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

ORIGINAL

PRINTED: 03/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER
LAKE ANDES SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE
740 EAST LAKE ST POST OFFICE BOX 130
LAKE ANDES, SD 57356

(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	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 3/7/16 through 3/9/16. Lake Andes Senior Living was found not in compliance with the following requirements: F224, F226, F280, F323, F371, F514, and F520.	F 000		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Ensure neglect and injury had not occurred for one of nine sampled residents (5) who remained on a bedpan for over eight hours. *Investigate the above event for abuse and neglect. Findings include: 1. Interview on 3/7/16 at 3:30 p.m. with the director of nursing (DON) revealed resident 5 had a pressure ulcer on her buttocks from laying on a bedpan too long on 2/18/16.	F 224	F224 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: 1. Investigation regarding Resident 5 was completed on 3/14/16. Initial report was made to SD DOH on 3/9/16. Final report was submitted on 3/14/16. 2. All incident reports were reviewed to assure if it was reportable it was reported. None were found. 3. Abuse, Neglect and Misappropriation of Property Policy/Procedure was reviewed on 3/18/16 by the Interim Executive Director (IED), Social Service Designee (SSD), Interim DNS (IDNS), and Interdisciplinary team. All employees were educated on the policy and what constitutes mistreatment, abuse, neglect, or misappropriation of property and what is reportable by Emergency Permit Holder Preceptor (EPHP) on 3/18/2016. All incidents will be reported to the IED and IDNS at the time of the incident. The IED and IDNS will review each incident report within 48 hours of notification to assure information is completed and investigation is documented. This will be an ongoing process. 4. The data collected will be taken to the QAPI Committee at least quarterly by the Interim Director of Nursing/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion Date: 3/30/2016	3/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candace Duvall
TITLE: EPH
(X6) DATE: 3/31/16

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.

