

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2016
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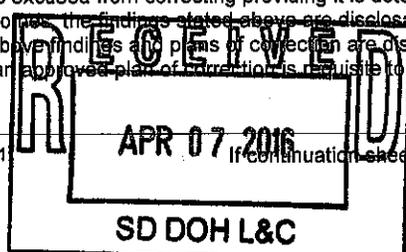
NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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 4/25/16 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 3/15/16 through 3/17/16. Hudson Care and Rehab Center LLC was found not in compliance with the following requirement(s): F159, F161, F221, F431, and F441.</p>	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 provision of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p>	[REDACTED]
F 159 SS=E	<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>	F 159	<p>F159: The resident trust fund was transferred to an interest bearing account for all residents regardless of the amounts in the accounts. This account was separated from all other facility accounts so there was no comingling of funds between the residents and the facility. The accounts of residents 12, 13, and 14 were combined with the interest bearing resident trust account so they no longer had three separate accounts. Resident 13 received an up to date statement form the bank to verify the facility ledger and the bank statement balance matched.</p> <p>The Administrator and the Interdisciplinary team reviewed the policy and procedure for the management of resident funds and highlighted the findings cited in the deficiencies. The staff responsible for the handling of resident funds was educated by the administrator on the proper handling of resident funds.</p> <p>The business office manager and the administrator will work together on tracking the resident trust accounts and their amounts. The business office manager will be responsible for the day to day transactions and the business office manager and administrator will work together on reconciling the accounts at the end of each month.</p>	*5/10/16 NR/SDDOH/EL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>04/05/2016</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 159	<p>Continued From page 1</p> <p>The system must preclude any commingling of 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: 35625 Based on record review and interview, the provider failed to manage one of one resident's trust fund account and one of three separate resident accounts (13) to ensure: *The balance that each resident deposited in one of one resident trust fund and three of three separate resident (12, 13, and 14) accounts was not limited. *One of one resident trust fund was not kept separate from other facility accounts. *Accurate accounting was kept for one of one resident's (13) account. Findings include:</p> <p>1. Interview and review of the residents' trust fund and separate account documents on 3/15/16 at 1:50 p.m. and 3/16/16 at 2:25 p.m. with the</p>	F 159	<p>The administrator or designee will audit the resident funds once per month for three months to ensure appropriate accounting of resident funds deposited with the facility.</p> <p>The administrator or designee will report the audit findings at the monthly QAPI meeting.</p> <p><i>*QAPI will review and make recommendations for when the audits should be discontinued. NK/SDDOHE/L</i></p>		

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F 159	<p>Continued From page 2 business manager revealed: *The resident trust fund had a current balance of \$6112.48. -It included a line item for coca-cola with a zero balance. -It included a line item listed as "donations for res [resident] activities" with a balance of \$5673.00. -Fifteen long-term care residents were listed on the account with a balance between zero and fifty dollars. *The residents were limited to a balance of \$50.00 in the resident trust fund. *The resident trust fund was a non-interest bearing checking account. *The \$5673.00 line item was for a fundraising event held by the facility for a wheelchair accessible trailer. *Residents 12, 13, and 14 had a separate interest-bearing savings account for balances between \$50.00 and \$2000.00. -Each account was in the resident's name with the business manager as an authorized signer. -Resident 13's account did not have an up-to-date statement from the bank to verify if the facility ledger and the bank statement balance matched.</p> <p>Interview on 3/16/16 at 1:45 p.m. with the emergency permit holder regarding the resident trust fund and personal accounts revealed: *He acknowledged the residents' money should have been in one account and the amount not limited. *The residents had access to their funds via a locked resident cash box kept with the business manager. -He was able to access the cash box in the business managers absence.</p> <p>Interview on 3/17/16 at 9:20 a.m. with the</p>	F 159		

