

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><i>*Addendums noted with an asterisk per 5/2/16 per telephone with facility emergency permit holder. DH/SDDOH/EL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 16385</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/21/16 through 3/23/16. Northeast Care Center was found not in compliance with the following requirements: F325, F364, and F371.</p>	F 000		
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 32331</p> <p>Based on observation, record review, interview, and policy review, the provider failed to administer thickened liquids correctly at three of three observed meals for one of one sampled resident (4) who was on thickened liquids. Findings include:</p> <p>1. Review of resident 4's medical record revealed she had:</p> <p>*A diagnosis that had included dementia (disease affecting memory and decision making).</p>	F 325	<p>A corrective action resident #4 pureed diet is being prepared according to physician order.</p> <p>The facility identified that all resident's that have a therapeutic diet potential to be affected by the same deficient practice.</p> <p>Measures put in place to ensure that the deficient practice will not reoccur is the following approach. The dietary supervisor provided education 04/12/16 to dietary staff on following the physician prescribed diet orders on therapeutic diets to reduce the risk of choking. Staff reviewed Dysphagia puree (Level 1) diet and reviewed the correct food texture appropriate for a MS#3 diet.</p> <p>The dietary supervisor provided education 04/12/16 to dietary staff and current thickener directions were updated and posted on 04/12/16 in one place in the kitchen for staff to follow the manufactures direction to correctly prepare consistencies of food and/or liquids.</p> <p>Continued...</p>	<i>*4/12/16 DH/SDDOH/EL</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeanne Magnuson</i>	TITLE <i>RN/ Emergency Permit Holder</i>	(X8) DATE <i>4-14-16</i>
---	---	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 325	<p>Continued From page 1</p> <p>*A 8/12/15 consultant registered dietitian (RD) progress note revealed: *She had recommended increasing her liquids from honey to pudding consistency to have prevented: -Choking. -Food running out of her mouth. *A physician's order on 3/8/16 for "Low Na [sodium] Diet - Pudding Thick Liquids, MS [mechanical soft] #3 [dysphagia (problems with swallowing) puree (Level 1) diet] 4 oz [ounce] variety of nutritional supplement thickened to pudding consistency po [by mouth] qd [every day]."</p> <p>Review of resident 4's 2/27/16 care plan revealed: *She had problems with swallowing liquids. **"Thicken liquids to pudding thick consistency." *She was unable to make her needs known.</p> <p>Review of the provider's menu card for resident 4 revealed she was on thickened liquids of pudding consistency.</p> <p>Observation and interview on 3/21/16 at 5:35 p.m. with dietary assistant E revealed: *She had prepared resident 4's thickened liquids before she received her meal. *She used two different products' thickening directions that were posted on a cupboard in the kitchen in preparing the liquids. *She stated she had used both of them to prepare the liquids. *She had been unsure of the correct directions to have followed for thickening her liquids.</p> <p>Observation on 3/21/16 at 6:15 p.m. at the evening meal with certified nursing assistant</p>	F 325	<p>Quality Assurance was started on 4/12/16 to monitor and record that pureed foods have the correct consistency at meals. The monitoring will be done by the Dietary supervisor. This will be check every meal on residents receiving a pureed diet for 1 week and then weekly on Wed for a total of 3 months. Then once a month for a total 3 months then as needed. Results will be reported to the QA committee at the quarterly meeting.</p> <p>Corrective action will be effective 04/12/16. Completed correction date of QA will be 12/15/2016. The Dietary supervisor will reported the findings to the QA committee quarterly till the completion of the QA.</p>	
-------	---	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 2</p> <p>(CNA) A in the main dining room revealed resident 4 was: *Seated in a wheelchair. *Needed assistance with eating as she was unable to feed herself. *Coughed several times during her meal. *Her chocolate nutritional supplement drink was thicker than pudding consistency. -A spoon was able to stand up in that drink. *CNA A stated resident 4: -Coughed on liquids that were too thin or too thick. -Needed foods that were easier to swallow. -Had been unable to make her needs known.</p> <p>Interview on 3/21/16 at 6:45 p.m. with registered nurse (RN) B regarding resident 4 revealed she: *Needed pudding thickened liquids. *Had to have had her liquids and foods "just right" otherwise she could choke. *Had needed to have the right consistency with her diet.</p> <p>Observation and interview on 3/22/16 at 11:20 a.m. with dietary assistant F revealed: *He had prepared resident 4's thickened liquids before she received her meal. *He used two different products' thickening directions that were posted on a cupboard in the kitchen in preparing the liquids. *He stated he had used both of them to prepare the liquids. *He had been unsure of the correct directions to have followed for thickening her liquids.</p> <p>Observation and interview on 3/22/16 at 12:00 noon in the main dining room with CNA C assisting resident 4 with eating revealed: *She had received a prepackaged four oz</p>	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 3</p> <p>container of gelatin.</p> <p>*Her water was of a honey-thick consistency.</p> <p>*She stated she coughed on liquids that were too thin such as gelatin and honey-thick liquids.</p> <p>*CNA C then obtained a pudding to replace the gelatin dessert.</p> <p>Observation and interview on 3/22/16 at 5:55 p.m. at the evening meal in the main dining room with CNA D revealed resident 4's:</p> <p>*Chocolate nutritional supplement drink was thicker than pudding consistency.</p> <p>-A spoon was able to stand up in that drink.</p> <p>*Foods needed to be not too thick and easier to swallow.</p> <p>Interview on 3/22/16 at 6:07 p.m. with the consultant RD by phone regarding resident 4's thickened liquids confirmed:</p> <p>*She was to have received pudding consistency thickened liquids.</p> <p>*The correct thickened liquids consistency needed to have been provided for her.</p> <p>*The physician's order for pudding-thickened liquids needed to have been followed.</p> <p>Interview on 3/23/16 at 8:15 a.m. with the assistant director of nursing regarding resident 4's thickened liquids confirmed:</p> <p>*She was to have received pudding consistency thickened liquids.</p> <p>*She had difficulties with swallowing and had needed the correct consistency of liquids prepared and provided to her.</p> <p>*The physician's order for pudding-thickened liquids needed to have been followed.</p> <p>Interview on 3/23/16 at 9:15 a.m. with the dietary manager regarding resident 4 revealed:</p>	F 325			