APR 04 2016
SD DOH L&C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 224	Continued From page 1 Review of resident 5's medical record (both a paper chart and an electronic medical record) revealed: *A Weekly Pressure Ulcer Record dated 2/20/16 and 2/26/16 indicating a 2 centimeter (cm) by 2 cm unstageable pressure ulcer to her sacrum (large triangular bone at the base of the spine). That pressure ulcer had been documented as healed on 3/5/16. *The electronic medical record (EMR): -Had no documentation in the interdisciplinary progress notes on 2/18/16 regarding any events that could have led to being left on a bedpan or a pressure sore. -A 2/19/16 entry by registered nurse (RN) N indicated the resident's urine was dark, but nothing about a pressure sore. *On 2/20/16 at 3:29 p.m. RN H had documented a 2 cm fluid-filled blister on the resident's coccyx (tailbone). *No documentation regarding the resident having been left on a bedpan until a late entry was documented on 3/8/16 at 9:27 p.m. by RN A. *That 3/8/16 entry had indicated RN A had laid her down at 10:00 p.m., and the bedpan was discovered under the resident the next morning at 6:30 a.m. *A 3/7/16 physician's progress note had indicated open areas to her buttocks "that have been present for a couple of weeks." Her left buttock had "a triangular shaped open area" and "a few other excoriated areas laterally to the triangular shaped wound." *There was no nursing documentation in the medical record regarding those above left buttock open areas. Interview on 3/8/16 at 3:15 p.m. with the social services designee regarding her role in incident	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 224	Continued From page 2 investigations revealed: *She was usually notified when an incident occurred. *She did not actively participate in the investigations. *The interim executive director (ED) and the emergency permit holder (EPH) normally handled the investigations. *When asked how she would ensure residents, family, and staff felt free to communicate their needs she stated: -She attended the care conferences for the residents. -There was a box for families to write their thoughts or concerns in. Observation on 3/9/16 at 8:45 a.m. of resident 5's buttocks during care revealed: *A darkened line had remained around her buttocks where the bedpan had left a mark after laying on the bedpan on 2/18/16. *RN K confirmed that darkened line had been the same line caused from laying on the bedpan on the night of 2/18/16. *Two open areas to the left buttock in the same spot as the bedpan mark. Interview with resident 5 at the above time revealed she was unable to provide appropriate information regarding the events on 2/18/16 and 2/19/16. Interview on 3/9/16 at 9:00 a.m. with the DON revealed: *Resident 5 had been placed on a bedpan on the evening of 2/18/16. *The DON had not been aware of what time the bedpan had been placed under the resident. *She had not been aware of who had placed the	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 224	Continued From page 3 bedpan under her. *RN A and certified nursing assistant (CNA) B had repositioned the resident at 1:00 a.m. and 4:00 a.m. but had not noticed the bedpan under her. *The bedpan was discovered on 2/19/16 by the morning CNAs. *The initial pressure ulcer had healed on 3/5/16. *She had not been aware of the two open areas to the left buttock. She was sure they were not present when she looked at resident 5's buttocks on 3/8/16. Interview on 3/9/15 at 3:00 p.m. with RN A revealed: *She stated she had asked CNAs B, C, and E if all of their residents' cares were completed on the evening of 2/18/16. Those CNAs told her everything had been done. *Resident 5 had been eating a snack in bed on 2/18/16 at 10:00 p.m. *RN A entered her room after she finished her snack and lowered the head of her bed, so she could sleep. *She was not aware the resident was sitting on a bedpan at that time. *RN A and CNA B had repositioned resident 5 at 1:00 a.m. and 4:00 a.m. They had not noticed the bedpan under her. *The resident had not told her she was laying on a bedpan, nor asked for assistance getting off the bedpan. *The morning CNAs L and M had notified her of the bedpan at 6:30 a.m. *She had not interviewed CNAs B, C, or E later to find out what had happened. It could have been any of those CNAs who had placed a bedpan under her. *It required two people to place a bedpan under	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 224	Continued From page 4 resident 5. *She had notified the DON when the bedpan was discovered. *She had not notified the physician, the family, or the administrator. *RN H had notified the family of the incident on 2/20/16 when the pressure ulcer blister was found. Interview on 3/9/16 at 3:30 p.m. with CNA B revealed: *She had worked the evening of 2/18/16 and continued to work through the entire night. *She stated she had not assisted with repositioning resident 5 at 1:00 a.m. and 4:00 a.m. *She stated if she had repositioned her she would have noticed the bedpan under her. Individual interviews with CNA C on 3/9/16 at 3:25 p.m. and CNA B at 3:30 p.m. revealed both CNAs had denied placing the resident on a bedpan. Interview on 3/9/16 at 3:50 p.m. with the interim ED and the EPH preceptor revealed: *They had not been notified of the incident until the afternoon of 3/9/16 after it was identified by the survey team. *They had agreed resident 5 had been neglected by staff by not having removed her from the bedpan when she was finished using it. *They would have expected the nurse finding the bedpan to have notified both the DON and the interim ED at the time it happened. *They would have suspended the staff in question, investigated the event, and then reported the event to the South Dakota Department of Health (SD DOH). *The social services designee was sometimes	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 224	Continued From page 5 involved in incidents but not consistently. Review of the provider's undated Job Description and Essential Functions for Social Services Director revealed essential duties were: *To assist residents and families with social and emotional issues. *Provide in-service training for facility staff and the community. Review of the provider's undated Abuse, Neglect, and Misappropriation of Property Prevention Policy revealed: *Neglect was "A failure, through inattentiveness, carelessness, seclusion, or omission, without a reasonable justification, to provide timely, consistent, and safe services, treatment, and care to a resident." *All employees would be required to attend training through orientation and annual meetings on issues related to abuse prevention and intervention including what constituted neglect. *Employees would report findings of suspicious abuse and neglect immediately to their supervisor. *An incident report would have been written and was to have been followed-up by the DON or administrator. *Any valid findings would have been acted upon immediately by the administrator. *All incidents would have been investigated thoroughly by the administration. *Any complaints would have been reported within twenty-four hours to the SD DOH, followed by a written report within five working days.	