

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

ORIGINAL

PRINTED: 03/07/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRYANT PARKVIEW CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221</b>	
(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 000	<p><i>*Addendums noted with INITIAL COMMENTS an asterisk per 4/1/16 Per telephone with facility administrator.</i></p> <p>Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/23/16 through 2/24/16. Bryant Parkview Care Center was found not in compliance with the following requirements: F281 and F323.</p>	F 000	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 and federal law. Without waiving the foregoing statement, the facility states that with respect to;	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on record review, interview, and policy review, the provider failed to ensure medication concerns and registered dietitian (RD) recommendations were communicated in a timely manner to the physician for one of nine sampled residents (4). Findings include:</p> <p>1. Review of resident 4's February 2016 medication administration record revealed: *An order dated 1/26/16 for Etodolac 400 milligrams two times a day for pain. *The Etodolac had been held from the second dose on 2/9/16 through the first dose on 2/16/16. *The Etodolac had been given once on 2/17/16. *The remaining doses for the month indicated to hold the medication. orders. The DON or designee will report on these at the monthly QAPI meetings for review. The audits will be done once per week for 4 weeks and then Review of resident 4's 2/9/16 interdisciplinary progress note (IDPN) revealed: as the QAPI committee advises. **Social services brought concern to a change in</p>	F 281	<p>Resident #4 medication administration regimen was reviewed and clarification orders were obtained from resident #4's physician, if necessary.</p> <p>All other residents' medication Administration regimens were reviewed and compared to physician orders to ensure appropriate medications are being administered per physician orders.</p>	4/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Melody Johnson* TITLE *Admin* (X6) DATE *3/17/16*

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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F 281	<p>Continued From page 1</p> <p>resident speech. Went to assess resident and has a blank stare and is not blinking, she is verbally refusing to stand up and go to lunch. Resident does make negative comments such as 'I don't care,' when advised that we will continue to monitor her. When asked if resident is aware of where she is at she states 'yes.' Speech is slightly slurred. Resident has been currently put on a new medication and will consult with the doctor to put the medication on hold to see if this is a reaction to that."</p> <p>*The above IDPN note had been faxed on 2/9/16 to resident 4's physician with additional information of two new medications Etodolac and Megace she had been started on.</p> <p>*The fax had requested "Any new orders?"</p> <p>*The physician's response on 2/10/16 noted "Probably her pain meds."</p> <p>-No new orders were given.</p> <p>Further review of resident 4's medical record revealed no further communication with her physician regarding holding her Etodolac medication.</p> <p>Interview on 2/23/16 at 1:45 p.m. with registered nurse A regarding resident 4 revealed: *She "gets catatonic." *Nursing judgement had been used to hold her Etodolac medication. *Her physician had not made any changes in her medication in response to the nurses' concerns.</p> <p>Interview on 2/24/16 at 8:30 a.m. with the director of nursing (DON) regarding resident 4 confirmed: *Her Etodolac medication had been held because of nurses' concerns. *The fax to her physician should have better communicated the nurses' concerns.</p>	F 281			

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F 281	<p>Continued From page 2</p> <p>*Her physician should have been informed the medication had been held, and what the results were of the medication being held.</p> <p>Review of the provider's December 2012 Administering Medications policy revealed if a medication had been identified as having potential adverse consequence for the resident the resident's attending physician should be contacted to discuss the concerns.</p> <p>2. Review of resident 4's nutrition/dietary notes revealed: *On 2/10/16 the RD noted resident 4 had: -Decreased appetite and unintended weight loss. -Majority of meal intakes of less than 25 percent (%). -Lost 19 pounds (lb) over three months, a 12% weight change indicating severe weight loss. -Lost 6.9 lb over one month, a 4.7% weight change indicating a significant weight loss. -Recommended to try a nutritional supplement to provide 475 additional calories per day. *On 2/13/16 the dietary manager (DM) noted: -Will try nutritional supplement with medication pass. -The supplement had to be ordered. *On 2/15/16 the DM noted: -The resident tried the nutritional supplement with medication pass and stated "it was good." -Her physician would be faxed for an order for nutritional supplement.</p> <p>Review of resident 4's medical record revealed: *A fax dated 2/17/16 to her physician requested a nutritional supplement. *The fax had been returned to the provider on 2/23/16 with an order for the nutritional supplement four times a day.</p>	F 281			

