

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016
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NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369
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F 000	<p>INITIAL COMMENTS</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 6/20/16 through 6/22/16. Platte Care Center was found not in compliance with the following requirements: F159, F281, F323, F514, and F518.</p>	F 000	<p><i>*Addendums noted with an asterisk per 8/01/2016 per telephone with facility administrator. NK/SDDOHJEL</i></p>	
F 159 SS=D	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p>	F 159	<p>It is recognized that the facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account that is separate from facility's operating accounts should resident choose to. It is acknowledged that facilities previous policy and procedure as it related to these funds, even though didn't restrict any resident access of interest bearing funds over \$50, didn't do enough to support the regulatory intent of this requirement. Effective 7/15/2016, facility has amended its policy with regard to resident's personal funds, whereas, residents will be given the option for the facility to hold, safeguard, manage and account for such resident funds within facilities resident trust fund. Furthermore, stated policy will allow for resident funds in an interest bearing account in excess of \$50 and additionally such resident funds will assure each</p>	07/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 7/8/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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: 33265 Based on interview, record review, and policy review, the provider failed to ensure there was no limit on the amount of funds any resident could place in one of one resident trust fund. Findings include:</p> <p>1. On 6/21/16 at 9:00 a.m. the individual quarterly statement of one resident with funds in the resident trust fund was requested of the director of nursing and administrator. That information was not received before the end of the survey.</p> <p>Interview and record review on 6/21/16 at 1:55 p.m. with the administrator revealed: *A resident was allowed to put a maximum of \$50 in his or her resident trust fund account. *Any amount over \$50 would need to be removed</p>	F 159	<p>resident's funds will be maintained by a system with full and separate accounting. The individual financial record will be available to each resident who holds such account with the facility, through quarterly statement and on request from the resident or their legal representative. Education to staff that is responsible or involved in the resident trust fund or the administration of such will be educated to the new policy and procedures of such during the week of 7/11/2016. Notification of the new policy to residents will be sent to each resident via US Mail on 7/15/2016. Continued compliance will be monitored quarterly by [REDACTED] *NK/ISDDOHHIEL</p> <p>[REDACTED] Facility will also amend facility's admission agreement to reflect new policy to assure proper notice to any new residents post 7/15/2016. NK/ISDDOHHIEL</p> <p>→ *resident Financial Service representative and report results to Quality team. Care Center Council (QAPC) will review quarterly audits and determine when audit will cease. 100% of resident trust accounts will be included in quality reviews.</p>	

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F 159	<p>Continued From page 2 and put in a separate account elsewhere.</p> <p>Interview on 6/22/16 at 9:30 a.m. with the administrator revealed: *He understood the concern regarding the \$50 limit on the resident trust fund. *There were individual statements sent out quarterly to the residents who had funds in the resident trust fund account. *There were residents who had funds in the petty cash and also had an interest bearing bank account, but he was not able to provide a list of those residents.</p> <p>Review of the provider's 4/9/14 Protection and Management of Resident's Funds policy revealed: *The provider established a resident trust fund account for any resident that wanted to maintain an easily accessible means of maintaining petty cash funds. *When a resident had funds over \$50 an account would have been opened in a bank or savings and loan. That would have: -Alleviated the problem of maintaining large sums of cash in the facility. -Provided accurate records. -Given earned interest. *Whenever an eligible resident's personal funds were at or over \$2,000 the department of Social Service was to be notified.</p> <p>Review of the provider's undated Residents Bill of Rights revealed: *Residents were allowed to keep less than \$50 in the resident trust fund. *Those funds under \$50 would not be interest bearing.</p>	F 159		