F 224		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	F226 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as continued pg 7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 226	Continued From page 6 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to have documentation to reflect investigations had been completed and reported to the South Dakota Department of Health (SD DOH) for one of one sampled resident (5) who had one incident where pressure areas had developed on her buttocks. Findings include: 1. Interview on 3/7/16 at 4:00 p.m. with the director of nursing (DON) revealed resident 5 had developed a pressure ulcer to her buttocks on 2/18/16 after having been left on a bedpan. Review of resident 5's medical record revealed: *A Weekly Pressure Ulcer Record dated 2/20/16 indicating a 2 centimeter (cm) by 2 cm unstageable pressure ulcer to her sacrum (large triangular bone at the base of the spine). *The electronic medical record (EMR) had no documentation regarding the resident having been left on a bedpan until a late entry was written on 3/8/16 at 9:27 p.m. by RN A. *That 3/8/16 entry had indicated RN A had laid her down at 10:00 p.m., and the bedpan was discovered under the resident the next morning at 6:30 a.m.	F 226	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: 1. Investigation regarding Resident 5 was completed on 3/14/16. Initial report was made to SD DOH on 3/9/16. Final report was submitted on 3/14/16. 2. All incident reports were reviewed to assure if it was reportable it was reported. None were found. 3. Abuse, Neglect and Misappropriation of Property Policy/Procedure was reviewed on 3/18/16 by the Interim Executive Director (IED), Social Service Designee (SSD), Interim DNS (IDNS), and Interdisciplinary team. All employees were educated on the policy and what constitutes mistreatment, abuse, neglect, or misappropriation of property and what is reportable by Emergency Permit Holder Preceptor (EPHP) on 3/18/2016. All incidents will be reported to the IED and IDNS at the time of the incident. The IED and IDNS will review each incident report within 48 hours of notification to assure information is completed and investigation is documented. This will be an ongoing process. 4. The data collected will be taken to the QAPI Committee at least quarterly by the Interim Director of Nursing/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion Date: 3/30/2016	3/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 226	Continued From page 7 Interview on 3/9/16 at 9:00 a.m. with the DON revealed: *There was no documentation of the bedpan having been found under the resident at the time it occurred. *The nurse working at the time the bedpan was discovered had notified her of the incident. *She was not sure if the interim executive director (ED) had been notified of the incident. If she had been notified it would have occurred in passing in the hall. *No incident report had been documented. *The incident had not been investigated. *She stated she did not believe resident 5 had been neglected. *The incident had not been reported to the SD DOH. Surveyor: 32331 Interview on 3/9/16 at 2:40 p.m. with the social service designee regarding incident reporting and investigations revealed she: *Was to have been only notified. *Had no further involvement in incident reporting or with the investigations. *Would have preferred to have had a more active role. Surveyor: 32332 Interview on 3/9/16 at 3:50 p.m. with the interim ED and the emergency permit holder (EPH) preceptor regarding resident 5 having been left on a bedpan revealed: *They stated they had just found out about the above incident on 3/9/16. *They would have expected to have been notified by RN A at the time of the incident. *They agreed the resident having been left on a	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 226	Continued From page 8 bedpan overnight would have been neglect. Review of the provider's undated Abuse, Neglect, and Misappropriation of Property Prevention Policy revealed: *Employees would report findings of suspicious abuse and neglect immediately to their supervisor. *An incident report would have been written and was to have been followed-up on by the DON or administrator. *Any valid findings would have been acted upon immediately by the administrator. *All incidents would have been investigated thoroughly by the administration. *Any complaints would have been reported within twenty-four hours to the SD DOH followed by a written report within five working days.	F 226		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	F280 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: 1. Resident 4, 5, and 8's Care Plans were updated on 3/15/16 to reflect accurate plan of care. 2. All care plans were reviewed/ revised by 3/15/16 by the IDT to assure they reflect each individual's plan of care. 3. Interdisciplinary Team and Charge Nurses were re-educated to the updating and accuracy of care plan to assure they reflect each individual's plan of care on 3/15/16 by the MDS Consultant. Continued on pg. 10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 280	Continued From page 9 each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Surveyor: 32332 Surveyor: 35121 Based on observation, record review, interview, and guideline review, the provider failed to ensure care plans were updated to reflect the current status for three of nine sampled residents (4, 5, and 8). Findings include: 1. Observation of resident 8 on 3/8/16 at 5:42 p.m. in the dining room, revealed his meal was pureed. Review of resident 8's medical record revealed: *A physician's order for pureed food on 2/9/16. *His diet card was labeled "puree." *His 1/8/16 care plan stated "Follow diet as ordered by MD. (Regular w/[with] ground meat)." 