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

PRINTED: 04/09/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 4</p> <p>*She was to have received pudding consistency thickened liquids.</p> <p>*The correct thickened liquids consistency needed to have been provided to her.</p> <p>*There had been two different products' thickening directions posted on a cupboard door in the kitchen for the staff to have followed for preparing her thickened liquids.</p> <p>-Those directions had been confusing for staff.</p> <p>-They contained different amounts of thickener for thickening her fluids.</p> <p>*The current product's directions needed to have been posted for the staff to have followed when preparing her liquids.</p> <p>*The physician's order for pudding-thickened liquids needed to have been followed.</p> <p>Review of provider's 2006 Dysphagia Puree (Level 1) Diet or MS #3 diet manual information revealed:</p> <p>*The diet was to have been used for individuals who had severe chewing and/or swallowing problems.</p> <p>*All foods were to have been of the consistency of moist mashed potatoes or pudding.</p> <p>*Fluids were ordered at thickness smooth and of one consistency such as spoon thick (pudding thick).</p> <p>*Foods to avoid had included gelatin.</p> <p>Review of directions on the provider's thickener product information revealed the food texture had been an important factor in a resident's ability to have swallowed safely.</p> <p>Review of the provider's 3/19/14 Thickened Liquids policy revealed:</p> <p>*All individuals requiring thickened liquids ordered by the physician were to have been served liquids</p>	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 5 in a form to: -Minimize the risk of choking. -Minimize the risk of aspiration (breathing in a foreign object such as food or liquids into the lungs). *Manufacturer's instructions were to have been followed when using thickening agents to have provided the ordered consistency of liquids.	F 325		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure nutritional value of food was maintained for one of three observed meal services for three of three sampled residents (4, 12, and 13) who were on pureed (puree consistency) diets. Findings include:  1. Observation on 3/21/16 at 5:30 p.m. in the kitchen with the dietary manager revealed he: *Prepared the pureed mixed vegetables for residents 4, 12, and 13 by the following method: -Placed three servings of the vegetables into a blender. -Added approximately three-fourth cup of tap water from the two compartment sink into the blender with the vegetables.	F 364	F 364 A corrective action was taken right away on 3-22-16 to ensure that resident #4, #12, #13 to appropriately maintain and conserve, flavor, appearance and to maintain nutritional value. The facility identified that all resident's that have a therapeutic diet with a nutritional value has potential to be affected by the same deficient practice. Measures put in place is to ensure that the deficient practice will not reoccur is the following approach.  The dietary supervisor provided education 04/12/16 to dietary staff on the importance and how to appropriately maintain and conserve, flavor, appearance and to maintain nutritional value by using a liquid with nutritive value such as broth or vegetable juice.  Continued...	*4/12/16 DH/SDDOH/EL