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F 281 F 281 SS=D	Continued From page 3 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, policy review, and owner's manual review, the provider failed to ensure nebulizer equipment was properly cleaned after each use for three of three randomly observed residents (3, 12, and 13) receiving nebulizer treatments. Findings include: 1. Observation on 6/21/16 at 9:20 a.m. with licensed practical nurse (LPN) G during medication pass revealed she: *Took the mask off resident 12 at the conclusion of his nebulizer treatment. *Disassembled the face mask, medication cup, and tubing, and placed them in a small plastic basket. *Put the basket inside a small mesh bag and placed it near the nebulizer machine. *Did not rinse the nebulizer equipment before placing it in the basket or the mesh bag. Observation on 6/21/16 at 9:30 a.m. with LPN G during medication pass revealed she: *Took the mask off resident 13 at the conclusion of his nebulizer treatment. *Disassembled the face mask, medication cup, and tubing, and placed them in a small plastic basket. *Put the basket inside a small mesh bag and	F 281 F 281	It is acknowledged that Nursing Staff at the Platte Care Center did not have a policy that required staff to rinse Hand Held Nebulizers after each use and the nurses were not rinsing nebulizers after each use. In addition Nebulizer parts were stored in mesh bags and not manufactured suggested plastic containers. On June 22, 2016 a memo was given to RN's and LPN's to instruct them to rinse nebulizer equipment after each use. In addition plastic containers with tops were provided to store nebulizers. The policy was updated to reflect manufactures recommendations on July 6, 2016. Policy and procedure will be reviewed at nurse staff in-service on July 12, 2016. Starting July 15, 2016. DON will perform [redacted] monthly compliance to ensure hand held nebulizer procedure is followed. DON will report compliance on the care center dashboard monthly, report to the Care Center Council [redacted] monthly beginning in August 2016 and the Platte Health Center Quality team quarterly beginning October, 2016. *on all residents receiving HAN treatments including residents 3, 12, and 13. Care Center Council (OAPI) team will review audits at monthly meetings and determine when audits will cease.	07/15/16

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F 281	<p>Continued From page 4 placed it near the nebulizer machine. *Did not rinse the nebulizer equipment before placing it in the basket or mesh bag.</p> <p>Observation on 6/21/16 at 9:43 a.m. with LPN G during medication pass revealed she: *Took the mouthpiece from resident 3 at the conclusion of her nebulizer treatment. *Disassembled the mouthpiece, medication, and tubing, and placed them in a small plastic basket. *Put the basket inside a small mesh bag and placed it near the nebulizer machine. *Did not rinse the nebulizer equipment before placing it in the basket or mesh bag.</p> <p>Interview on 6/21/16 at 9:45 a.m. with LPN G regarding nebulizer treatments revealed: *She did not rinse or wash the nebulizer equipment after each treatment. *The nebulizer equipment was washed in a vinegar solution for all residents each night.</p> <p>Interview on 6/22/16 at 9:40 a.m. with registered nurse (RN) I regarding cleaning nebulizer equipment revealed she rinsed the nebulizer parts with water after each use.</p> <p>Interview on 6/22/16 at 10:30 a.m. with LPN H regarding cleaning nebulizer equipment revealed she followed the same practice as LPN G.</p> <p>Interview on 6/22/16 at 12:45 p.m. with the director of nursing revealed: *It was not her expectation the nebulizer parts were cleaned after each use. *The overnight shift was responsible for cleaning all nebulizer parts in a vinegar solution.</p> <p>Review of the provider's 11/9/11 Hand Held</p>	F 281		

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F 281	Continued From page 5 Inhalers/Nebulizers policy revealed: *"Following each use take the equipment apart and allow to air dry." *"Each evening the equipment will be soaked in a vinegar solution (3 ounces of vinegar to 1 quart of water) for 30 minutes." *The policy did not address cleaning the nebulizer equipment after each use. Review of the Direct Supply Attendant Compressor Nebulizer owner's manual revealed: *"It is recommended that the nebulizer and mouthpiece are thoroughly cleaned with hot water after each use." *The cleaning section of the owner's manual revealed instructions for rinsing after each use and included: -Step 1: Disconnect the air tube, nebulizer, and mouthpiece. -Step 2: Gently twist the nebulizer to open it -Step 3: Rinse the nebulizer and mouthpiece with water. -Step 4: Dry them with a clean soft towel or let air dry. -Step 5: Reassemble the nebulizer when completely dry and put these parts in a dry, sealed container."	F 281			
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.	F 323	It is acknowledged that one time out of two observations of sling lift transfers with resident #2 the staff did not have the sling positioned properly on resident # 2. It is acknowledged that improper sling placement places resident at risk for discomfort and potential injury. On June 22, 2016 memo was distributed to staff of deficiency and need to ensure positioning of slings on residents is	07/14/16	

