled resident (28) who was discharged home. Findings include: 1. Review of resident 28's 2/19/16 Discharge	F 283	<i>*NO corrective action is indicated for resident 28 as unable to change past events.</i> F283 Facility will review/revise as necessary Procedures about Discharge Summary of a Resident stay when discharged to other than death by 8/30/16. An in-service will be conducted for all RN coordinators regarding the above stated procedure by 8/31/16. Audits will be conducted on closed charts of those discharged, utilizing facility Audit Checklist. 100% of Residents discharged closed charts will be audited using the Audit Checklist to be completed weekly for 4 weeks (Sept), then monthly for 3 months (Oct/Nov/Dec.), then quarterly x2 thereafter. Monitoring will be done by Household Coordinator (RN) and reported to the Director of Quality who will compile findings and report monthly for the first 4 months then quarterly for one year thereafter to facility QAA Committee for review and appropriate recommendations. <i>9/14/16</i>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 283	<p>Continued From page 3</p> <p>Instructions note revealed:</p> <ul style="list-style-type: none"> *That was the form completed upon discharge from the facility for the resident. *Within that form was instructions of care the resident was to have followed upon discharge to home. *There was no additional note within the discharge instructions regarding a summary statement of the resident's stay while he was at the facility. That statement should have been made by staff or the physician detailing his life from admission on 1/29/16. <p>Review of resident 28's 2/19/16 Discharge Comments note documented by the social worker revealed:</p> <p>***"Will discharge home with family today. I faxed the information to the home health nurse...Family will take him home. He chose to go home and stop therapy here even though he had medicare days available. He will be getting outpatient therapy..."</p> <p>Interview on 8/3/16 at 1:45 p.m. with registered nurse (RN) household coordinators (HHC) G, H, and I and social worker (SW) J regarding the above missing summary statement revealed: RN HHCs G, I, and SW J had never made a summary statement for a resident that had transferred from the facility to another or was discharged to their home.</p> <ul style="list-style-type: none"> *They were unaware they needed to have a summary statement that detailed the life of the resident's stay while at the facility. *RN HHC H was aware of a summary statement but had not done one that reflected the life of the resident while at the facility. <p>Interview on 8/3/16 at 2:30 p.m. with the director</p>	F 283			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 283	Continued From page 4 of nursing regarding resident 28's missing summary statement revealed: *There was no documentation to show a summary statement was made to reflect the resident's life and care while at the facility. *They had no policy on discharge summaries or recapitulation of stays. *It was the RN HHCs responsibility to make one for the resident upon transfer or discharge.	F 283			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, record review, interview, testing, product information, and policy review, the provider failed to administer thickened liquids correctly at two of two observed meals for one of one sampled resident (16) who was on thickened liquids. Findings include: 1. Review of resident 16's medical record revealed he had: *A diagnosis that included:	F 325	F325 Facility will review/revise as necessary Policy and Procedures concerning providing appropriate thickened liquids and education by 8/30/16. An in-service will be conducted for all staff regarding the above stated policy & procedures by 8/31/16. Audits will be conducted on appropriate liquid consistencies on Resident #16 and [redacted] residents on thickened liquid, utilizing facility Audit Checklist. Audit Checklist will complete weekly for 4 weeks (Sept), then monthly for 3 months (Oct/Nov/Dec.), then quarterly x2, thereafter. Monitoring will be done by Certified Dietary Manager with results reported to the 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. *Including CNA K. JT/SDDOHT/EL	9/14/16 *all JT/SDDOHT/EL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 325	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Dementia. -Aphasia. -Dysphagia. -Parkinson's disease. *The 7/12/16 and 8/2/16 consultant registered dietitian progress notes revealed he: *Was on honey-thickened liquids. -Had swallowing problems. *A physician's order on 6/20/16 for speech therapy to evaluate and treat for changes in swallowing and intake. *A Speech Therapy Plan of Care on 6/21/16 for treatment of dysphagia. *Nursing and family had reported: -Decreased initiation of swallowing ability. -The above had resulted in loss of bolus, weight loss, and aspiration during meals for the last thirty days. *A goal for him to have been provided "liquefied portions of a honey consistency with 100% accuracy with ST [speech therapist] assist and education." *A physician's order on 6/28/16 "Patient will continue puree diet, but foods will be liquefied to honey consistency if pt is not taking presentations via spoon." *The above Speech Therapy Plan of Care had been signed by his physician on 6/29/16. <p>Review of resident 16's revised 7/29/16 care plan revealed:</p> <ul style="list-style-type: none"> *He needed assistance with eating. *"Speech to eval and treat due to difficulties with opening mouth and decrease in eating." *He had a history of coughing during meals. *He had a history of pocketing food and had needed a pureed diet. *He was offered a pureed texture and honey-thickened liquids. 	F 325		