2. Observation of resident 4 on 3/8/16 at 12:20 p.m. in the dining room, revealed her meal was pureed. Review of resident 4's medical record revealed: *A physician's order for pureed diet on 3/8/16. *Her diet card was labeled "puree." *Her current 4/16/15 care plan stated "Serve diet as ordered.(regular)." Surveyor: 32332	F 280	4. Two (2) Care plans will be audited one (1) time weekly for three (3) months by IDNS/Designee for accuracy and that it reflects each individual's plan of care. The data collected will be taken to the QAPI Committee at least quarterly by the Interim Director of Nursing/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion date: 3/30/2016	3/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 280	Continued From page 10 3. Review of resident 5's medical record revealed: *A Weekly Pressure Ulcer Record initiated 2/20/16 and assessed again on 2/26/16 indicating a 2 centimeter (cm) by 2 cm pressure area to her sacrum (the large triangular bone at the base of the spine). *The above pressure area had been documented as healed on 3/5/16. *Her updated 2/3/16 care plan revealed: *She had a potential for pressure ulcer development. *No indication the pressure area or other skin concerns were present. Interview on 3/9/16 at 9:00 a.m. with the director of nursing regarding resident 5's care plan revealed she agreed the care plan had not included pressure ulcer concerns. Surveyor: 32331 Interview on 3/9/16 at 9:40 a.m. with the certified dietary manager regarding updating the residents care plans that involved diets revealed: *She was responsible for updating the care plan when it had involved any changes with a resident's diet. *Those updates needed to have occurred whenever there was a change. Surveyor: 35121 4. Review of the provider's revised August 2013 Care Plan Completion Standards Guideline revealed all care plans "should include individual and/or combined focus problems that address...Nutritional Status - Any special nutritional supplements or diets." Review of the provider's revised 7/7/11	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 280	Continued From page 11 Guidelines for the Comprehensive Care Plan revealed the care plan was to: *"Meet the resident's medical, nursing, social, nutritional and psychological needs." *"Be updated in conjunction with any medical, nursing, social, nutritional and psychological changes experienced by the resident." *"Be reviewed and revised as needed."	F 280		
F 323 SS=D	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: 32332 Based on observation, interview, and policy review, the provider failed to maintain an environment free from potential accident hazards: *For six of six cement sidewalk pads in the "handicapped parking" area and two sidewalk pads in the visitor parking area. *To prevent resident access to hazardous chemicals for one of one housekeeping cart. Findings include: 1. Observation of the parking area by the front entrance to the building revealed an area with three signs marked "handicapped parking". Observation of the sidewalks in front of those signs revealed the six cement sidewalk pads had	F 323	F323 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: 1. Area identified by front parking area is scheduled to be repaired by 4/27/16. A new lockable housekeeping cart was implemented on 3/10/16. 2. Maintenance Supervisor inspected all sidewalks to ensure there are no other areas of concerns on 3/31/2016. All housekeeping carts were evaluated to assure they are lockable. 3. All Staff were re-educated by IED on 3/30/16 in-service that all chemicals must be secured/locked and inaccessible to residents at all times unless being used and under direct observation. Staff were educated to report any areas of safety concerns such sidewalks. 4. Sidewalks will be monitored by Maintenance Supervisor at least one (1) time monthly through visual observation for any areas of safety concern. . Housekeeping Supervisor will audit chemicals for secure and safe storage one (2) times weekly through observation. The data collected will be taken to the QAPI Committee at least quarterly by the Maintenance/Housekeeping Supervisor/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion Date: 4/27/2016 4/27/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 323	Continued From page 12 areas of cement that had broken away. All of the above pads had missing depths from one to three inches causing a hazard for falls and injury. *The pad closest to the entrance (1) had a missing area approximately 45 inches long and up to 5.0 inches wide across one edge. Another edge was 52 inches long and up to 11 inches wide at the widest area. *Pad 2 had a broken area across the bottom edge of 33 inches by 5.5 inches. *Pad 3 had missing areas of 23.5 inches by 6.5 inches and another area of 19 inches by 6.0 inches. Those areas were across the bottom edge, closest to the parking area. *Pad 4 had a missing area 10 inches by 3.5 inches. *Pad 5 had a missing area of 17.5 inches by 3.5 inches and another area 10 inches by 8.5 inches. *Pad 6 had a missing area of 8.5 inches by 6.5 inches. In the visitor parking section missing areas of concrete with depths of one-to-two inches included: *Pad 10 had a missing area of 10 inches by 8.5 inches. *Pad 11 had a missing area of 6.5 inches by 15 inches. *There was also a 3-inch gap between pad 11 and pad 12 approximately 50.0 inches long with a 1-inch gap. Interview on 3/8/16 at 2:15 p.m. with the maintenance supervisor revealed: *He agreed the above sidewalk had missing areas. *He agreed the missing areas were a hazard for potential falls. *He stated there had been plans to replace those	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 323	Continued From page 13 broken pads at one time, but he was not sure if there were still plans for replacing them in the near future. *He had been filling those broken areas in with black temporary patches in warmer weather, but they had broken away again during the winter. Interview on 3/9/16 at 3:50 p.m. with the emergency permit holder (EPH) preceptor and interim executive director (ED) revealed they agreed the broken sidewalks were a potential hazards for residents and their families to fall or become injured. Review of the provider's undated Accident and Prevention policy revealed it was the policy of the provider to ensure the resident environment remained as free of accident hazard as possible. Review of the provider's undated Safety Policy revealed "Roads and Walks: The facility is accessible to good roads and these are kept passable and open at all times. Sidewalks, fire escapes, and entrances are kept free of ice and snow." Surveyor: 35121 2. Observation and interview on 3/8/16 at 8:10 a.m. with housekeeping staff (D) revealed: *She had been pushing a cart with housekeeping supplies down the hallway. *There were five bottles of cleaning chemicals on the cart within reach of the residents: -Two bottles of 950 Bowl Cleaner (toilet cleaner) were on the base of the cart. -One bottle Century Q 256 (disinfecting cleaner) was hanging on the side of the cart. -One bottle of Sure Scent Rain Fresh (deodorizer) was hanging on the side of the cart.