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F 323	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, lift operating instructions review, and Smart Lift Competency Checklist review, the provider failed to ensure safe practices for one of one sampled resident (2) who required a total mechanical lift transfer. Findings include:</p> <p>1. Review of resident 2's 4/12/16 care plan revealed he: *Had increased spasticity in his legs and limited mobility and weakness. *Required a two person assist with showering and transfers. *Used a shower bed.</p> <p>Observation on 6/22/16 at 8:50 a.m. of resident 2 as certified nursing assistants (CNA) D and E revealed: *The resident required a total mechanical lift for the transfer from his bed to a shower bed. *Due to the resident's physical condition he was unable to assist with the transfer. *A mesh sling was placed under the resident and the sling was attached to the mechanical lift. *As the mechanical lift was in motion and the resident was lifted off of the bed it was noted: -The sling only came up to his mid back leaving the upper one-third of his back, neck, and head unsupported. -A surplus of material on the sling was also observed below his buttock as if the sling was not properly in place. *The resident had a spell of spasticity and rigidity during the transfer that lasted a couple of seconds.</p>	F 323	<p>correct. CNA staff will have mandatory in-service On July 13 & 14, 2016. In-service content will consist of demonstration of placement of sling lift. In addition staff will be in serviced on hooded slings as an alternative for resident transfers. Staff will also receive in-service on use of Smart Stand lift, EZ way stand and Sling list. Each student shall complete a return demonstration on each apparatus to demonstrate competency. Competency will be documented on checklists which include proper placement of sling when using the EZ lift. Staff members not attending in- service will need to demonstrate competency by August 1, 2016. Beginning in July, Don or designated RN will in conduction with monthly restorative evaluations, assess staff placement of slings on residents and resident safety during transfer with mechanical lifts. DON or designated RN will also complete an evaluation upon staff concern with lift or manual transfer s. Documentation will be on restorative evaluation intervention in EMR and any new interventions will be entered on resident's plan of care. DON will perform chart audits using the restorative evaluation on residents using sling and standing lift. DON will report compliance on the care center dashboard monthly, report to the Platte Care Center Council (QIPI team) monthly beginning August, 2016 and to Platte Health</p>	<p><i>Handwritten:</i> NELSDDOHE *including resident 2. DR/SDDOHE</p>

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F 323	<p>Continued From page 7</p> <p>*The resident stated "Oh my back is killing me." *At one point the resident's upper body teetered towards the floor. CNA E re-balanced the resident. *The resident was then placed on the shower bed.</p> <p>Interview on 6/22/16 at 9:10 a.m. with the director of nursing (DON) regarding resident 2 revealed: *She had not observed his transfer recently but she was aware he had a decline in his condition. *She could not explain why the above transfer had occurred as it had. *They used to have a sling for EZ lifts that supported the head, but they had not used it for many years.</p> <p>Observation and interview of resident 2 on 6/22/16 at 9:25 a.m. with CNAs D and E revealed: *They transferred him from the shower bed to his wheelchair using the same mechanical lift. *The sling was placed so his entire upper back was covered by the sling. -The resident only had to support his head during the transfer. *The resident verbalized this transfer had gone much better and had been more comfortable. *CNA E stated during the previous transfer the sling had not been properly placed and that was why the resident had been so uncomfortable. -The sling should have come up to his shoulders.</p> <p>Interview on 6/22/16 at 9:30 a.m. with the DON revealed: *Staff received ongoing training on the use of mechanical lifts. *CNAs D and E had completed that training in the past year.</p>	F 323	<p>Center Quality Assurance team quarterly beginning October 2016.</p> <p><i>*Care Center Council (CCPI) will review monthly audits and determine when audits will cease.</i></p> <p><i>NR/SDOOTT/EL</i></p>	

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F 323	Continued From page 8 *The sling should have been placed at his shoulders. Review of the provider's Lift operating instructions and Smart Lift Competency Checklists revealed neither of them addressed where on the resident's back the sling should have been placed.	F 323		
F 514 SS=D	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: 26180 Based on interview, record review, and policy review, the provider failed to ensure medical record documentation for 1 of 11 sampled residents (8) had been complete and accurate regarding a personal loss. Findings include: 1. Interview on 6/20/16 at 3:30 p.m. with resident 8 revealed he had a significant personal loss in the past year.	F 514	It is recognized that a facility must maintain clinical records on each resident that are complete; accurately documented; readily accessible; and systematically organized. It is acknowledged that this requirement was not met for resident 8 regarding a recent significant personal loss. The facility will provide a place in residents' permanent chart for counseling services to document visits as presently there is not access available in the Meditech system for their documentation, the Social Worker will then add a note in Meditech to refer to counselor's charting in the file. IDT will be educated on the process to complete an audit in order to retrieve an original care plan. Ongoing documentation will occur regarding visits provided by staff as they occur as well as the "Activity Attendance" intervention regarding residents' daily activities involving in the room and out of the room experiences. In addition, the Social Worker will monitor any changes in mood and reflect any new behaviors on the daily mood logs that CNA's chart on daily, after every shift. Furthermore residents' care	07/14/16