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

PRINTED: 04/03/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	<p>Continued From page 6</p> <p>-Turned on the blender and pureed the vegetables and tap water together. -Poured approximately a one-half cup serving of the vegetable into three white three-compartment plates. -Placed those plates on the counter next to the stove.</p> <p>Interview at the above time and location with the dietary manager revealed he: *Had needed to thin down the vegetables for the pureed consistency. *Used lukewarm tap water to make the pureed vegetables less thick.</p> <p>Review of provider's menu cards for the above residents on pureed consistency diets revealed: *Resident 4 was on a puree low sodium diet. *Resident 12 was on a diabetic puree diet. *Resident 13 was on a diabetic pureed diet.</p> <p>Observation on 3/21/16 from 5:40 p.m. through 5:45 p.m. in the kitchen with the dietary manager revealed the above vegetables were heated in the microwave and served to residents 4, 12, and 13.</p> <p>Interview on 3/22/16 at 6:07 p.m. with the consultant registered dietitian by phone revealed: *She would have expected the dietary manager to have used a liquid with nutritive value such as the vegetable juice or broth to make the required pureed consistency. *She confirmed the addition of the water added no additional nutritional value for the vegetable portions served to those residents on a pureed diet.</p> <p>Interview on 3/23/16 at 9:15 a.m. with the dietary manager agreed the addition of the water added</p>	F 364	<p>Current policy for pureed diets review with staff. Reviewed that the practice of using water during the survey was not according to facility policy and it does not maintain and conserve the flavor or appearance and decreases the nutritional value of the food.</p> <p>Quality Assurance was started on 4/12/16 to monitor and record that pureed foods have been appropriately prepared to maintain and conserve, flavor, appearance and have maintain nutritional value after being prepared. The monitoring will be done by the Dietary supervisor. This will be check every meal on resident receiving a modification involving changes in food and/or liquid texture for 1 week and then weekly on Wed for a total of 3 months. Then once a month for a total 3 months then as needed.</p> <p>Corrective action will be effective 04/12/16. Completed correction date of QA will be 12/15 2016. The Dietary supervisor will report to the QA committee quarterly till the completion of the QA.</p>	

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

PRINTED: 04/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST, POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 364	<p>Continued From page 7</p> <p>no additional nutritional value for the vegetable portions served to those residents on a pureed diet.</p> <p>Review of the provider's undated Pureed Diets policy for vegetables revealed to have added liquid from vegetables as needed to make smooth.</p> <p>Review of the provider's 2006 Dysphagia [problems with swallowing] Puree Diet revealed directions for pureed vegetables included the following:                      *Cook vegetables as appropriate.                      *Drain those vegetables and reserve the liquid.                      *Add melted butter.                      *Add additional vegetable liquid slowly.                      *Blend to mashed potato consistency.</p> <p>Review of Lisa Eckstein and Katheryn Adams, Pocket Resource for Nutritional Assessment, 2013 Ed., Chicago, IL., 2013, pp. 103 and 106, revealed:                      *A resident with dysphagia can interfere with adequate nutrition and hydration.                      *To minimize swallowing problems, and maximize nutrition, hydration, and quality of life for the resident, dietary modifications involved changes in food and/or liquid texture.                      -To have helped compensate for loss of function.                      -To maintain appropriate nutritional and hydration status.                      -To reduce the risk of aspiration.                      *Those might have included temperature changes and order of food/liquid presentation changes such as moistening and providing a cohesive bolus (to hold an amount together) by adding gravy or sauce.</p>	F 364			