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 323	Continued From page 14 -One bottle Glance HC (glass and surface cleaner) was hanging on the side of the cart. *There was an area of the cart that had three sides for an enclosed area, but one side had been removed. *There was no way to store the chemicals under lock and key on the cart. *She agreed: -The residents could have easily accessed those chemicals. -They should have been kept out of residents' reach to prevent injury. -There was no door or lock to secure the chemicals. Interview on 3/9/16 at 8:50 a.m. with the housekeeping supervisor regarding the cart and chemicals revealed he confirmed the: *Chemicals were within reach of the residents. *Residents could have been harmed if any of them had swallowed the chemicals or had sprayed the chemicals in their eyes. *Cart did not have a door or lock to secure the chemicals. Review of the 6/7/13 Safety Data Sheet (SDS) for the 950 Bowl Cleaner revealed it: *Was harmful if swallowed. *Caused severe skin burns, eye damage, and respiratory irritation. Review of the 7/21/14 SDS for the Century Q 256 revealed it: *Was harmful if swallowed. *Caused severe skin burns, eye damage, and allergic skin reactions. Review of the 5/22/15 SDS for the Sure Scent Rain Fresh revealed:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 323	Continued From page 15 *"Do not get in eyes, on skin, or on clothing." *"Do not breathe vapors or spray mist." *It was to be stored separate from acids. Review of the 9/30/08 SDS for the Glance HC Glass and Multi-Surface Cleaner revealed it: *Was harmful or fatal if swallowed. *Caused burns to the skin, eyes, mouth, throat, and stomach. *Caused respiratory irritation and corrosion. Review of the provider's undated Safety Policy revealed "Poisons: All poisonous or dangerous chemicals and compounds...must be stored independently under lock and key."	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and record review, the provider failed to maintain sanitation in the kitchen with the potential of cross-contamination (bacteria transferred from one area to another) with uncleanable surfaces and uncleaned areas in the following areas:	F 371	F371 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: 1. The identified window around the AC above the 3 compartment sink will be repaired by 4/15/16. The window AC above the grill will be removed and window sill repaired by 4/15/16. The three drawer cabinet was replaced on 3/28/16. The wall behind the mixer was repaired on 3/29/16. All areas identified are cleanable surfaces. 2. The kitchen is scheduled to be re-painted, floors stripped and waxed by 4/27/2016. 3. Schedules and systems for cleaning have been reviewed/revised to maintain a sanitary kitchen. All staff were re-educated on 3/30/16 to procedures in reporting repair and maintenance concerns. continued on pg. 17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 371	Continued From page 16 *Two of two windowsills containing air conditioning (a/c) units. *Two of two fans in the two-door refrigerators. *Four of four vents in the ceiling. *One of one cabinet's three handles. *The wall behind the mixer and a storage area for baking sheet pans. Findings include: Observation on 3/7/16 from 2:25 p.m. through 3:00 p.m. in the kitchen revealed: *Two windowsills that contained a/c units in them. -One of the above windowsills was located above the three-compartment sink that contained dishes being sanitized. -A second windowsill was located directly above a food preparation counter. *Located on the sides of each of those a/c units in the windowsills contained: -Raw, unfinished wood. -Moderately large black and brown spots that resembled dirt. -Chipped and peeling paint. -The above windowsills were no longer a cleanable surface. *Two fans located in the inside of the two double-door refrigerators. -Those fans contained moderately large amounts of lint and brown, black, and tan spots. -The above fans were running and blowing directly over the food stored there. *Four vents attached to the ceiling in the following locations: -Above the entrance door to the dining room. -Above the entrance to the dry food storeroom. -Above the dishmachine. -In the janitor's storage closet. *Each of the above vents contained moderately large amounts of lint and brown, black, and tan	F 371	4. CDM/Designee will audit kitchen for cleanable surfaces and completion of assigned cleaning duties two (2) times per week for 1 month; one (1) times per week for two (2) months. The data collected will be taken to the QAPI Committee at least quarterly by the CDM/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion Date: 4/27/16	4/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 371	Continued From page 17 spots. *Those above vents had not been cleaned. *One three-door cabinet's handles located next to the three-compartment sink had: -One handle made out of dark-colored string. -Two handles with a build-up of debris with one of those handles half attached to the cabinet and half of it hanging down. *The above cabinet contained clean utensils used to serve residents' food. *Those above handles were no longer a cleanable surface. *The wall located directly behind the mixer stored on top of a three-tired cart that contained cleaned baking sheet pans had: -Approximately three half-dollar sized pieces missing from the above wall. -That wall area was no longer a cleanable surface. Interview on 3/8/16 at 9:00 a.m. with the certified dietary manager (CDM), at 11:50 a.m. with the consultant registered dietitian, and at 12:30 p.m. with the maintenance supervisor regarding the above areas in the kitchen revealed: *They agreed the windowsills next to the a/c units were uncleanable surfaces. *The fans located in the two-door refrigerators were not clean and were blowing directly over the foods being stored there. *The vents needed to have been cleaned on a more frequent basis. *The three-door cabinet's handles were not cleanable surfaces. *The wall located behind the mixer and the