

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

ORIGINAL

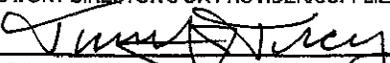
PRINTED: 04/11/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>43A098</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/18/2016</b>
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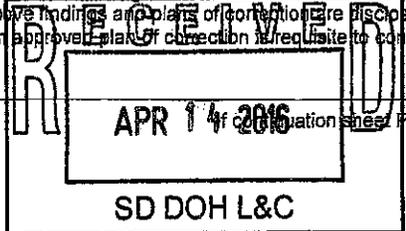
NAME OF PROVIDER OR SUPPLIER  <b>SANFORD CARE CENTER VERMILLION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20 S PLUM STREET VERMILLION, SD 57069</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS  Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/16/16 through 2/18/16. Sanford Care Center Vermillion was found not in compliance with the following requirements: F281 and F441.  F 281 SS=D 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: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Physician's orders were followed for the administration of an Advair inhaler for (asthma and chronic obstructive pulmonary disease) for one of one sampled resident (9). *Physician's orders were followed for laboratory orders and psychiatry visits for one of one sampled resident (1). *A physician's order was obtained according to their policy for one of one sampled resident (9) for do not resuscitate (DNR) orders. Findings include:  1. Observation on 2/18/16 at 8:00 a.m. of resident 9's Advair inhaler in the medication cart revealed there was: *An open date of 1/22/16 at 8:00 p.m., and it contained sixty inhalations. *Twelve doses were left in the inhaler.	F 000	<u>ASSERTION OF DENIAL</u>  The facility objects to the allegation of noncompliance for the following cited deficiencies: F281, F-441, and state tags S169 and S236. The facility also disagrees with the findings cited. Submission of the Response and Plan of Correction is <u>not</u> a legal admission that any deficiency exists or that these Statement of Deficiencies were correctly cited, and is also not to be construed as an admission of interest against the Facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in the Response and Plans of Correction. In addition, preparation and submission of the Plans of Correction do not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or the correctness of any conclusion set forth in this allegation by the survey agency.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>CEO</b>	(X8) DATE <b>4/11/16</b>
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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 for continued program participation.



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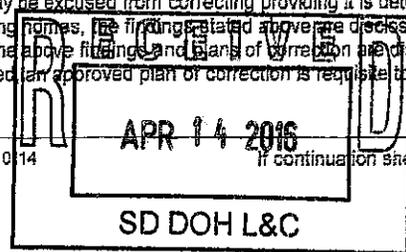
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<p>F 000</p> <p>F 281 SS=D</p>	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/16/16 through 2/18/16. Sanford Care Center Vermillion was found not in compliance with the following requirements: F281 and F441.</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Physician's orders were followed for the administration of an Advair inhaler for (asthma and chronic obstructive pulmonary disease) for one of one sampled resident (9). *Physician's orders were followed for laboratory orders and psychiatry visits for one of one sampled resident (1). *A physician's order was obtained according to their policy for one of one sampled resident (9) for do not resuscitate (DNR) orders. Findings include:  1. Observation on 2/18/16 at 8:00 a.m. of resident 9's Advair inhaler in the medication cart revealed there was: *An open date of 1/22/16 at 8:00 p.m., and it contained sixty inhalations. *Twelve doses were left in the inhaler.</p>	<p>F 000</p> <p>F 281</p>	<p>Accordingly, the Facility has prepared and submitted these Plans of Correction solely because of the requirements under state and federal law that mandate submission of a Plan of Correction for each deficiency cited within the time parameters set forth by regulation as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plans of Correction within this time frame should in no way be considered or construed as agreement with the allegations of noncompliance of admission by the facility.</p> <p><u>POSITIONS FOR DENIAL</u></p> <p>The Facility denies the allegations set forth and in support of the denial offers the following explanatory information pertaining to all deficiencies cited. The allegations of noncompliance also fail to allege or identify any negative resident outcomes or</p>	
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F 000	INITIAL COMMENTS  Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/16/16 through 2/18/16. Sanford Care Center Vermillion was found not in compliance with the following requirements: F281 and F441.	F 000	that the Facility has provided substandard quality of care to the residents. The facility denies the citations and believes they were based upon the surveyors' failure to obtain complete information prior to citing the deficiencies. Furthermore, the written citations are merely findings and demonstrate no negative resident outcomes, no patterns and no failure in the delivery of quality care in the Facility. Additionally, the facility denies the proposed deficiencies based upon professional judgment. In our professional opinion, nursing judgment by the Facility staff nurses is more likely to be held appropriate. This belief is based upon the education and experience of the staff nurses and the attending physicians at the Facility and upon local nursing and medical practice standards. Allegations of noncompliance with the	
F 281 SS=D	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: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Physician's orders were followed for the administration of an Advair inhaler for(asthma and chronic obstructive pulmonary disease) for one of one sampled resident (9). *Physician's orders were followed for laboratory orders and psychiatry visits for one of one sampled resident (1). *A physician's order was obtained according to their policy for one of one sampled resident (9) for do not resuscitate (DNR) orders. Findings include:  1. Observation on 2/18/16 at 8:00 a.m. of resident 9's Advair inhaler in the medication cart revealed there was: *An open date of 1/22/16 at 8:00 p.m., and it contained sixty inhalations. *Twelve doses were left in the inhaler.	F 281		