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

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F 325	<p>Continued From page 6</p> <p>*He had problems understanding others and impaired decision making.</p> <p>Observation, testing, and interview on 8/2/16 at 12:15 p.m. with resident 16's significant other revealed:</p> <p>*She was assisting him with eating his noon meal.</p> <p>*She stated he "has choked" when liquids had been too runny for him.</p> <p>*He had received a Jell-O type dessert.</p> <p>-It was slightly watery when tested with a plastic spoon.</p> <p>*He had received a pureed chocolate eclair.</p> <p>-It was a nectar consistency when tested with a plastic spoon.</p> <p>*He was to have received honey-thickened liquids and foods liquefied to a honey consistency.</p> <p>Observation, testing, and interview on 8/2/16 at 6:25 p.m. with certified nursing assistant (CNA) K revealed resident 16:</p> <p>*Was being assisted by her with eating his evening meal.</p> <p>*She stated he "sometimes chokes and coughs at meals."</p> <p>*He had been unable to make his needs known.</p> <p>*He had received one cup Ensure in a nose cup.</p> <p>-It was a nectar consistency when tested with a plastic spoon.</p> <p>*He had received one cup of a red-colored juice in a nose cup.</p> <p>-It was a nectar consistency when tested with a plastic spoon.</p> <p>*CNA K had agreed both of the above liquids were not a honey-thickened consistency.</p> <p>*She had known he was to have received honey-thickened liquids.</p>	F 325		

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

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F 325	<p>Continued From page 7</p> <p>Interview on 8/3/16 at 1:30 p.m. with the nutrition services coordinator and dietary manager C regarding resident 16 revealed: *He was to have received honey-thickened liquids. *Had needed to have the right consistency with his diet per speech therapy recommendations and physician's orders. *Simply Thick was used for preparing honey-thickened liquids. *There was not a specific policy on thickened liquids.</p> <p>Interview on 8/3/16 at 1:50 p.m. with speech therapist D, the nutrition services coordinator, and dietary manager C regarding resident 16 revealed: *Speech therapist D stated a gelatin dessert "like Jell-O" was not to have been given for honey-thickened liquids. *All agreed physician's orders needed to have been followed for any food or liquid consistency modification.</p> <p>Interview on 8/3/16 at 2:10 p.m. with the director of nursing and at 2:15 p.m. with registered nurse household coordinator E regarding resident 16 revealed: *He was on honey-thickened liquids. *Both agreed physician's orders needed to have been followed for any food or liquid consistency modification.</p> <p>Review of directions on the provider's SimplyThick thickener product information revealed the thickening gel: *Was a food and beverage thickener. *Was used for residents with dysphagia.</p>	F 325			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 8 Review of provider's undated Diet Order Clarification and Liberalization policy revealed: *Healthcare professionals made recommendations based on their area of expertise. *The diet order came from a physician.	F 325		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	*The incorrectly labeled vials were destroyed. F431 JT/SDDOHEL Facility will review/revise as necessary the Procedure about Outdated Medications regarding specifically Insulins by 8/30/16. An in-service will be conducted for all Teamleaders regarding the correct expiration dates for all Insulins by 8/31/16. Audits will be conducted on all Insulin bottles opened in the facility utilizing facility Audit Checklist. Audit Checklist will be completed weekly for 3 weeks, (Sept) then monthly for 3 months (Oct, Nov, Dec), then quarterly thereafter. Monitoring will be done by Household Coordinator (RN) with results reported to the Director of Quality who will compile findings and report monthly for the first 3 months then quarterly thereafter to facility QAA Committee for review and appropriate recommendations.	9/14/16