clean baking sheet pans had needed to have been repaired. *The maintenance supervisor was responsible for repairing the windowsills, cabinet handles, and	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 371	Continued From page 18 wall, and cleaning the fans and vents in the kitchen. *The maintenance supervisor stated: -The fans in the refrigerators were cleaned when repairs had occurred with the refrigerators. -The vents were cleaned on an as needed schedule. -He had never cleaned the vents above the entrance to the dining room and to the dry goods storeroom. *They confirmed all the above areas were exposed to an uncleanable surface that had a potential for cross-contamination. Record review of Work History Reports revealed: *On 5/31/15 and 11/30/15 the reach-in refrigerators had been cleaned as required. *On 5/31/15, 8/31/15, 11/30/15, and 2/29/16 the exhaust fans had been cleaned if necessary. -Those above reports did not specify what exhaust fans had been cleaned. Interview on 3/9/16 at 8:10 a.m. with the maintenance supervisor revealed: *There was not a policy on cleaning the vents. *He had expected the dietary staff to have informed him of the following in the kitchen: -Repairs needed with the windowsills, cabinet's handles, and the wall. -Cleaning of the two-door refrigerator fans and vents as needed. Review of the provider's revised January 2014 unlabeled list of the cleaning schedule in the kitchen revealed: *The interior of the refrigerators were to have been cleaned once per week. -The above had not included any information regarding cleaning the fans.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 371	Continued From page 19 *The a/c units were to have had all areas wiped down around the air conditioner with hot water and a bleach. *The cabinet containing the utensils was to have been wiped down on the outside with hot water and a bleach. *The above cleaning schedule had not included any information regarding cleaning the kitchen wall. Interview on 3/9/16 at 10:10 a.m. with the CDM stated there was no policy on the sanitation of the storage of foods in the refrigerators. The above cleaning schedule was the only information on the cleaning of the refrigerator, a/c units area, the cabinet containing the utensils, and the kitchen wall.	F 371		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 32332	F 514	F514 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: 1. Resident 1, 2, 4 and 8's medical records were updated by the IDT to be accurate in each section on 3/15/16. 2. All resident's medical records were reviewed by 3/15/16 to ensure most recent advanced directives were in the chart and reflected and on the care plan. Continued on pg. 21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 514	Continued From page 20 Surveyor: 35121 Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to maintain accurate documented records regarding advance directives (written instructions for health care decisions if a resident was unable to act or respond for themselves) for four of nine sampled residents (1, 2, 4, and 8). Findings include: 1. Review of resident 1's medical record revealed: *She had been admitted on 11/10/10. *Her diagnoses had included dementia (mentally losing touch with reality) with behavioral disturbance and major depressive disorder. *On 4/29/15 her combined financial, personal, and medical information sheet (face sheet) listed her code status as full code (all life-saving measures were to have been done). *On 10/20/15 her physician and power of attorney (POA) (legal representative) had signed a Directives to Define Scope of Medical Care form for: -"DNR (Do not Resuscitate): In the event of acute [a disease of short course] or impending [about to happen] respiratory [lungs and breathing] arrest [a state of inactivity], no cardiopulmonary [heart and lungs] resuscitation [revive] shall be initiated." -"DNI (Do not Intubate): In the event of acute or impending respiratory arrest, endotracheal [a tube inserted through the mouth or nose] to provide sustained [continuing] assisted ventilation [to mechanically move breathable air] should not be performed. DNI does not prohibit emergency management to prevent or reverse acute airway	F 514	3. Interdisciplinary Team and Charge Nurses were re-educated to procedure for ensuring accurate Advanced Directives in the medical record. Staff were also directed where to place the advanced directives in the chart for fast and easy access. 4. Social Services/Designee will audit two (2) medical records per week for three (3) months to ensure advanced directive is correct in all areas of the medical record. The data collected will be taken to the QAPI Committee at least quarterly by the SSD/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion Date: 3/30/16 3/30/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 514	Continued From page 21 obstruction [blockage]." *Cardiopulmonary resuscitation (CPR) means if she had suffered a cardiac (heart) or respiratory arrest (the heart suddenly stops beating or breathing stops) efforts were to have been made to resuscitate (revive) her. *On 1/13/16 the Care Conference Summary Sheet had her advance directives listed as "DNR/DNI." *On 1/18/16 a physician's order revealed her code status as a full code. *On 3/7/16 her medication administration record (MAR) had her advanced directive listed as a code status of DNR/DNI. Review of resident 1's revised 1/8/16 care plan revealed: *She had an advance directive to have had CPR with no ventilators. *Her goal was to have had advanced directives to have been honored as written on the care plan. *Her medical record was to have been marked clearly as to her preferences. *Her advance directives were to have been reviewed quarterly. Review of resident 1's 1/4/16 Minimum Data Set (MDS) quarterly assessment, section C, revealed: *She had a Brief Interview for Mental Status (testing of thought processes) score of 99. *A score of 99 indicated she was unable to have been interviewed. Surveyor: 35121 2. Review of resident 8's medical record revealed: *A Directives to Define Scope of Medical Care form indicating DNR and DNI that was signed by the physician with no legible date.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 514	Continued From page 22 *A code status of DNR on the signed 2/2/16 order summary report. *His: -MAR listed his code status as DNR/DNI pending confirmation. -Treatment administration record (TAR) listed his code status as DNR/DNI pending confirmation. -Current 1/8/16 care plan stated "Advanced Directives: DNR/DNI." -Face sheet had nothing listed for his code status. 