

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/09/2016
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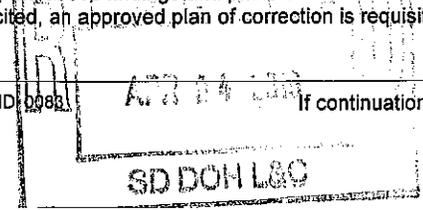
NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 18560 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. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirements: F279 and F441.	F 000	*Addendums noted with an asterisk per 4/7/16 per telephone with facility administrator. PE/SDDOHEL	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy	F 279	F279 On 3/30/16, residents 1, 2 and 8 care plans were reviewed and updated to include all fall interventions that are still applicable for each resident. All resident falls from July 2015 to current were also reviewed on 3/30/16 to account for each fall intervention that had been tried. All current resident care plans were then reviewed and updated to include all fall interventions that are still applicable. The care plans will be reviewed and updated by the DON, MDS coordinator or Restorative Aide at each fall meeting with any interventions being implemented. Audits will be completed by the administrator to review all falls and interventions from the previous	04/01/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shannon Schmidt</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/1/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261		
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F 279	<p>Continued From page 1</p> <p>review, the provider failed to ensure care plans were reviewed and revised for three of eight sampled residents (1, 2, and 8) with frequent falls. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *Her 2/4/16 quarterly Minimum Data Set (MDS) assessment revealed she was independent with transfers and walking in her room. *On 8/14/15 at 3:30 a.m. she had an unwitnessed fall in her room. -She had a laceration to the left side of the head. -She was complaining of shoulder pain. -She was transferred to the emergency room (ER) for evaluation. She required two stitches to the head and had a fractured left clavicle (collarbone). *On 9/2/15 at 1:35 a.m. she had an unwitnessed fall in her room. -She had a laceration to her chin. -She was transferred to the ER for evaluation and required three stitches to her chin. *Her undated care plan revealed interventions to follow protocol should a fall occur and to remove the bed-side table from her room unless eating since she was using it as a mobility device.</p> <p>Interview on 3/9/16 at 10:45 a.m. with the MDS/quality assurance (QA) nurse revealed: *The above falls had been discussed in their QA meetings. *Interventions were established in the meeting that included making sure her gripper socks were in place, removing the bed-side table, using a night light, and obtaining a lift chair. *She acknowledged only the bed-side table intervention had been added to her care plan.</p>	F 279	<p>month and check that interventions</p> <p>were added to the care plan. Administrator will report audit findings at the monthly QAPI meetings for four consecutive months. The QAPI committee will review findings and provide further recommendations.</p> <p><i>*Inservice was completed for all staff related to care plans.</i> PE/SDDOH/EL</p>		

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F 279	<p>Continued From page 2</p> <p>Surveyor: 33265</p> <p>2. Review of resident 2's complete medical record revealed:</p> <p>*Her 4/28/15 care plan stated she had changes in her mobility and was at risk for falls. The interventions to deal with the mobility issues included:</p> <p>-A door alarm placed to alert staff to her leaving her room.</p> <p>*On 5/5/15:</p> <p>-Close the door at night and leave the bathroom light on to help direct her to bathroom instead of out of room.</p> <p>-Check on her after taking her to the toilet at night.</p> <p>*No other interventions had been documented since 5/5/15.</p> <p>*There had been nineteen falls recorded in the nurses notes between 5/6/15 and 3/8/16.</p> <p>3. Review of resident 8's complete medical record revealed:</p> <p>*His 6/26/14 care plan stated he had changes in his mobility and was at risk for falls.</p> <p>-One undated intervention that had been written in was to put a mat on the floor beside the bed. There were no other interventions listed.</p> <p>*There had been seven falls recorded in the nurses notes between 8/1/15 and 3/8/16.</p> <p>4. Interview on 3/9/16 at 9:15 a.m. with the MDS/QA nurse revealed:</p> <p>*She was aware residents 2 and 8 had multiple falls.</p> <p>*The issue of falls had been addressed by the QA committee and multiple interventions had been initiated for residents who had frequent falls.</p> <p>*She agreed the multiple interventions started had not been noted on either resident's care plan.</p>	F 279			

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F 279	Continued From page 3 Interview on 3/9/16 at 1:20 p.m. with the director of nursing regarding the above revealed not all interventions for residents with frequent falls were documented on the care plan. Review of the provider's 2/28/15 Care Plan/Comprehensive Interdisciplinary policy revealed the comprehensive care plan would be periodically reviewed and revised by the interdisciplinary team after each resident's quarterly assessment or when there had been a significant change.	F 279			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	F441 The Tub Operation Instructions sheet was updated on 3/29/16 to reflect the correct cleaning and disinfecting procedure as outlined in the tub operations manual. This instruction sheet was then posted in the tub room on 3/30/16. On 3/31/16, administrator provided training to the two bath aides on the new disinfecting/cleaning procedure. All CNAs will be trained on the new procedure at the staff inservice training on 4/6/16. A training/evaluation checklist was created on 3/30/16 to be used to train all staff and also for evaluations. The	*4/28/16 PE/SDD/SH/EL	