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

PRINTED: 04/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371 F 371 SS=F	Continued From page 8 483.35(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, testing, record review, manufacturer's instructions, and policy review, the provider failed to ensure sanitary conditions were maintained in the kitchen for one of one dishmachine's parts per million (ppm) levels for chemical sanitization of the dishes and utensils for all residents on oral diets. Findings include:  1. Observation and testing on 3/21/16 at 2:35 p.m. in the dishmachine area revealed: *The rinse level was at zero ppm using a chlorine test strip (a specific type of paper that tests the level of available chlorine) in the dishmachine. *A sticker affixed to the front on the dishmachine revealed: -"Required 50 ppm available chlorine." *A level below 50 ppm had not been adequate for chemical sanitization of the dishes and utensils put through the dishmachine.  Interview and observation on 3/21/16 at 2:40 p.m.	F 371 F 371	F 371 A corrective action taken on 3/21/16 and the 100ppm available chlorine required for adequate chemical sanitization of the dishes and utensils put through the dish machine have been met and monitored. The facility identified that all residents in the facility are potentially affected by the same deficient practice. Measures put in place is to ensure that the deficient practice of not meeting the required 100ppm available chlorine will not reoccur is the following approach.  The dietary supervisor provided education 04/12/16 to dietary staff on the importance to meet the required 100ppm available chlorine. Staff instructed if the 100ppm are not met by the testing strips available that the dietary supervisor or maintenance supervisor must notified immediately.  Continued...	*4/12/16 DK/SDDO/HJEL	

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

PRINTED: 04/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 9</p> <p>with the dietary manager and the maintenance supervisor in the dishmachine area revealed: *The dishmachine was a low temperature machine, and it needed the minimum chemical levels for sanitizing the dishes and utensils. *Both agreed a level below 50 ppm available chlorine had not been adequate for chemical sanitization of the dishes and utensils put through the dishmachine. *The dietary manager stated manual cleaning of dishes and utensils and the usage of paper products would need to be used until a minimum of 50 ppm available chlorine could be obtained for chemical sanitization. *The maintenance supervisor stated he had problems with the dishmachine in the past with the tubing.</p> <p>Observation, testing, and interview on 3/21/16 at 5:07 p.m. with the dietary manager in the dishmachine area of the kitchen revealed: *The rinse level was at an acceptable level of 100 ppm using a chlorine test strip. *The dietary manager stated he had been unsure how long the rinse level had been at less the minimum of 50 ppm of available chlorine. *There needed to have been a minimum of 50 ppm of available chlorine for adequate chemical sanitization of the dishes and utensils put through the dishmachine.</p> <p>Interview on 3/21/16 at 5:12 p.m. with dietary assistant E in the dishmachine area of the kitchen revealed: *She had not been instructed on how to have monitored the ppm of available chlorine in the rinse cycle of the dishmachine. *She was unsure of the appropriate levels for chemical sanitization with the dishmachine.</p>	F 371	<p>The Dietary aide is responsible to test the water before dishes are put through the dish machine after each meal is done and before dishes are put through the dish machine every day.</p> <p>Dietary supervisor, dietary staff or maintenance supervisor checks tubes daily to ensure tubes stay in place on the dish washing machine is properly working. Extra tubes are available if one is cracked.</p> <p>Quality Assurance was started on 4/12/16 to monitor and record that required for adequate chemical sanitization of the dishes and utensils put through the dish machine have been met and monitored.</p> <p>This will be check daily and monitored by the Dietary supervisor for 1 week and then weekly on Wed for a total of 3 months. Then once a month for a total 3 months then as needed.</p> <p>Corrective action will be effective 04/12/16. Completed correction date of QA will be 12/15/2016. The Dietary supervisor will report to the QA committee quarterly till the completion of the QA.</p>		