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F 514	Continued From page 9 Review of resident 8's 3/1/16 physician progress note addressed the resident's personal loss and stated "He has been visiting with a counselor and that has been going well." Interview on 6/22/16 at 1:00 p.m. with the social services designee (SSD) regarding resident 8 revealed: *She had followed the resident closely after his loss. *He had many friends and family that supported him and visited often. *She would stop in frequently and make sure he was doing okay. -She had not documented those visits. -She primarily documented every three months with the required assessments. -Interventions such as those visits should have been documented if there was something significant. *He had been seen by the counselor on an informal basis, because the counselor was not being reimbursed for those visits. -They did not have any copy of the reports from those visits. -She wondered if the physician had visited with the counselor, and that was how the physician knew the resident was being seen. -She could call the counselor's office and see if she had any reports to send them. *The activity director (AD) was responsible for the psychosocial piece of the care plan. Interview and review of resident 8's care plan on 6/23/16 at 1:15 p.m. with the AD revealed: *She visited with the resident frequently and thought he was doing quite well. *Review of the 4/17/16 care plan revealed it had	F 514	plans will be reflecting various disciplines and responsibility in care plans will be documented under the intervention section of the care plan. Staff will be educated at upcoming meetings; 7-12-16, 7-13-16 and 7-14-16 regarding importance of documentation as well as letting the IDT aware of any changes observed in residents' who have experienced a recent significant loss; and any noted changes in moods/behaviors so that it can be charted and followed-up by staff. Social Worker will report compliance on the Care Center dashboard monthly and report to the Platte Health Center Quality Team monthly beginning August 1, 2016. <i>*Care Center Council (QAPI) team will review monthly audits and determine when audit will cease. NR/SDDOTHEL</i>		

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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
F 514	Continued From page 10 not addressed the loss the resident had. *The AD explained the care plan had been updated, but the resident's loss had been taken off because he was doing so much better. *Their electronic medical record required they complete an audit to retrieve the original care plan, but they were unsure how to do that. Review of the provider's 3/17/75 Medical Record Documentation and Corrections policy revealed the purpose of the policy was to "Set standards of document which will assure a permanent legal record; to provide a mechanism for interdisciplinary communication; to enhance quality patient care and continuity."	F 514		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview and policy review, the provider failed to ensure four of four randomly interviewed staff members (A, B, C, and F) were able to identify and respond to a tornado warning situation. Findings include: 1. Interview on 6/21/16 at 9:35 a.m. with licensed practical nurse A regarding a tornado warning situation revealed she: *Was not sure what would be announced on the	F 518	Under our New Employee Orientation Checklist the line Fire/Emergency/Disaster Plan would address the training for Tornado Warning and Tornado Watches. It is in the External Disaster Plan which is a subcategory of the Disaster Plan. While this is not specifically a line item on the Checklist it is covered and all employees are required to read upon hire and complete annual testing using I Learns. (I Learns are a computer based learning site from Avera) To remedy the failure of staff awareness of what to do during a Tornado Warning we will be doing training during staff meetings. We will also be conducting an unannounced simulated drill that will train the staff during the week of July 11 th . Furthermore, annual additional training will be conducted with supervisory staff, whereas, supervisory staff, in accordance	07/15/16