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F 159	Continued From page 3 business manager regarding resident 13's account revealed: *The bank had corrected an error in the account on 3/16/16, and they were not able to forward a copy of the updated balance until the current day (3/17/16). *Acknowledged that the statement given to the surveyor on 3/16/16 was a quarterly statement from 6/30/15. *Was able to locate the 9/30/15 quarterly statement but not the 12/31/15 statement in the resident's file. -Verbalized she would request a duplicate copy from the bank. Policies concerning residents' accounts held by the facility were requested from the business manager and emergency permit holder. None were received by the end of the survey.	F 159			
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review and interview, the provider failed to ensure one of one purchased surety bond ensured the security of the full balance of residents' personal funds that had been deposited with the provider. Findings include:	F 161	<p>→ QAPI will review and make recommendations of when the audits should be discontinued. NK/SPD/ee</p> <p>F161: The administrator will contact the facility insurance carrier to increase the amount of the surety bond to amply cover the amount of funds in the resident trust account.</p> <p>The administrator or designee will audit all other surety bonds to make sure the amount of the bond has the necessary coverage for its purpose.</p> <p>The Administrator and the interdisciplinary team reviewed the policy and procedure for the management of resident funds and highlighted the findings cited in the deficiencies. The staff responsible for the handling of resident funds was educated by the administrator on the proper handling of resident funds.</p> <p>The administrator or designee will audit the surety bonds once per month for three months to ensure that each bond has the necessary coverage for its purpose.</p> <p>The administrator or designee will report the audit findings at the monthly QAPI meetings for review. *</p>		

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F 161	Continued From page 4 1. Review of the provider's current surety bond premium bill revealed: *It was paid up until 9/10/16. *It was in the amount of \$10,000.00. *It was a Nationwide Mutual Insurance Company Surety Bond. Review of the residents' funds deposited with the provider revealed a balance of \$10,377.06. Interview on 3/15/16 at 1:55 p.m. with the emergency permit holder regarding the surety bond revealed: *He was unaware the balance of residents' funds exceeded the value of the surety bond. *He acknowledged that an additional bond would need to be purchased to adequately cover the residents' funds. Policies concerning the surety bond were requested from the emergency permit holder. None were received by the end of the survey.	F 161	<i>*QAPI will review and make recommendations for when the audits should be discontinued. NRISDDOHL</i> <i>*All staff members recieved written education which covered restraints: types of restraints, certified need for use of restraints, physician order for restraint and</i>	<i>*5/6/16 NRISDDOHL</i>
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to determine, assess, and care plan a wheelchair seat belt as a restraint for one of one (9) sampled	F 221	F221: The Director of Nursing or designee will perform a needs assessment for the wheelchair seat belt for resident 9. The records of all other residents were examined to ensure that no other resident was under restraint without having a proper reason and assessment done. In the future all residents will be given an assessment to determine the need for restraints. Proper documentation and care planning will be overseen by the Director of Nursing. The Director of Nursing or designee will audit all restraints once per month for three months to ensure that a needs assessment is completed, care planning is done and proper documentation is completed. *Audits will include types of restraints and which residents have the potential to be restrained. The Director of Nursing or designee will report audit findings at the monthly QAPI meetings for review.	<i>assessment required. This education was completed on 5/5/16 NRISDDOHL</i>

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F 221	<p>Continued From page 5 resident. Findings include:</p> <p>1. Observation on 3/16/16 at 10:20 a.m. showed resident 9 in her wheelchair in the living room area with a blue seat belt on.</p> <p>Observation and interview on 3/16/16 at 12:55 p.m. of resident 9 with certified nursing assistant (CNA) E revealed: *When asked by this surveyor to remove her seat belt, she appeared confused and did not remove her seat belt. *CNA E also asked the resident to remove her seat belt without success. *Regarding the resident's ability to remove her seat belt CNA E stated "Sometimes she does, but not to command. She doesn't know it's there."</p> <p>Interview on 3/16/16 at 1:05 p.m. with licensed practical nurse F regarding resident 9's ability to remove her seatbelt revealed "Sometimes she removes it."</p> <p>Review of resident 9's medical record revealed: *She had been admitted on 4/10/15. *She had diagnoses of dementia (a gradual worsening of mental capacity) and history of a stroke with right sided weakness. *A physician's order for the seat belt: "May use self released alarmed seat belt while in wheel chair per daughters request." *A physician's nursing home visit note from 2/17/16 that stated "She uses a seat belt for safety and she can release it." No medical symptom was cited for the use of the seat belt. *No initial or ongoing assessments were found to determine: -If resident was physically and mentally capable of removing the seat belt upon request to do so.</p>	F 221			