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F 281	Continued From page 3  Interview on 2/24/16 at 8:30 a.m. with the DON revealed the DM would fax the RD's recommendations to the physician. When the order was received nursing would note the order on the medication administration record and administer.  Interview on 2/24/16 at 9:30 a.m. with the DM revealed she had requested an order for the nutritional supplement from resident 4's physician. She was not aware the order had not been received by the provider.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, testing, and policy review, the provider failed to monitor water temperature throughout the facility including two randomly tested areas (vacant room 111 and restorative therapy). Findings include:  1. Observation and testing on 2/23/16 at 4:00 p.m. revealed: *The water temperature in vacant room 111 was 125.4 Fahrenheit (F).	F 323	A water temperature check log was created with room designations so water temperatures will be monitored throughout the facility weekly. *The water temperature will be audited and monitored by the maintenance director or Administrator, DON, and maintenance director have reviewed, revised, and created as necessary, the policy and procedures to ensure a safe and hazard free environment with appropriate water temperatures.  The updated policy will be presented to all staff and those staff responsible to the water temping task will be educated on the correct process.  The maintenance director or designee will audit the water temperature logs once per week for 4 weeks and once per month for 2 more months.  The maintenance director or designee will present the audit findings at the monthly QAPI meetings for review.  *The maintenance director or designee will audit the water temperature logs once per week for 4 weeks, then monthly until the next QAPI meeting, then as the QAPI committee advises. NLSDDH/EL	4/8/16  designee NLSDDH/EL

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F 323	<p>Continued From page 4</p> <p>*The water temperature in the restorative therapy room was 125.0 F.</p> <p>Interview on 2/24/16 at 9:30 a.m. with the maintenance supervisor revealed he:</p> <p>*Had not checked water temperatures in residents rooms' or in any areas where residents would be able to use hot water.</p> <p>*Had not had a thermometer to check water temperatures.</p> <p>*Had not maintained a safety log or a routine schedule for safety checks of water temperatures.</p> <p>*Checked the temperatures on the water heaters randomly but had not recorded them.</p> <p>*Was part time at the facility (three days per week) and was the only person in the maintenance department.</p> <p>Interview on 2/24/16 at 10:25 a.m. with the director of operations revealed he would have expected maintenance to check water temperatures and keep a log.</p> <p>Review of the provider's December 2009 Safety of Water Temperatures policy revealed:</p> <p>*Maintenance staff were responsible for checking thermostats and temperature controls in the facility and recording in a maintenance log.</p> <p>*Maintenance staff shall conduct periodic tap water temperature checks and record in the safety log.</p> <p>*If at any time water temperatures feel excessive to the touch, staff were to report findings to immediate supervisor.</p>	F 323			

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K 000	<p><i>*Addendums noted with an asterisk per 3/31/16 per telephone with facility administrator.</i></p> <p>Surveyor: 32334 <i>LF/SDDOHJEL</i></p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/23/16. Bryant Parkview Care Center was found not 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 upon correction of the deficiency identified at K050, K062, K066, K069, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>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 and federal law. Without waiving the foregoing statement, the facility states that with respect to;</p>	
K 050 SS=C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms.</p> <p>18.7.1.2, 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on document review and interview, the provider failed to ensure fire drills were conducted at least quarterly per year on each shift to ensure staff were familiar with the fire plan procedure. Findings include:</p>	K 050	<p>A fire drill log was created to ensure fire drills are conducted at least quarterly per year on each shift.</p> <p>The Maintenance Director or Designee will audit fire drills once per [redacted] for 3 [redacted] to ensure fire drills are conducted at least quarterly on each shift.</p> <p>The Maintenance Director or Designee will present the fire drill audit findings at the monthly QAPI meetings for review.</p>	1/8/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*Melody Johnson* *Admin* *3/17/16*

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K 050	Continued From page 1  1. Document review of the fire drill records revealed missing fire drills for the months of July, August, September, October, and November 2015. A fire drill should have been conducted each of those months to ensure the required minimum fire drill was conducted once per shift per quarter per year.  Interview with the director of nursing at 10:30 a.m. on 2/23/16 revealed she had just started the position and was not aware the drills were missing over the past year. Interview with the administrator at 2:30 p.m. on 2/23/16 revealed she was not aware the above fire drills were missing. A preventative maintenance plan was in place provided by the maintenance director indicating a fire drill was conducted monthly. Interview with the maintenance director indicated he was part-time and did not participate in the fire drills on a regular basis.	K 050		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with	K 062	The fire sprinkler inspection contractor will be contacted to ensure quarterly testing of the dry pipe low air alarm and the wet pipe water flow alarm.  The Maintenance Director or designee Will audit records once per month for 3 months to ensure the dry pipe low air alarm and the wet pipe water flow alarm are tested quarterly.  The Maintenance Director or designee will report audit findings at the monthly QAPI meetings for review.	4/8/16

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K 062	<p>Continued From page 2</p> <p>National Fire Protection Association (NFPA) 25. Quarterly dry pipe and wet pipe sprinkler system testing over the past year was not being performed on the sprinkler system. Findings include:</p> <p>1. Document review of the fire sprinkler inspection reports prepared by Midwestern Mechanical Inc. revealed missing required periodic testing requirements. In accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems the following testing shall be required for the dry pipe and wet pipe fire sprinkler system installed at the facility: quarterly testing of the dry pipe low air alarm and the wet pipe waterflow alarm.</p> <p>Interview with the maintenance supervisor at 10:15 a.m. on 2/23/16 revealed he was not aware of the above testing requirements. He indicated he believed Midwestern Mechanical Inc. was conducting all the required testing.</p> <p>This deficiency has the potential to affect five of five smoke compartment and all twenty-six residents.</p>	K 062		
K 066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p>	K 066	<p>A metal container with self-closing cover will be purchased and placed around the wood structure where smoking is permitted and old ashtray will be removed.</p> <p>All staff will be educated on the new ashtray.</p> <p>The fire extinguisher will be serviced.</p> <p>The Maintenance Director or designee will audit the new ashtray system and fire extinguisher once per month for 3 months to ensure appropriate ashtray is being used and the fire extinguisher charge is being checked.</p>	4/8/16

