

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

ORIGINAL

PRINTED: 08/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 35121 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/25/16 through 7/27/16. Sanford Chamberlain Care Center was found not in compliance with the following requirement: F252.	F 000	*Addendums noted with an asterisk per 9/16/16 per telephone with facility administrator. ML/SDDO/H/EL	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation and interview, the provider failed to monitor residents' room refrigerators for temperature and cleanliness to ensure food safety for seven of seven random and sampled residents (2, 7, 12, 13, 14, 15, and 16) with refrigerators. Findings include: 1. Observation on 7/25/16 during the initial tour revealed some of the residents had room refrigerators. Interview on 7/26/16 at 11:35 a.m. with the director of nursing (DON) revealed: *There were seven residents' rooms with refrigerators. *No one had been monitoring them.	F 252	*Resident 14 and 15's refrigerators have been cleaned and have thermometers in them. F252 ML/SDDO/H/EL → Policy on resident room refrigerators implemented on 7/28/2016. Education on new resident room refrigerators policy provided to staff on 8/9/2016. Letter of education sent to all resident families on 8/9/2016. LTC Family Council educated on 8/11/2016. DON or designee will monitor resident room refrigerators for cleanliness & temperature and report to QA committee weekly x 1 *daily month, then monthly x 3 months then quarterly until QA determines audit can be discontinued. QA committee meets monthly. *all ML/SDDO/H/EL	8-11-16

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

TITLE

(X6) DATE

[Signature]

[Signature] Director

8.16.16

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

AUG 18 2016
SD DOH L&C

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F 252	Continued From page 1 Further observation on 7/27/16 at 10:00 a.m. of the residents' refrigerators revealed: *Some of the residents were either physically or mentally unable to clean them. *Some food and crumbs inside resident 14's refrigerator. *Resident 15's was full of different food items and had food residue on the shelves. Interview on 7/27/16 at 3:35 p.m. with the DON regarding the residents' refrigerators revealed: *She agreed they had not been monitored for temperature or cleanliness and should have been. *No policy for that existed.	F 252			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 2 REPLACEMENT BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 07/26/2016
NAME OF PROVIDER OR SUPPLIER SANFORD CHAMBERLAIN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 S BYRON BLVD CHAMBERLAIN, SD 57325	
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K 000	INITIAL COMMENTS Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 7/26/16. Sanford Chamberlain 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 new health care occupancies upon correction of deficiencies identified at K062 and K108 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 062 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to maintain and test a complete automatic sprinkler system. There was no documentation a quarterly inspection/testing had been performed for the NFPA 13 fire sprinkler system for one of four annual quarters (second 2016). Findings include: 1. Review of the provider's sprinkler system test reports indicated the annual inspection/testing for the sprinkler system had been completed on 10/13/15. Quarterly inspection had been completed by the maintenance department in 9/28/15 and 1/28/16. There was no record for the testing for the second quarter of 2016. Interview	K 062	K062 Inspection & testing of sprinkler system completed on 7/29/2016. Maintenance manager or designee will monitor proper inspection & testing of sprinkler system and report to QA committee quarterly x 4 until QA determines audit can be discontinued. QA committee meets monthly.	7-29-16

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

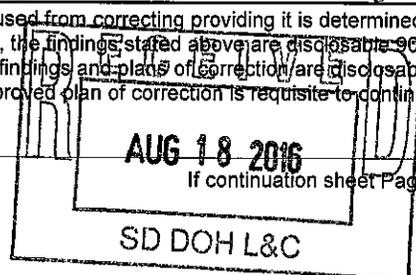
TITLE

(X6) DATE

[Signature]

Sr Director 8/10/16

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K 062	Continued From page 1 with the maintenance supervisor at the time of the record review revealed the provider was aware of the quarterly requirement for inspection/testing on the sprinkler system. Interview with the maintenance person at that same time confirmed he had missed the quarterly test for April, May, and June.	K 062		
K 108 SS=B	This citation had the possibility to affect all residents who resided in the nursing home. NFPA 101 LIFE SAFETY CODE STANDARD Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, document review, interview, the provider failed to test the emergency lighting for at least ninety minutes annually. The battery backup emergency light at the transfer switch had never been tested annually. Findings include: 1. Observation on 7/26/16 at 11:00 a.m. revealed there was a battery backup emergency light installed in the mechanical room at the transfer switch locations for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was not aware if his maintenance department checked that battery back-up light annually. Review of the preventive maintenance documents revealed there was no confirmation the light had ever been tested annually for ninety minutes. Further, there was no documentation the light was tested monthly. Interview with the maintenance supervisor at the	K 108	K 108 Battery backup emergency light was replaced on 7/29/2016. Battery backup emergency light testing placed on monthly PM for maintenance on 7/29/2016. Maintenance manager or designee will monitor battery backup emergency light testing and report to QA committee monthly x 6 months then quarterly until QA determines audit can be discontinued. QA committee meets monthly.	7-29-16

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K 108	Continued From page 2 time of the record review confirmed that finding. He stated he was aware of the requirement as they had checked the battery back-up lights in the hospital. But he had not added that light to the nursing home preventive maintenance documents or checklists. This citation had the possibility to affect all residents in the nursing home.	K 108			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10606	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
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NAME OF PROVIDER OR SUPPLIER
SANFORD CHAMBERLAIN CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
**300 S BYRON BLVD
CHAMBERLAIN, SD 57325**