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F 221	<p>Continued From page 6</p> <p>-If the seat belt was safe for the resident.</p> <p>Review of resident 9's 5/27/15 and 2/11/16 Minimum Data Set (MDS) assessments revealed: *Her Brief Interview for Mental Status (BIMS) assessments were coded as a 3, that indicated severe mental impairment. *Physical restraints were coded as a 0 indicating they were not used.</p> <p>Review of resident 9's undated care plan revealed: *On 10/29/15 "Daughter requests the use of an alarm seat belt. It is Velcro and resident is able to self-release." *Nothing is mentioned on how and when to use the seat belt or why.</p> <p>Interview on 3/16/16 at 3:40 p.m. with the Minimum Data Set Assessment coordinator regarding the seat belt for resident 9 revealed: *"She [resident 9] uses it for safety." *She was unaware that initial and ongoing assessments had not been done for the use of the seat belt. *She had not done an assessment of resident 9 to determine if she could remove the seat belt. *She was not aware that it was a restraint.</p> <p>Interview on 5/17/16 at 3:10 p.m. with the emergency permit holder regarding the use of a seat belt for resident 9 revealed: *The director of nursing was unavailable to interview. *"He will look into it [the concern] *He had not gotten back to me regarding the concern before we exited.</p> <p>Review of the provider's undated Restraints</p>	F 221			

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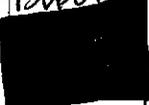
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F 221	Continued From page 7 Assessment policy revealed: *"The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Prior to a restraint being applied, a physical restraint assessment will be performed." **"Medical Symptom: an indication or characteristic of a physical or psychological condition."	F 221		
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	F 431	F431: Both of the labels for residents 4 and 13 were sent back to pharmacy to assure that they matched the physician's orders. The current medications in stock were examined and compared to the MAR to make sure that they matched one another. In the future, when medication is delivered to the facility it will be immediately cross referenced against the MAR to make sure the instructions match up with one another. If they do not they will be sent back to pharmacy receive the necessary corrections. The Director of Nursing or designee will audit the residents medications once per month for three months [redacted] to ensure that the medications for each residents match the physician's orders. The Director of Nursing or designee will report the results of these audits at the monthly QAPI meeting for review. <i>*QAPI will review and make recommendations for when the audits should be discontinued.</i>	<i>NK/SPDOH/EL</i> <i>*5/6/16</i>  <i>*all NK/SPDOH/EL</i> <i>*to ensure that the medications NK/SPDOH/EL</i>

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F 431	<p>Continued From page 8</p> <p>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 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and record review, the provider failed to ensure pharmacy medication label instructions matched the physician's orders for two of two (4 and 13) residents randomly observed during medication administration. Findings include:</p> <p>1. Observation on 3/15/16 at 5:40 p.m. of licensed practical nurse (LPN) G passing medications to resident 4 revealed: *The resident's medication administration record (MAR) showed: "Tylenol 325 mg. (milligram) two tablets three times a day." *The pharmacy label on the Tylenol bottle for that resident showed: "Tylenol 325 mg. one tablet three times a day."</p> <p>Interview at that time with LPN G about the difference in the pharmacy label instructions and the MAR revealed: *She would go with the directions on the MAR to decide which was the correct dose. *She was unaware anything further needed to be done.</p> <p>Review of resident 4's medical record revealed the dose given from the MAR was correct.</p>	F 431			

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F 431	Continued From page 9 2. Observation on 3/16/16 at 9:15 a.m. of LPN F passing medications to resident 13 revealed: *The resident's MAR showed: Baclofen (a medication used to relax muscle activity) 5 mg. twice a day. *The pharmacy label on the medication package showed: Baclofen 5 mg. three times a day. Interview at that time with LPN F about the difference in the pharmacy label instructions and the MAR revealed: *She stated "I know the physician's order that is on the MAR is correct." *She agreed the pharmacy label instructions and the orders on the MAR should match. *Stated she would call the pharmacy for further instructions. Review of resident 13's medical record revealed the dose given from the MAR was correct. Interview on 5/17/16 at 3:10 p.m. with the emergency permit holder regarding the physician's orders on the MAR not matching the pharmacy medication labels revealed: *The director of nursing was unavailable to interview. *He understood that both the MAR and the pharmacy label instructions should match. *No specific policy for this existed when requested.	F 431			
F 441 SS=E	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	F 441	F441: The conditions of residents 12, 13, 15, and 16 were tracked in the infection log. Moving forward, each time there is suspicion of a resident illness it will be tracked in the infection log in order to try and control and track the infection and identify any infection trends within the facility. For residents 3 and 7, each will get their own staff member to assist them with eating so there is no cross contamination that occurs when only one staff member is assisting them.		<i>*5/16/16</i> <i>NR/SDDO/H/EL</i> 