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

PRINTED: 04/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 10</p> <p>*She had not known that levels of less than 50 ppm had needed to have been followed-up on by the dietary manager or the maintenance manager immediately.</p> <p>Interview and testing on 3/22/16 at 7:55 a.m. with the maintenance supervisor and the dietary manager in the dishmachine area revealed: *The rinse level was at 100 ppm using a chlorine test strip. *The maintenance supervisor stated there had been a crack in the tubing that had prevented sanitizer to be pumped through the rinse cycle. -That above tubing had been changed about two months ago. *Both were unsure on how long the tubing had been cracked and had prevented proper sanitizing of the dishes and utensils put through the dishmachine.</p> <p>Interview on 3/22/16 at 11:20 a.m. with dietary assistant F in the dishmachine area of the kitchen revealed: *He had not been instructed on how to have monitored the ppm of available chlorine in the rinse cycle of the dishmachine. *He was unsure of the appropriate levels for chemical sanitization for the dishmachine. *He had not known that levels of less than 50 ppm had needed to be followed-up on by the dietary manager or the maintenance manager immediately.</p> <p>Interview on 3/22/16 at 6:07 p.m. with the consultant registered dietitian by phone regarding the dishmachine chemical sanitization levels revealed: *A level below 50 ppm had not been adequate for chemical sanitization of the dishes and utensils</p>	F 371		

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

PRINTED: 04/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 11 put through the dishmachine. *There needed to have been a minimum of 50 ppm of available chlorine for adequate chemical sanitization of the dishes and utensils put through the dishmachine.</p> <p>Review of the provider's 2/1/16 through 3/22/16 Dishmachine Sanitizer Log a.m. and p.m. sanitizer concentration levels that were recorded revealed: *From 2/1/16 through 2/29/16 the levels had been from a range of the 15 to 225 ppm. *From 3/1/16 through 3/22/16 the levels had been from a range of 10 to 165 ppm. *Acceptable range was 100 ppm or higher.</p> <p>Review and observation of the provider's Ecolab chlorine test strips used to test the available chlorine in the rinse cycle of the dishmachine revealed the following directions: *"Dip [in the rinse water] and remove quickly. *Blot immediately with paper towel. *Compare to color chart at once." *The color chart on the test strip bottle revealed the following: -10 was a white color. -50 was a light purple color. -100 was a medium purple color. -150 was a dark purple color. *There were no levels higher than 150 on those chlorine test strips.</p> <p>Review of the provider's 1/28/16 and 3/15/16 Ecolab Routine Preventative Maintenance Service Detail-Warewashing reports revealed: *No inspection had been completed of the dishmachine available chlorine levels. *There was not a February 2016 report available.</p>	F 371		
-------	--	-------	--	--

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

PRINTED: 04/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 12 Review of the provider's undated Dishwashing policy revealed: *The machine was to have been operated according to manufacturer's instructions. *The above had included the proper addition of chemical sanitizers.	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435121</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
--	---	---	---

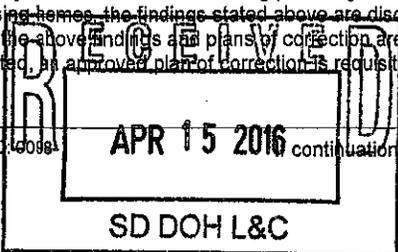
NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 1ST AVENUE EAST POST OFFICE BOX 108 ROSHOLT, SD 57260</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/23/16. Northeast Care Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Geanne Magnuson RN/Emergency Permit Holder</i>	TITLE  <i>Emergency Permit Holder</i>	(X6) DATE  <i>4-14-16</i>
--	---	---------------------------------

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.