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F 518	<p>Continued From page 11 overhead paging system. *Would have staff pull the window shades. *Would move residents out to the nurses station area.</p> <p>Interview on 6/21/16 at 9:40 a.m. with certified nursing assistant (CNA) C regarding a tornado warning situation revealed she: *Was not sure what would be announced on the overhead paging system, severe weather or tornado warning. *Would pull the window curtains. *Would move residents to the dining room and pull room divider partitions.</p> <p>Interview on 6/21/16 at 9:45 a.m. with CNAs B and F regarding a tornado warning situation revealed: *CNA B had never been in a tornado warning situation. -Was not sure what would be announced on the overhead paging system. -Would pull the window shades. -Would move residents out to the nurses station area. *CNA F stated she would move residents to the dining room and pull room divider partitions. *Neither had been in a tornado warning drill.</p> <p>Interview on 6/22/16 at 11:00 a.m. with the director of nursing revealed: *She believed severe weather warning and tornado warnings were different events and had different responsibilities. *She provided the education for new staff regarding weather emergencies. *She stated they were to move residents into the hallway area and close doors and drapes. *There was a computerized annual training</p>	F 518	<p>to Disaster policy, are required to direct other staff on the step by step duties of non supervisory staff in the event of a tornado type disaster. This training will be done by the Director of Plant Operations in conjunction with DON at Supervisory staff meetings. To address the failure to have a Tornado Drill the following remedy is proposed, Director of Plant Operations will add Tornado Training/ Drill to Quality Assurance dashboard to be done annually in the spring [redacted] compliance to be reported to Platte Health Center Quality team.)</p> <p><i>NK/SPDOTTJEL</i></p> <p><i>*With one drill in the am shift and one in the evening shift. These two drills will catch staff at the end of one shift and staff that are just coming on for the next shift. Attendance will be recorded and DON and Director of Plant Operations will confirm that all staff has attended one of these and provide those who missed with substitute training, with *by the director of plant operations, care</i></p>	

*when audits will
cease.
NK/SPDOTTJEL*

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A072	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/22/2016
NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369		
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F 518	<p>Continued From page 12</p> <p>segment each employee needed to complete that identified what to do during weather emergencies. *They had not had a tornado warning drill. *She had no response regarding the above four staff members not being sure of what: -Was announced for a tornado warning. -To do during a tornado warning.</p> <p>Review of the provider's undated New Employee Checklist revealed: *Fire and disaster were identified as areas covered. *Severe weather/tornado warning were not on the checklist.</p> <p>Review of the provider's January 2011 External Disaster Plan policy revealed: *The external disaster situation list included: -Weather. -Tornado watch. -Tornado alert. *Severe weather watch was listed separately. *If a tornado warning for the area was made the provider announced "Severe weather alert: Tornado warning" three times over the public address system. *Staff were to move residents and visitors to safe areas in hallways and close doors. *Staff were to give each person a blanket for protection if time permitted. *Disaster tags were to have been issued for each resident.</p>	F 518		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016
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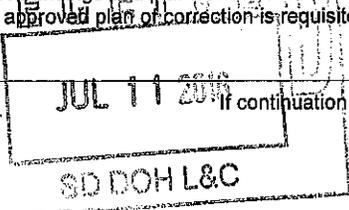
NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/22/16. Platte Care Center was found not 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 upon correction of deficiencies identified at K011 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure proper fire rated wall separation was provided between the nursing home and the hospital in one randomly observed location (mechanical room). Findings include: 1. Observation at 12:15 p.m. on 6/22/16 revealed a mechanical room in the nursing home. The north wall of that room was common to the	K 011	Window was covered with two layers of 5/8 inch sheet rock and fire caulked around edges. On 6-24-2016 In-service was held with Maintenance Staff on 7-5-2016 to remind them to be conscious of what is needed for firewalls and to be watching for problems as they are working in and around the buildings. Any area in question should be brought to Director for investigation and repair. Observations to ensure firewalls are sealed and in compliance will be added to our Quality Assurance Program and will be the Director of Plant Operation Responsibility.	07/05/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 7/8/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

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K 011	Continued From page 1 hospital and rated for two hour fire rated separation. A wall opening approximately 36 inch x 36 inch for an old unused window was in place. The window was not fire rated. During construction of the hospital the window was covered by a single layer of 5/8 inch gypsum board on the hospital side of the common wall. No additional protection was provided on the nursing home side. That window should have been removed and properly covered with two hour fire rated construction at the time the hospital was built. Interview with the plant operations supervisor at the time of the above observation confirmed that condition. He indicated he was not sure why the window opening had not been properly covered.	K 011		

ORIGINAL

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10664	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2016
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NAME OF PROVIDER OR SUPPLIER PLATTE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 E 7TH POST OFFICE BOX 200 PLATTE, SD 57369
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S 000	Compliance/Noncompliance Statement Surveyor: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/20/16 through 6/22/16. Platte Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/20/16 through 6/22/16. Platte Care Center was found in compliance.	S 000		

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

[Handwritten Signature]

TITLE

CEO

(X6) DATE

7/8/16