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F 441	<p>Continued From page 10 to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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 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. 32331</p>	F 441	<p>A mandatory all staff in-service will be held on 04/11/2016 to educate the staff on proper infection control procedures. More specifically, those procedures that include infection and illness tracking, proper hand sanitizing, the use of protective devices such as masks when sick, and the proper way to assist residents with eating to control infection.</p> <p>The administrator met with the Director of Nursing to create a new policy about employee illness. The new policy was reviewed with the Interdisciplinary team. The policy included what to do when an employee is ill, the use of masks to prevent the spread of infection, and tracking illness in the infection control log. They also discussed the formation of an Infection control committee that would include the administrator, the Director of Nursing, one kitchen staff member, one nursing staff member, and one environmental services staff member.</p> <p>The Director of Nursing will be in charge of the infection control procedures and will review the tracking log and any other relevant material weekly. The Infection control procedures and statistics will be reviewed at each QAPI meeting monthly.</p> <p>The administrator or designee will audit the infection control logs weekly for one month and monthly for two more months to ensure that the facility is tracking and dealing with infectious situations in a timely manner. Results of these audits will be reported at the monthly QAPI meetings for review.</p> <p>The Director of Nursing or designee will audit once per week for four weeks and once per month for two more months the assistance during meal times to ensure that proper infection controls procedures are being followed.</p> <p>The Director of nursing or designee will report audit findings at the monthly QAPI meetings for review.</p> <p><i>*QAPI will review and make recommendations for when the audits should be discontinued.</i></p> <p><i>NR/SDD/HJL</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/17/2016
NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034		
(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 11 Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to ensure an infection control program was active for the monitoring, tracking, and trending of resident and staff illnesses including: *One of one charge nurse (licensed practical nurse [LPN] G) who was working while ill. *One of two facility hallways with 4 of 11 random long-term care residents (12, 13, 15, and 16) with cold symptoms. *Proper hand hygiene with 1 of 1 certified nursing assistant (CNA) I during feeding assistance for 2 of 2 residents (3 and 7) at the same table during one observed meal. Findings include: 1. Observation on 3/15/16 from 5:45 p.m. through 6:00 p.m. in the resident dining room with LPN G revealed she: *Was experiencing cold-like symptoms (runny nose) while on duty. *Was administering oral (by mouth) medications to multiple residents. *Was in close proximity to each resident as she gave the medication. *Had no mask in place to prevent the spread of infection. 2. Random observations from 3/15/16 at 9:15 a.m. through 3/16/16 at 5:00 p.m. of residents in the 100 hallway revealed: *Four of the eleven long-term care residents (12, 13, 15, and 16) were experiencing cold-like (runny nose, congestion, and coughing) symptoms while in hallways, dining, and living areas. *One resident had finished her third series of	F 441			