**ORIGINAL**

South Dakota Department of Health

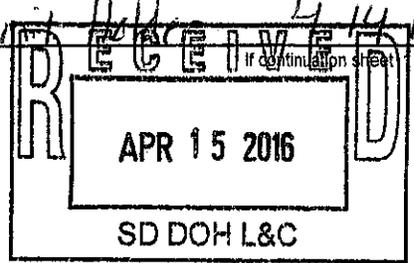
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10672</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 FIRST AVE E POST OFFICE BOX 108 ROSHOLT, SD 57260</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement  Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/21/16 through 3/23/16. Northeast Care Center was found not in compliance with the following requirement: S169.	S 000	*Addendums noted with an asterisk per 5/2/16 per telephone with facility emergency Northeast Care Center will provide electrically activated audible alarms at all unattended exterior doors. The facility identified that all residents have the potential to be affected by the same deficient practice. <i>Permit Holder. DH/SDDOH/EL</i>	
S 169	44:73:02:18(5-7) Occupant Protection  The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility;  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 16385 Based on observation, interview, and policy review, the provider failed to maintain the electrically activated audible alarm at two of five exit doors (front and north). Findings include:  1. Observation on 3/21/16 at 3:00 p.m. revealed the front and north exit doors were equipped with	S 169	Measures put in place is to ensure that the deficient practice will not reoccur is the following approach. All exterior doors are now alarmed 4/11/16.  New Policy in place for Occupant Protection [redacted] <i>*DH/SDDOH/EL</i> New Occupant Protection Policy was posted 4/11/16 with staff educated at that time on new policy. Occupant Protection Policy will also be reviewed on 4/24/16 at all staff meeting.  Quality Assurance was started on 4/11/16 to monitor and record that all alarms are on during all shifts. This will be checked every shift by the Charge Nurse for one week and then weekly on Wed on every shift by the Charge Nurse for a total of 3 months. Then once a month on the 15 <sup>th</sup> on every shift by the Charge Nurse for a total 3 months then as needed thereafter. The QA will be monitored and reported to the QA Committee at the Medical Director meeting Quarterly till the completion of the QA by the Administrator.	*4/12/16 <i>DH/SDDOH/EL</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeanne Magnuson RN / Emergency Permit Holder TITLE: Permit Holder (X6) DATE: 4/14/16

STATE FORM 8898 T5CH11



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10672</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 FIRST AVE E POST OFFICE BOX 108 ROSHOLT, SD 57260</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 169	<p>Continued From page 1</p> <p>an audible alarm. The alarm was not activated at the time of the observation. The front exit door was within sight distance of the nurses station when staff were present. The north exit door was the delivery and staff exit door accessible through the service wing.</p> <p>The front and north exit doors were observed not activated and not monitored on: *3/22/16 at 7:30 a.m. *3/22/16 at 11:20 a.m. *3/22/16 at 6:10 p.m.</p> <p>Observation of the door alarm panel on 3/22/16 at 3:30 p.m. revealed the front and north exit alarm switches had been in the off position.</p> <p>Interview on 3/22/16 at 3:30 p.m. with the administrator confirmed the front and north exit alarm switches had been in the off position during the day hours.</p> <p>Review of the provider's 6/10/15 policy for locking doors revealed: *"The night shift nurse, will at the beginning of the 10:30 PM shift, lock the front door, the north exit door and the west exit door and assure alarms are in place." *"At 10:30 PM, the nurse will also check the panel on the wall by the med room, to assure that all of the system is turned on so any door that is opened will alert the staff by sounding an alarm."</p>	S 169	<p>Continued...</p> <p>Corrective action will be effective 04/11/16. Completed correction date of QA will be October 11, 2016.</p> <p><b>Occupant Protection Policy of the Northeast Care &amp; Rehabilitation Center</b></p> <p>RE: All exterior doors</p> <p>Effective: 04/11/2016</p> <p>All exterior doors will be alarmed at all times unless there is direct supervision of that door. The west, front &amp; north doors will be locked by the PM Charge Nurse at 7 pm. The door will be unlocked by the night Charge Nurse at 5:15 am. The alarm panel is located by the med room doors. It is the responsibility of the Charge Nurse to assure the alarms are on at all times unless the exterior door has direct supervision by a staff member of NECRC.</p>	
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide</p>	S 000		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10672</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>NORTHEAST CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>85 FIRST AVE E POST OFFICE BOX 108 ROSHOLT, SD 57260</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Continued From page 2  training programs, was conducted from 3/21/16 through 3/23/16. Northeast Care Center was found in compliance.	S 000		