*by DON
JT/SDDOHEL

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	<p>Continued From page 9 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, and policy review, the provider failed to ensure insulin vials were labeled with the correct expiration date when opened for insulin given in one of five neighborhoods (Chalkstone). Findings include:</p> <p>1. Observation on 8/2/16 during morning medication pass at Chalkstone neighborhood revealed: *Novolog insulin for two randomly observed residents had been labeled as opened on 7/4/16, and the expiration date had been labeled as 8/3/16 on the vial. *One vial of Levemir insulin had been labeled as opened on 7/4/16, and the expiration date had been labeled as 8/3/16 on the vial.</p> <p>Interview on 8/3/16 at 11:00 a.m. with registered nurse (RN) L revealed: *All insulin vials were good for twenty-eight days after being opened. *She was unable to correctly determine what the date for expiration would be on a vial opened on 7/4/16. -She stated "I don't know."</p> <p>Interview on 8/3/16 at 11:10 a.m. with RN M revealed: *All insulin vials should have had a twenty-eight day expiration date after opening. *That date should have been written on the vial of</p>	F 431		

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F 431	Continued From page 10 insulin. *The correct date would have been 7/31/16. Review of the provider's Insulin Injection Administration Procedure policy revealed to discard all insulin vials twenty-eight days after it was first used.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441	F441 Facility will review/revise as necessary Policy and Procedures about Infection Prevention and Control relevant to cleaning Glucometer and handwashing/glove use by 8/30/16. An in-service will be conducted for all Nursing staff regarding the above stated Infection Policy & Procedures by 8/31/16. Audits will be conducted on handwashing routine with personal cares and glove changes on Resident #5 and others and Glucometer cleaning procedures utilizing facility Audit Checklist. Random Audit Checklist will completed weekly for 4 weeks (Sept), then monthly for 3 months (Oct/Nov/Dec.), then quarterly x2. Monitoring will be done by Household Coordinator (RN) supervisor with results reported to the 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.	9/14/16