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2016
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034
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F 441	<p>Continued From page 12</p> <p>antibiotics for an upper respiratory infection on 3/15/16.</p> <p>Surveyor: 32331</p> <p>3. Observation on 3/15/16 from 12:48 p.m. through 12:59 p.m. of residents 3 and 7 during the noon meal service in the dining room revealed:</p> <p>*CNA I:</p> <ul style="list-style-type: none"> -Was assisting residents 3 and 7 with eating. Those residents were seated at the same table. -At 12:48 p.m. she wiped resident 7's face with a towel, repositioned his clothing protector, lifted his chocolate drink, and gave him a sip of the liquid. -At 12:49 p.m. she placed residents 3's glass of clear liquid into his hand. -At the same time as the above she coughed into her hand. -At 12:50 p.m. she continued feeding resident 7 his pureed food. -At 12:54 p.m. she wiped resident 7's face with his clothing protector and removed it. -At 12:55 p.m. she pushed resident 7's wheelchair away from the table. -At 12:56 p.m. she returned to resident 3 and picked up his fork and encouraged the resident to feed himself with the fork. -At the same time as the above she placed the fork back down on the resident's place setting. -At 12:59 p.m. she left the table and obtained a wet wash cloth and wiped resident 7's face with that cloth. -She then placed the above wash cloth into a laundry container and obtained a clean wash cloth. -At the same time as the above she took the clean wash cloth and wiped resident 7's face. <p>*At no time during the above observation were</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034		
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F 441	<p>Continued From page 13</p> <p>her hands washed or a hand sanitizer used between the feeding of the two residents.</p> <p>Interview on 3/15/16 at 6:00 p.m. with the dietary manger regarding CNA I assisting residents 3 and 7 with eating revealed she would have expected the policy for hand hygiene to have been followed.</p> <p>Interview on 3/17/16 at 8:35 a.m. with the emergency permit holder (EPH) regarding assisting residents 3 and 7 with eating revealed he would have expected the policy for hand hygiene to have been followed.</p> <p>Review of the provider's 8/14/13 Handwashing policy revealed: *To have reduced the transmission of infections handwashing was an essential element. *The term "hand hygiene" included: -Handwashing with either plain or antiseptic (slows or stops the growth of germs) soap. -The use of alcohol-based products that did not require the use of water. *Procedures had included for handwashing: -Wet hands. -Apply soap thoroughly under nails and between fingers. -Rub the hands together with a rotating, frictional motion for at least twenty seconds. -Wash the fingers and the spaces between them, interlacing the fingers, and rubbing up and down. -Rinse hands well. -Dry thoroughly with a paper towel. -With a paper towel turn off the water faucet. -Discard paper towel. *Procedure had included for alcohol-based hand rub or waterless antiseptic: -Apply to hands.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034		
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F 441	<p>Continued From page 14</p> <p>-Rub hands together until dried.</p> <p>Review of the provider's 7/10/13 Handwashing Checklist revealed handwashing was to have occurred when:</p> <p>-Hands were soiled. -Before and after caring for each resident. -Before having contact with a resident (for example, face and mouth).</p> <p>Surveyor: 35625</p> <p>4. Interview on 3/15/16 at 3:00 p.m. with the director of nursing (DON) revealed:</p> <p>*She was new to her job duties having assumed the role in February 2016. *Although she was in the facility she was currently on personal leave. *In addition to her role as DON, she was responsible for the infection control program. *A log book was kept at the nurses station to identify diagnosed resident and staff infections. -It identified the date, resident/employee name, symptoms, medical provider diagnosis, antibiotic, and date the symptoms resolved. -It did not identify the results of any cultures (additional testing that identifies the type of bacteria) that might have been completed. -An illness was not recorded in the book until a diagnosis was made by a medical provider. -She acknowledged the information in the log was not always kept current, and the previous DON told her she checked it monthly. -Review of the log listed four entries between 5/26/15 and the current date. -It did not include a resident diagnosed with an upper respiratory infection in February 2016 and prescribed antibiotics. -She stated that the information on the log was not used for to identify any illness trends.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034		
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F 441	<p>Continued From page 15</p> <ul style="list-style-type: none"> *There was no infection control committee *An monthly infection control report listing the number of each illness was given to the quality assurance (QA) committee. *There was no monitoring or tracking of illnesses, such as a cold or stomach virus, that did not require a medical provider's care. <p>Interview on 3/17/16 at 10:00 a.m. with the EPH regarding infection control revealed:</p> <ul style="list-style-type: none"> *There was no policy in place to address the steps employees needed to take when they were ill. That included: <ul style="list-style-type: none"> -The use of a mask over the face to prevent the spread of infection. -Guidelines on when to stay home or return to work from illness. *He agreed the resident and employee illness log likely was not complete. *He verified there was not a specific infection control committee, and an infection control report was brought to the monthly QA meeting. *The QA committee would discuss what each department could do to prevent the spread of infection. *Acknowledged the information was not used to identify any trends in illness. <p>Review of the provider's 8/14/13 Infection Control Surveillance Guidelines policy and procedure revealed:</p> <ul style="list-style-type: none"> *Components of infection control were to include: <ul style="list-style-type: none"> -Surveillance-collect data and identify infections in residents. -Outbreak control-a system for detection, investigation, and control of infection outbreaks. -Antibiotic stewardship-review and control of antibiotics. 	F 441			