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F 441	<p>Continued From page 4</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and manufacturer's instructions review, the provider failed to: *Ensure one of one whirlpool tub was disinfected (killing of germs) between use and at the end of the day according to manufacturer's instructions. *Ensure one of one dishroom window area used for putting dirty dinnerware into the kitchen area had cleanable surfaces. Findings include:</p> <p>1. Observation and interview on 3/8/16 at 8:56 a.m. in the whirlpool tub room with bath aide A revealed she: *Sprayed TURBO CLEAN, a detergent not a disinfectant, on all the surfaces. *Scrubbed all areas except under the pads with a long handled brush. *Waited ten minutes. *Then returned and rinsed off the detergent with water using the hand held sprayer.</p>	F 441	<p>infection control nurse or administrator will complete evaluation of each bath aide monthly for three months and [REDACTED] thereafter. Infection control nurse will report findings to QAPI committee for further recommendations. On 3/30/16, the unfinished wooden stick used on the hallway side of the dishroom opening which held the vertical sliding door open, was removed and destroyed. The window does not need any device to hold it open, as there are weights on the kitchen side of window that pull on the pulley system, which maintains the opening. On 3/31/16, maintenance director received price quotes from three vendors for materials to replace current dishroom window. Maintenance director will obtain non-porous material that is a cleanable surface, such as aluminum, stainless steel or polycarbonate, and replace the current wooden frame, wooden vertical sliding window and the stationary wooden piece above</p>		

**random for additional six months PE/SDOCH/EL*

**monthly PE/SDOCH/EL*

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F 441	<p>Continued From page 5</p> <p>*Stated that was the usual way of cleaning the whirlpool tub between residents. The last cleaning of the day was different.</p> <p>Observation and interview on 3/8/16 at 10:47 a.m. with bath aide A revealed she:</p> <p>*Filled the whirlpool tub up to the bottom of the seat. She stated that was about ten gallons of water.</p> <p>*Measured out ten ounces of Cid-A-L II, a disinfectant, and poured it into the water.</p> <p>*Turned the whirlpool jets on and let it run for two minutes.</p> <p>*Returned and added water to the usual fill line. -That changed the concentration of the mixture, and it was no longer what was suggested by the manufacturer. She had not done any scrubbing.</p> <p>*Waited ten minutes.</p> <p>*Returned and drained the tub. As the tub drained she used the hand held sprayer to rinse the tub.</p> <p>*Had not removed the pads from the seat, back, or headrest area.</p> <p>*Stated that was her usual way of cleaning the whirlpool tub after the last bath of the day.</p> <p>Interview on 3/9/16 at 9:15 a.m. with the infection control nurse revealed she was not involved with whirlpool tub cleaning or with training new staff in cleaning of the whirlpool tub.</p> <p>Interview on 3/9/16 at 1:10 p.m. with the director of nursing revealed:</p> <p>*They followed the whirlpool tub cleaning as it was written and posted on the clipboard in the whirlpool tub room.</p> <p>*There was no other policy or procedure on whirlpool tub cleaning.</p> <p>Review of the undated "TUB OPERATION TIPS"</p>	F 441	<p>opening to create a safe and cleanable dishroom window area for all residents and staff. This will be completed by 5/15/16.</p>	

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F 441	<p>Continued From page 6 posted in the whirlpool tub room revealed: *"TUB CLEANING/DISINFECT BETWEEN BATHS -Put on gloves prior to disinfecting/cleaning tub. -After each bath, you need to disinfect/clean tub and chair with TURBO KLEEN. -Hold spray bottle of TURBO KLEEN 6-8 [inches] from surfaces and spray all surfaces of tub and chair with TURBO KLEEN. Disinfect for 10 min. -Scrub tub/chair with brush, and when tub/chair is clean, rinse with shower wand. Back flush the jets using hand wand." *"TUB DISINFECTION AT END OF DAY -Put on gloves before disinfection tub. -Disinfect at end of day. -Close drains, place chair in tub, fill with 10 gallons of water to fill line. -Add 10 ounces of Cid-A-L II using measuring cup. -Turn on whirlpool and let disinfectant (Cid-A-L II) circulate through the jets. -Turn off whirlpool. Allow Cid-A-L II to disinfect for 10 minutes on all wet surfaces and jets. -After 10 minute disinfecting period, use shower wand to rinse all surfaces and drain water from tub. -Close drain. Refill tub to fill line with clear water. Turn on jets, allowing a rinse cycle for a couple of minutes, shut off jets and drain tub. -Disinfecting complete." Review of the undated whirlpool tub manufacturer's instructions revealed: *Cleaning procedures included: -Rinse all areas of tub to remove dirt. -Close the drain. -Spray the disinfectant on all surfaces of the chair, pads, and tub. -When there was two gallons of disinfectant/water</p>	F 441		