3. Review of resident 4's medical record revealed: *On 2/23/16 her physician had signed a Directives to Define Scope of Medical Care form indicating DNR and DNI. *There was no advanced directive order on the signed 2/23/16 order summary report. *Her: -Face sheet had her code status listed as DNR/DNI. -MAR listed her code status as DNR/DNI. -TAR listed her code status as DNR/DNI pending confirmation. -2/20/16 Care Conference Summary Sheet had listed DNR/DNI as her advanced directives. -Current 4/16/15 care plan stated "Advanced Directives: To Resuscitate." Surveyor: 32332 4. Review of resident 2's medical record revealed: *His most recent 2/9/16 physician recertification orders had indicated his code status was: "Full Code." *A living will declaration signed by the resident 10/13/97 had indicated he wanted no life-sustaining treatment. If life sustaining treatment had begun he wanted it terminated.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 514	Continued From page 23 A Directives to Define Scope of Medical Care signed by the resident, physician, and social services designee on 3/17/14 had indicated: -DNR. He did not want CPR initiated if his heart stopped. -DNI. He did not want a tube inserted to assist with breathing if he stopped breathing. *His 1/18/13 face sheet had indicated his advanced directive was "Code Status: Full Code." *His March 2015 MAR indicated advanced directive, "Code status: DNR/DNI." *His revised 12/2/15 care plan indicated: -"Advanced Directives/Full Code Status." -"Review directives every quarter or upon resident request." *His 2/17/16 Care Conference Summary Sheet indicated "Advanced Directives: DNR." Surveyor: 32331 5. Interview on 3/8/16 at 2:55 p.m. with registered nurse (RN) H regarding a resident's code status if needed in an emergency would have been the resident's admission record's face sheet in the resident's medical record. Interview on 3/8/16 at 5:25 p.m. with RN A regarding a resident's code status if needed in an emergency would have been the resident's Directives to Define Scope of Medical Care form in the resident's medical record. Interview on 3/9/16 at 8:35 a.m. with licensed practical nurse K regarding a resident's code status if needed in an emergency would have been the resident's MAR. Interview on 3/9/16 at 11:20 a.m. with the director of nursing regarding residents documented records regarding advance directives revealed:	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 514	Continued From page 24 *The social service designee was responsible for each resident's code status upon admission. *Medical records and nursing were responsible for updating those above records as needed. *She agreed those documents had needed to have been kept current in each resident's medical records. Interview on 3/9/16 at 2:40 p.m. with the social services designee regarding residents documented records regarding advance directives revealed: *The MDS coordinator was responsible for updating the resident's face sheet. *The social service designee was responsible for: -Updating the resident's care plan. -Care conference summary sheet. -Communicating changes to staff regarding the Directives to Define Scope of Medical Care form. *She agreed those documents had needed to have been kept current in each resident's medical records. Review of the provider's undated CPR policy revealed the facility would have: *Reviewed decisions about a resident's CPR status at the following: -Each initial care review. -Quarterly care conferences. -Resident or family request. -Any permanent, significant change in the resident's status that had resulted in the development of a new care plan Surveyor: 35121 Review of the provider's revised August 2013 Care Plan Completion Standards Guideline revealed all care plans "Should include individual and/or combined focus problems that	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 514	Continued From page 25 address...Code Status/Advanced Directives." Review of the provider's revised 7/7/11 Guidelines for the Comprehensive Care Plan revealed the care plan was to: *"Meet the resident's medical, nursing, social, nutritional and psychological needs." *"Be updated in conjunction with any medical, nursing, social, nutritional and psychological changes experienced by the resident." *"Be reviewed and revised as needed." Review of the provider's revised March 2015 Practice Guideline and Procedure: Advanced Care Planning and POLST (provider orders for life sustaining treatment) revealed "A signed physician order denoting the resident's choice of status: DNR or FULL CODE, is required in all medical records."	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520	F520 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: 1. Quarterly QAPI Meeting is scheduled for 4/19/2016. The Medical Director is scheduled to attend. On 4/19/16 previous QAPI minutes will be reviewed with Medical Director. 2. EPH, IED and IDNS were re-educated to the QAPI policy and procedure by Emergency Permit Holder Preceptor on 3/30/2016. 3. Meetings will be scheduled with QAPI committee including Medical Director and consultant pharmacist at least quarterly. continued on pg 27	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435097		03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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 520	Continued From page 26 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on interview, record review, and policy review, the provider failed to maintain quality assessment and assurance (QAA) quarterly meetings. Findings include: 1. Interview and record review on 3/9/16 at 11:00 a.m. with the director of nursing revealed: *A QAA meeting had been held on 6/18/15, 10/18/15, and 2/25/16. *There had not been quarterly QAA meetings held. *She agreed there had needed to have been at least quarterly QAA meetings. Review of the provider's undated The Quality Assurance Program policy revealed: *The QAA committee was to have met at least quarterly. *The goal of the program was to have provided: -The highest practical resident services that provided a positive customer service environment. -Meeting residents quality of life and quality of care needs.	F 520	4. IED/Designee will audit quarterly QAPI notes to ensure Medical Director is involved and meetings are being held at least quarterly. The data collected will be taken to the QAPI Committee at least quarterly by the IED/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion Date: 4/19/16	4/19/16