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

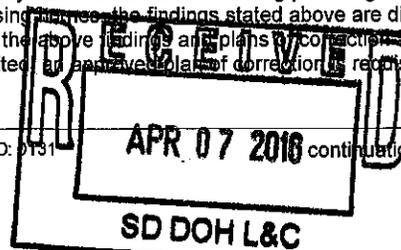
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED 03/16/2016
NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034		
(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 3/16/16. Hudson Care and Rehab Center LLC was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER-REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **04/05/2016**

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2016
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034
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S 000	Compliance/Noncompliance Statement *Addendum S000 noted with an asterisk per 4/25/16 per telephone with facility administrator. NR4SDDOH/EL		S000: 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 provision of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	[Redacted] *5/16/16 NR4SDDOH/EL
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; and hydration needs of residents; and (10) Dining assistance, nutritional risks, and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	S206: Employees A, B, C, D and the MDS coordinator were all given in-service material concerning orientation points 5, 9, and 10. Each of those points was added to the orientation checklist by the administrator. An orientation for abuse, neglect, mistreatment, and misappropriation of resident property and funds was also scheduled per requirements. The business office manager reviewed the old employee files to make sure that they met the required orientation procedures. The business office manager will review each new employee's orientation checklist to make sure that it is being completed. The business office manager or designee will audit employee files once per month for three months to ensure proper in-servicing is being completed during new employee orientation. The business office manager or designee will report audit findings at the monthly QAPI meetings for review.	*QAPI will review and make recommendations for when the awaits should be discontinued. NR4SDDOH/EL

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

[Signature]

STATE FORM

6899

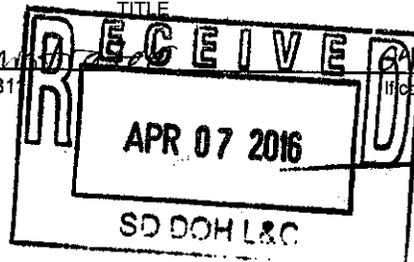
Y4QB1

TITLE

Administrator

(X6) DATE

4/05/2016



If continuation sheet 1 of 8

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2016
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034
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S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure: *Five of five newly hired sampled employees (A, B, C, D, and the Minimum Data Set (MDS) coordinator had received an orientation program on proper use of restraints and dining assistance, nutritional risks, and hydration needs of residents. *All staff had annual training for 1 of 11 mandated annual topics (abuse, neglect, mistreatment, and the misappropriation of resident property and funds). Findings include:</p> <p>1. Review of sampled employees A, B, C, D, and the MDS coordinator's orientation records revealed: *The employees had been hired on the following dates: -Certified nursing assistant (CNA) A on 1/25/16. -CNA B on 1/11/16. -CNA C on 11/12/15. -Cook/dietary assistant D on 1/25/16. -MDS coordinator on 12/4/15. *There had been no documented orientation training on proper use of restraints and dining assistance, nutritional risks, and hydration needs of residents.</p> <p>Interview on 3/17/16 at 10:30 a.m. with the business office manager and at 10:40 a.m. with the emergency permit holder (EPH) regarding the above employees orientation training revealed: *The employee's supervisor, the EPH, the</p>	S 206		
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2016
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S 206	Continued From page 3 Interview on 3/17/16 at 10:30 a.m. with the business office manager and at 10:40 a.m. with the EPH regarding the above mandated annual topic revealed: *Both agreed there was no documentation the annual topic had been given in 2015 through 3/17/16. *The EPH was responsible for the mandated annual topics to have been provided to employees. *He expected the annual education program for all employees to have been followed. Review of the provider's undated All Staff In-Services policy revealed topics were to have been based on federal and state training requirements.	S 206		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the	S 236	<p>S236: CNA A was given her two step test with negative results. CNA B was also given her TB two step test with negative results. Each newly hired employee will be given a TB two step test within 14 days of hire date. The Director of Nursing will oversee this process to make sure it is getting done and it will be tracked in the new employee orientation list which is kept in the office.</p> <p>The business office manager or designee will audit employee files once per month for three months to ensure that the proper TB testing is completed on all new employees.</p> <p>The business office manager or designee will report audit findings at the monthly QAPI meetings for review.</p> <p><i>*QAPI will review and make recommendations for when the audits should be discontinued.</i></p>	 <i>*5/10/16</i> <i>NR/SDDO/H/EL</i>