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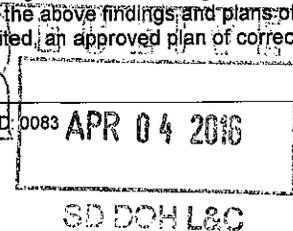
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F 441	<p>Continued From page 7</p> <p>mix in base of the tub turn off disinfectant, and then scrub all areas with a brush.</p> <p>-Allow contact time required of disinfectant.</p> <p>-Then open the drain and use shower wand to rinse all areas that were in contact with the disinfectant.</p> <p>*If last cleaning of the day:</p> <p>-Remove pads and place upright against the inside walls of the tub to drip-dry.</p> <p>Review of the undated label on the Cid-A-L II container revealed:</p> <p>*It was a disinfectant that killed bacteria, virus, and fungus.</p> <p>*The dilution was one ounce of disinfectant to one gallon of water.</p> <p>*The contact time needed to disinfect was ten minutes.</p> <p>Surveyor: 18560</p> <p>2. Observation and interview on 3/9/16 at 1:40 p.m. with the certified dietary manager (CDM) revealed:</p> <p>*An opening from the hallway into the dirty dish area of the kitchen.</p> <p>*A wooden vertically sliding window used to cover the above opening.</p> <p>*An unfinished wooden stick used on the hallway side to hold the window open.</p> <p>*The wooden window had been water stained along the bottom edge.</p> <p>*The bottom wood edge had separated and had jagged pieces.</p> <p>Further interview at the above time with the CDM confirmed the wooden window and stick were in poor condition and were not cleanable surfaces.</p>	F 441		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/09/16. Strand-Kjorsvig Community Rest Home 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 and the Fire Safety Evaluation System (FSES) dated 3/14/16. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches in the cross-corridor smoke barriers in both the east and west corridors. Findings include: 1. Observation at 2:30 p.m. on 3/09/16 revealed the cross-corridor doors in the east and west wing corridors were only 32 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report revealed those doors were the original doors.	K 028		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shannon Schmidt TITLE: Administrator (X6) DATE: 4/1/16

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K 028	Continued From page 1 The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		

South Dakota Department of Health

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STREET ADDRESS, CITY, STATE, ZIP CODE
**801 S MAIN POST OFFICE BOX 195
ROSLYN, SD 57261**

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S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/7/16 through 3/9/16. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirement: S169.	S 000	*Addendums noted with an asterisk per 4/6/16 per telephone with facility administrator. CH/SDDOH/EL	
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: 18087 Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition for one of five exterior doors (main entrance). Findings include: 1. Observation and testing at 1:30 p.m. on	S 169	S169 The code that is entered into the keypad to allow the door to open without sounding an alarm has been moved away from the keypad and door. At the east entrance, the code is posted at the left side of the window in the hallway, just over 5 feet away from the door and keypad. At the west entrance, the code was moved and posted 5 feet three inches away from the door and keypad. *the posted code was relocated by the maintenance director who reported the change to the administrator. The administrator will audit the code placements and report their status to QAPI →	04/01/16

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

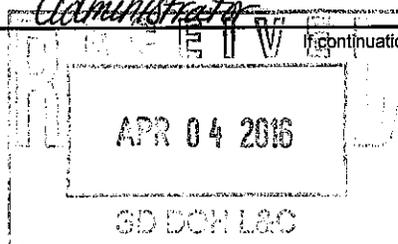
Shannon Schmidt

TITLE

Administrator

(X6) DATE

4/1/16



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10673	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/09/2016
NAME OF PROVIDER OR SUPPLIER STRAND-KJORSVIG COMMUNITY REST HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261		
(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>3/09/16 revealed the east (main entrance) exit door was equipped with a delayed egress magnetic lock. That door would also unlock if the proper code was typed into a keypad. The code to unlock the door was posted on a sign beside and above that keypad. Once the proper code was entered and the door was opened the alarm did not sound. The posted code would allow residents to input the code and leave the building without sounding the door alarm.</p> <p>Interview with the maintenance supervisor at the time of the observation confirmed that condition. He added the west exit was similarly equipped, and both doors had door alarms in addition to the delayed egress magnetic locks. The door alarms were shut off for those doors between 4:45 a.m. and 10:00 p.m. each day. That allowed staff to pass through those doors using the keypads to unlock the doors without sounding the door alarm. He added the south exits (from each wing) were equipped with door alarms only that were always in service.</p>	S 169	<p>monthly for one year unless advised by QAPI to discontinue the audits. CH/SPDOH/EL</p>	