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K 066	<p>Continued From page 3</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure smoking regulations were adopted for areas where smoking was permitted to ensure the designated smoking area did not increase the potential for fire. Findings include:</p> <p>1. Observation at 11:35 a.m. on 2/23/16 near the south service wing exit revealed a combustible wood structure that abutted the exterior of the south wing and sat partially under the main building eave. That structure provided a sheltered outside designated smoking area. The ashtray provided for the area did not have a self-closing cover. Because there was no cover, disposed cigarettes were being blown on the ground inside the structure along with other leaves and debris. A fire extinguisher was provided in the structure, but the fire extinguisher gauge indicated it was in need of being recharged. The tag on the extinguisher indicated it had been last inspected in January which was acceptable.</p> <p>Interview with the administrator and maintenance supervisor at 2:45 p.m. on 2/23/16 during the exit</p>	K 066	<p>The Maintenance Director or designee will report the results of these audits at the monthly QAPI meetings.</p>	

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K 066	Continued From page 4 interview revealed they were unaware of the above condition. The maintenance supervisor indicated the extinguisher was fine when it was last checked in January. They did not indicate if the area was on a cleaning schedule to ensure combustible debris was cleaned from the area. They indicated they were not aware the open bowl ashtray container was not an acceptable container.	K 066		
K 069 SS=C	This deficiency has the potential to affect one of five smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the commercial kitchen hood was continuously maintained in reliable operating condition in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (system not tied to building fire alarm). Findings include:  1. Document review revealed a commercial kitchen equipment inspection report dated 10/19/15. That report was prepared by Heiman Fire Equipment. The report revealed no indication if the commercial kitchen hood fire suppression system was connected to the building fire alarm signaling system. Review of the fire alarm inspection report dated February 18, 2015 prepared by Automatic Building Controls Inc. did not indicate if they were checking the relay between the commercial kitchen hood and the	K 069	The kitchen hood fire suppression contractor will be contacted to verify if the kitchen hood fire suppression system is connected to the building fire alarm signaling system. If it is, we will acquire a report stating as such. If it is not, we will initiate an agreement to have a contractor to connect the kitchen hood fire suppression system to the building fire alarm signaling system.  The Maintenance Director or Designee will audit the kitchen hood fire suppression connection to the building fire alarm signaling system once per month for 3 months.  The Maintenance Director or designee will report audit findings at the monthly QAPI meetings for review.	4/8/16

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:  <b>435077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRYANT PARKVIEW CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221</b>	
(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 069	Continued From page 5 building fire alarm system.	K 069		
K 144 SS=D	<p>Interview with the administrator and the maintenance director at 2:45 p.m. on 2/23/16 during the exit interview revealed they were not aware of the above requirement. They indicated they were not sure if the kitchen hood system and building fire alarm system were connected.</p> <p>Phone call with Heiman Fire Equipment on 2/24/15 at 3:30 p.m. revealed the commercial kitchen hood system was not provided with the relay between the kitchen hood Ansul system and the building fire alarm system.</p> <p>This deficiency has the potential to affect one of five smoke compartments.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110, 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on observation and interview, the provider failed to install a remote stop button for one of one generator. Findings include:</p> <p>1. Observation at 11:00 a.m. on 2/23/16 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator.</p> <p>All Level 2 installations shall have a remote</p>	K 144	<p>A contractor will be contacted to install an emergency stop button for the generator.</p> <p>The Maintenance Director or designee will audit the installation of an emergency stop button for the generator once per month for 3 months.</p> <p>All staff will be educated on the existence of the new emergency shut-off for the generator.</p> <p>The Maintenance Director or Designee will report audit findings at the monthly QAPI meetings for review.</p>	4/8/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435077</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRYANT PARKVIEW CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221</b>		
(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 144	Continued From page 6 manual stop station of a type similar to a break-glass station located outside the room housing the prime mover or located elsewhere on the premises as the prime mover was located outside the building (National Fire Protection Association 110, Chapter 3-5.5.6, 1999 Edition).	K 144		

ORIGINAL

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10602</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BRYANT PARKVIEW CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 W 6TH AVE POST OFFICE BOX 247 BRYANT, SD 57221</b>
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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: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/23/16 through 2/24/16. Bryant Parkview Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement  Surveyor: 33265 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 2/23/16 through 2/24/16. Bryant Parkview Care Center was found in compliance.	S 000		

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

*Melody Johnson*

TITLE

*Admin.*

(X6) DATE

*3/17/16*