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034
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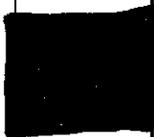
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S 236	<p>Continued From page 4</p> <p>last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on employee file review, interview, and policy review, the provider failed to ensure two of five newly hired sampled employees (A and B) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include:</p> <p>1. Review of certified nursing assistant (CNA) A's employee file revealed: *A hire date of 1/25/16. *The one-step and a two-step TB skin testing had not been completed. *The TB skin tests had not been completed fourteen days after having been hired.</p> <p>2. Review of CNA B's employee file revealed: *A hire date of 1/11/16. *There was a documented one-step TB skin test on 2/3/16. *There was no documentation a two-step TB skin test had been given. *The TB skin tests had not been completed fourteen days after having been hired.</p> <p>3. Interview on 3/17/16 at 10:30 a.m. with the business office manager and at 10:40 a.m. with</p>	S 236		

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER
HUDSON CARE AND REHAB CENTER, LLC

STREET ADDRESS, CITY, STATE, ZIP CODE
**720 PARKWAY
HUDSON, SD 57034**

(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 236	<p>Continued From page 5</p> <p>the emergency permit holder (EPH) regarding the TB screening for employees A and B revealed: *There was no completed documented TB skin testing. *The business office manager confirmed: -CNA A had been hired on 1/25/16. -CNA B had been hired on 1/11/16. *Both agreed the TB skin tests had not been given in a timely manner. *Both confirmed the TB skin tests had not followed the state guidelines for TB screenings for new employees.</p> <p>Interview on 3/17/16 at 10:45 a.m. with licensed practical nurse H regarding the TB screenings for new employees revealed the nursing staff were responsible for the employee's TB skin tests to have been given in a timely manner.</p> <p>Review of the provider's revised 8/7/14 TB Screening policy revealed each new employee was to have received the two-step method of TB skin testing within fourteen days of employment.</p>	S 236		
S 296	<p>44:73:07:11 Director of Dietetic Services</p> <p>A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the</p>	S 296	<p>S296: Two of the three cooks went to a ServeSafe class in Mitchell, SD on 03/31/2016 to get their ServeSafe Certification. The other cook on staff is attempting to obtain her certification through and online class. The Dietary Director also enrolled in a ServeSafe class to get her certification. The facility will maintain at least one cook and the dietary manager are serve safe certified to be in compliance with state regulations. The administrator will monitor this program to make sure it is being followed. The Dietary Director will also oversee the ServeSafe Certification Program.</p> <p>The administrator or designee will audit dietary staff files once per month for three months to ensure that the facility dietary director and one other employee have completed the Serve Safe program.</p>	<p> *5/6/16 NR/SPD/CH/EC</p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10632	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/17/2016
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034
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S 296	<p>Continued From page 6</p> <p>Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on interview, the provider failed to ensure the dietary manager and at least one cook possessed a current ServSafe Food Protection Program certificate. Findings include:</p> <p>1. Interview on 3/15/16 at at 6:00 p.m. with the certified dietary manager (CDM) revealed: *None of the cooks that worked in the kitchen possessed a current ServSafe Food Protection Program certificate. *She had planned to have three cooks attend an upcoming class for ServSafe.</p> <p>Interview on 3/17/16 at 8:30 a.m. with the CDM revealed she: *Did not have a current ServSafe Food Protection Program certificate.</p>	S 296	<p>The administrator or designee will report audit findings at the monthly QAPI meeting for review.</p> <p><i>* QAPI will review and make recommendations for when the audits should be discontinued. NK/SDDCH/EL</i></p>	
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NAME OF PROVIDER OR SUPPLIER HUDSON CARE AND REHAB CENTER, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 720 PARKWAY HUDSON, SD 57034		
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S 296	Continued From page 7 *Had been aware the dietary manager and at least one cook working in the kitchen had needed to have a current ServSafe certificate. Interview on 3/17/16 at 10:40 a.m. with the emergency permit holder revealed: *He had expected the dietary manager and at least one cook to have possessed a current ServSafe Food Protection Program certificate. *The provider had no policy on the ServSafe certificate program. *The regulation for the dietary manager and at least one cook to have possessed a current ServSafe certificate had not been followed.	S 296		
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 3/15/16 through 3/17/16. Hudson Care and Rehab Center LLC was found in compliance.	S 000		