(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: 35121 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/25/16 through 7/27/16. Sanford Chamberlain Care Center was found not in compliance with the following requirements: S121 and S165.	S 000	*Addendums noted with an asterisk per 8/15/16 per telephone with facility administrator. CHRIS DOTTTEL	
S 121	44:73:02:01 Sanitation The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases and ensure the safety and well-being of residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to ensure: *Two of two tub chairs/lifts did not have pitted and chipped paint. *Two of two dryer chair lint filters were cleaned of lint and debris. *One of one shampoo chair plastic cover was cleaned and sanitized between residents. Findings include: 1. Observation on 7/26/16 from 8:30 a.m. to 11:00 a.m. revealed: a. The two tub chairs/lifts in the two whirlpool rooms had pitted and chipped paint on the rolling platform legs. Interview at the time of the observation with the maintenance supervisor	S 121	S 121 Chipped & pitted paint on tub chairs repaired on 8/5/2016. Inspection of chairs placed on monthly PM for maintenance on 8/5/2016. Maintenance manager or designee will monitor for chipped & pitted paint on tub chairs and report to QA committee weekly x 1 month, then monthly x 3 months then quarterly until QA determines audit can be discontinued. QA committee meets monthly. Dryer chair filters cleaned on 7/29/2016. Cleaning of dryer chair vents added to PM list on 8/11/2016. Plastic cover on shampoo chair cleaned on 8/10/2016. Education provided to beauticians regarding cleaning plastic cover after each use on 8/12/2016. Maintenance or designee will monitor cleaning of dryer chair filters & plastic cover on shampoo chair and report to QA committee weekly x 1 month, then monthly x 3 months then quarterly until QA determines audit can be discontinued. QA committee meets monthly.	

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

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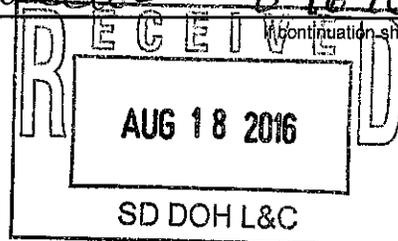
(X6) DATE

STATE FORM

6899

RJ4W11

Continuation sheet 1 of 4



[Handwritten Signature]

SR Director 8/16/16

SD Department of Health Vital Records

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S 121	<p>Continued From page 1</p> <p>confirmed those findings. He stated aides would use those tub chairs/lifts to transport the residents to and from their rooms. He was unaware the platform legs had chipped and pitted paint.</p> <p>b. The two dryer chairs in the beauty shop had air filters on the back of the chairs. Those black filters were white with layers of lint and debris where they did not make contact with the grille.</p> <p>c. The plastic cover that slides over the back of the shampoo chair was sticky to the touch and showed different colored drips that had run down the front and back of the cover.</p> <p>Interview at the time of the observation with the maintenance supervisor confirmed the findings for b and c. He stated the social services person was responsible for the people who used the beauty shop. He was unaware if they checked the shop for cleanliness.</p>	S 121		
S 165	<p>44:73:02:18 Occupant Protection</p> <p>Each facility shall be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the residents admitted to the facility.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to ensure: *Six of six bariatric door leaves were free of sharp</p>	S 165	<p>S 165</p> <p>Damaged aluminum angle irons on bariatric doors in whirlpool & resident rooms were replaced with solid steel pieces on 7/31/2016. Education to remove key & hang on side of the cupboard when electric stove is not in use provided to dietary staff on 8/11/16 & nursing staff via e-mail on 8/15/2016. (Cont on page 3 of 4)</p>	<p>*CHV/SODDCH/EL</p> <p>8-15-16</p>

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S 165	<p>Continued From page 2</p> <p>metal edges. *Two of two electric stoves in the two satellite kitchens were off when staff were not present. Findings include:</p> <p>1. Observation on 7/26/16 from 8:30 a.m. to 11:00 a.m. revealed:</p> <p>a. The bottom of the leaf of the bariatric doors to both whirlpool rooms and the four bariatric resident rooms had jagged metal edges at the bottom of the doors. That jagged metal edge was sharp to the touch and was directly in line with the toes or foot of a resident. Interview with the maintenance manager at the time of the above observations confirmed those findings. He stated he was unaware those pieces of metal had been damaged and now stuck out a jagged points.</p> <p>b. The two electric stoves in the two satellite kitchens had been left in the on position. A keyed switch above the stoves was turned to the on position. There were at least two instances where staff were not in the kitchen area. Interview with the maintenance manager at the time of the observations confirmed those findings. He stated he was unaware of the dietary policy for the stove when not in use. He agreed the stoves created an accident hazard if residents should wander into the satellite kitchens. No policy for the use of the stoves in the satellite kitchens was given by dietary or administration at the time of the survey.</p>	S 165	<p>S 165 (Cont from page 3) Policy to remove key when not stove is not in use implemented 8/12/2016. Maintenance or designee will monitor that electric stove keys are in the off position when not in use and report to QA committee weekly x 1 month, then monthly x 3 months then quarterly until QA determines audit can be discontinued. QA committee meets monthly.</p>	
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 35121 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 7/25/16 through 7/27/16. Sanford Chamberlain Care</p>	S 000		

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S 000	Continued From page 3 Center was found in compliance.	S 000		