**by the
DON with
staff hand
attendance
JT/SPD/HL*

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

PRINTED: 08/15/2016
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 08/03/2016
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 11 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: 23059 Based on observation, interview, manufacturer's instructions review, and policy review, the provider failed to ensure proper infection control techniques were used for: *One of ten observations of one of nine resident's personal care (5) by one of eight observed staff (A). *One of three random observations of glucose meter cleaning by one of three licensed nurses (F). Findings include:</p> <p>1. Observation on 8/2/16 at 7:55 a.m. of nursing assistant (NA) A providing personal care for resident 5 revealed after she washed her hands and put on gloves she: *Washed the resident's back, under her arms, and her torso. *Dried the resident off and applied deoderant. *Lotioned the resident's arms. *Opened a drawer, obtained a shirt, and put it on the resident. *Placed the EZ stand sling behind the resident and assisted her to a standing position. *Moved the resident into the bathroom, removed her soiled incontinence brief, and assisted her onto the toilet.</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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(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 441	<p>Continued From page 12</p> <ul style="list-style-type: none"> *Washed the resident's dentures and handed them to her to place in her mouth. *Removed soiled linens from the bed and remade the bed. *Used the remote control on the EZ stand to assist the resident to a standing position. *Wiped the resident's bottom with a wet washcloth. *Adjusted her own uniform. *Placed a clean incontinence brief on the resident. *Pulled up the resident's pants. *Moved the EZ stand to the resident's wheelchair. *Assisted the resident to be seated in the wheelchair. <p>Interview on 8/2/16 at 8:10 a.m. with NAA revealed she had not yet passed her nursing assistant exam. She stated she had completed her classroom and clinical training, and she had been working with another certified nursing assistant until that week. She began working independently the day before. She stated the above was her usual practice.</p> <p>Interview on 8/3/16 at 7:35 a.m. with Riverfront household coordinator registered nurse B revealed she confirmed the above training process. She confirmed using the same gloved hands to lotion a resident, handle multiple items, remove a soiled brief, and clean dentures was not an acceptable practice.</p> <p>Review of the provider's revised May 2015 General Standards Precautions policy revealed gloves should have been changed when moving from a contaminated site and prior to contact with a clean site.</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 08/03/2016
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 13 Surveyor: 34030 2. Observation and interview on 8/2/16 at 11:00 a.m. of licensed practical nurse (LPN) F disinfecting an Accu-Chek glucometer after using it for a resident revealed: *She had been working in the Cabin neighborhood that day passing medications and doing procedures. *The glucometer she used was a multi-use glucometer. *After using it to obtain a resident's blood sugar reading she wiped it off with an alcohol wipe. *That was how she would disinfect it before using it on another resident.</p> <p>Review of the manufacturer's instructions on how to disinfect the Accu-Chek glucometer revealed: *It should be cleaned before disinfecting. *Disinfect with a Super Sani-Cloth. *Allow the surface of the meter to remain damp for two minutes. *Dry the meter thoroughly with a soft cloth or gauze.</p> <p>Review of the provider's 8/2/16 Infection Control in LTC policy revealed: "Glucometers. CDC [Centers for Disease Control] reports glucometers have been implicated in transmission of hepatitis B in long-term care centers. Therefore gloves should be worn when handling glucometers. Hands should be washed after removing gloves and glucometers should be disinfected with hospital grade disinfectant between residents."</p> <p>Interview on 8/3/16 at 1:55 p.m. with the DON regarding the disinfection of glucometers revealed: *She agreed glucometer disinfection should have</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		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 been done with the Super Sani-Cloth. *LPN F was not adequately disinfecting the glucometer after use on residents.	F 441		

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

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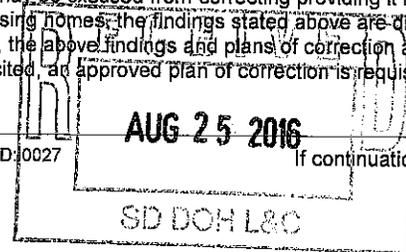
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2016
NAME OF PROVIDER OR SUPPLIER 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
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 8/9/16. Avera Sister James Care Center/Avera 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	<p>*Addendums noted with an asterisk per 8/29/16 per telephone with facility administrator. JB/SDDOHH/EL</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **8/22/16**

EXECUTIVE DIRECTOR of SENIOR SERVICES

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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - 2015 ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2016
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
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 8/9/16. Avera Sister James Care Center/Avera Yankton Care Center (Building 3 - 2015 addition) 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 New Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>*Addendums noted with an asterisk per 8/29/16 per telephone with facility administrator. [REDACTED] JB/SDDOHT/EC *JB/SDDOHT/EC</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 8/22/16

[Signature] EXECUTIVE DIRECTOR OF SENIOR SERVICES

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.

AUG 25 2016

SD DOH LSC

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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 08/09/2016
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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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(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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 8/1/16 through 8/3/16 and on 8/9/16. Avera Sr James Care Center/Avera Yankton Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 32331 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 8/1/16 through 8/3/16. Avera Sr James Care Center/ Avera Yankton Care Center was found in compliance.	S 000		

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

TITLE

(X6) DATE

[Handwritten Signature]

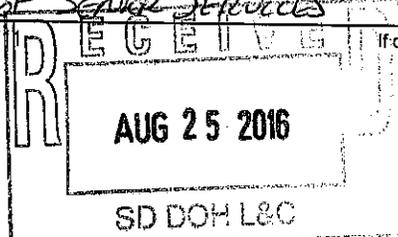
EXECUTIVE DIRECTOR of Senior Services

8/22/16

STATE FORM

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If continuation sheet 1 of 1