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

ORIGINAL

PRINTED: 03/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435097	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE ANDES SENIOR LIVING	740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356

(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	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/9/16. Lake Andes Senior Living was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candace [signature]
TITLE: EPH
(X6) DATE: 3/31/16

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.

RECEIVED
APR 04 2016
SD DOH L&C

ORIGINAL PRINTED: 03/22/2016
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10638	A. BUILDING: _____ B. WING _____	03/09/2016

NAME OF PROVIDER OR SUPPLIER: LAKE ANDES SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 740 E LAKE ST POST OFFICE BOX 130, LAKE ANDES, SD 57356

(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 3/7/16 through 3/9/16. Lake Andes Senior Living was not found in compliance with the following requirement: S206.	S 000	*Addendums noted with an asterisk per 4/8/16 per telephone per facility owner and administrator. SB/SDDOH/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; (10) Dining assistance, nutritional risks, and hydration needs of residents; 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 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: SB/SDDOH/EL *3/30/16 1. All staff were re-educated by the Emergency Permit Holder Preceptor on 3/18/2016 to Incidents and Diseases subject to mandatory reporting, reporting mechanisms, and identifying abuse, neglect, mistreatment, and the misappropriation of resident property. 2. All new hires, including temporary staff will receive training upon hire regarding Abuse, Neglect, Mistreatment, Injuries of Unknown Origin and Misappropriation of Property upon hire. 3. All staff will be re-educated to Abuse, Neglect, Mistreatment, Injuries of Unknown Origin and Misappropriation of Property at least annually. 4. IED/Designee will audit all new employee files & any new temporary staff one (1) time weekly for (3) months to ensure training was completed on Abuse, Neglect, Mistreatment, Injuries of Unknown Origin and Misappropriation of Property. IED/Designee will audit all staff training quarterly to ensure all areas of mandatory training are offered and completed per regulation 44:73:05:05. The data collected will be taken to the QAPI Committee at least quarterly by the IED/Designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. 5. Completion Date: 3/30/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Candace Swoboda

TITLE: ERH

(X6) DATE: 3/31/16

STATE FORM 6899 SPYI11 If continuation sheet 1 of 4

RECEIVED APR 04 2016 SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10638		03/09/2016

NAME OF PROVIDER OR SUPPLIER
LAKE ANDES SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE
740 E LAKE ST POST OFFICE BOX 130
LAKE ANDES, SD 57356

(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 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32332 Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure: *Nine of nine sampled employees (B, F, G, H, I, and J) had received an orientation program on incidents and diseases subject to mandatory reporting and the reporting mechanisms, and abuse, neglect, mistreatment, and the misappropriation of resident property and funds. *All staff had annual training for 2 of 11 mandated annual topics (incidents and diseases subject to mandatory reporting, and the reporting mechanisms, and abuse, neglect, mistreatment, and the misappropriation of resident property and funds). Findings include: 1. Review of sampled employees B, F, G, H, I, and J's orientation records revealed: *The employees had been hired on the following dates: -Certified nursing assistant (CNA) B on 9/25/15. -Cook F on 10/28/15. -Housekeeping assistant G on 11/25/15. -RN H on 9/26/15. -Dietary assistant I on 2/24/16. -CNA J on 1/29/16. *There had been no documented orientation training on incidents and diseases subject to mandatory reporting and the reporting mechanisms, and abuse, neglect, mistreatment, and the misappropriation of resident property and	S 206		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10638		03/09/2016

NAME OF PROVIDER OR SUPPLIER: LAKE ANDES SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 740 E LAKE ST POST OFFICE BOX 130, LAKE ANDES, SD 57356

(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 206	Continued From page 2 funds. Surveyor: 32332 Interview on 3/9/16 at 3:50 p.m. with the emergency permit holder (EPH) preceptor and the interim executive director (ED) revealed: *The interim ED was responsible for training employees during their orientation. *She had the employees read the abuse and neglect policy. *Mandatory reporting was included in that policy. *She had no documentation to show those above listed employees had received that training. *She was not able to locate documentation that any of those employees had received abuse and neglect training on orientation. Surveyor: 32331 Interview on 3/9/16 at 5:10 p.m. with the interim ED and the preceptor to the EPH confirmed the above orientation topics had not been conducted for all the sampled employees including all newly hired employees. Review of the provider's 5/25/14 Human Resources Management Employee Orientation policy revealed: *The following were to have been included in orientation: -Abuse. -Neglect. -Mistreatment. -Injuries of unknown origin. -Misappropriation of resident's property. 2. Review of the provider's inservice training for 2015 though 3/9/16 annual education programs for all employees revealed: *Two of the eleven mandated annual topics had not been conducted for all employees within the	S 206		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10638		03/09/2016

NAME OF PROVIDER OR SUPPLIER
LAKE ANDES SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE
740 E LAKE ST POST OFFICE BOX 130
LAKE ANDES, SD 57356

(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 206	Continued From page 3 annual time frame. *Those topics were as follows: -Incidents and diseases subject to mandatory reporting, and the reporting mechanisms. -Abuse, neglect, mistreatment, and the misappropriation of resident property and funds. Surveyor: 32332 Interview on 3/9/16 at 3:50 p.m. with the EPH preceptor and the interim ED revealed they had been unable to locate documentation that any employees had received abuse and neglect training on orientation since 4/29/15. Surveyor: 32331 Interview on 3/9/16 at 5:10 p.m. with the interim ED and the preceptor to the EPH confirmed the above annual topics had not been conducted for all employees. Interview on 3/9/16 at 6:15 p.m. with the preceptor to the EPH revealed: *The provider had no policy on the mandated annual topics for all employees. *She expected to have had the state regulation for the annual education program for all employees to have been followed.	S 206		
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 3/7/16 through 3/9/16. Lake Andes Senior Living was found in compliance.	S 000		