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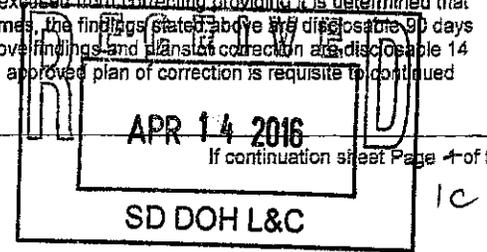
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F 000	INITIAL COMMENTS	F 000	requirement based on difference of professional opinion are not sufficient to allege the Facility failed to comply with any of the requirement(s).	
F 281 SS=D	<p>Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/16/16 through 2/18/16. Sanford Care Center Vermillion was found not in compliance with the following requirements: F281 and F441.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Physician's orders were followed for the administration of an Advair inhaler for (asthma and chronic obstructive pulmonary disease) for one of one sampled resident (9). *Physician's orders were followed for laboratory orders and psychiatry visits for one of one sampled resident (1). *A physician's order was obtained according to their policy for one of one sampled resident (9) for do not resuscitate (DNR) orders. Findings include:</p> <p>1. Observation on 2/18/16 at 8:00 a.m. of resident 9's Advair inhaler in the medication cart revealed there was: *An open date of 1/22/16 at 8:00 p.m., and it contained sixty inhalations. *Twelve doses were left in the inhaler.</p>	F 281	<p>*Addendums noted with an asterisk per 3/14/16 telephone with Quality Coordinator -- KR/SDDOH/EL</p> <p>F281- <u>PLAN</u></p> <p>1. There were no adverse effects for resident #9 from the missing 5 doses of Advair. The incident was reviewed by the pharmacist and DON on 2/21/16. Nursing education done by DON on 2/23/16 at Nurses Meeting; additionally DON provided one on one education to medication aides and the 3 nurses absent from the 2/23/16 from from 2/29/16 to 3/2/16 on always checking open date on inhaler medications and ensuring that</p>	

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F 281	Continued From page 1  Review of resident 9's 1/22/16 through 2/18/16 medication administration records (MAR) revealed: *The Advair inhaler was to have been administered twice a day at 8:00 a.m. and 8:00 p.m. *There was documentation she had received the inhaler from 1/22/16 at 8:00 p.m. through 2/17/16 at 8:00 p.m. There was no documentation any doses had been held or refused. *She had not yet received her dose on 2/18/16 at 8:00 a.m. *There should have been seven doses left in the Advair inhaler instead of twelve doses.  Interview on 2/18/16 at 8:15 a.m. with licensed practical nurse (LPN) A revealed she: *Confirmed there should have been seven doses left of the Advair inhaler instead of twelve. *Was unsure why the count of the Advair inhaler did not match what had been documented as administered.  Review of the provider's revised November 2015 Medication Administration Record policy revealed: **"Give the medication to the resident in accordance with medication requirements." **"Resident will receive the correct drug and dosage at the correct time without injury." **"If medication is not given for any reason, circle the time appropriately. If there is not enough room to document in the space, document the reason on the notes page of the medication administration record."  2. Review of resident 1's 3/31/15 physician's orders revealed: *Hemoglobin and hematocrit (laboratory tests for	F 281	dosage is given to resident before signing off that it is given. If question number of doses given, report to charge nurse to check. Director of Nursing (DON) or designee will perform bi-weekly audit *of three residents who use inhalers to check that the inhaler dose was given to resident per physician order. The DON will report results of this audit to the Care Center CQI committee quarterly beginning with the next meeting on 4/29/16 for discussion of further education or needs.  2. Resident #1's mood and behaviors haven been and are stable and she was seen by psychiatry on 3/3/16. A new order was obtained for psychiatry consult for resident #1 to be seen every 6 months and PRN. In future DON and MDS Coordinator will work together to ensure residents are		

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F 281	<p>Continued From page 2 anemia) yearly. *Thyroid stimulating hormone (TSH) and thyroid hormone (T4) (laboratory tests for thyroid) every six months. *See psychiatrist every two to three months and as needed.</p> <p>Review of resident 1's medical record revealed the last: *TSH/T4 had been done on 10/9/14. *Psychiatry visit had been done on 8/9/15.</p> <p>Interview on 2/18/16 at 8:30 a.m. with LPN A and the director of nursing regarding resident 1 revealed: *They had a new psychiatrist from out of town who saw four to five residents each month. *The residents were seen depending on their needs. *Resident 1's mood and behavior were stable now. *They should have gotten a new physician's order to change the frequency of her psychiatry visits. *The TSH/T4 should have been drawn two times in 2015. *The laboratory tests had been overlooked. *Reoccurring laboratory orders needed a new physician's order each year to be drawn.</p> <p>Surveyor: 32332 3. Review of resident 9's medical record revealed: *She had been admitted on 1/22/16 from another nursing facility. *Medical records received from that nursing facility had indicated she had "do not resuscitate" (DNR) orders previous to admission. *Her 1/22/16 physician's admission orders had</p>	F 281	<p>scheduled to see psychiatry consult within timeframe of physician orders. DON will perform bi-weekly audit to ensure residents are assessed by psych within physician order. Resident #1 also had a TSH and Free T4 drawn on 2/18/16 and the results were normal. The policy is for the night nurse to print out a lab report on Sunday nights showing the labs that are due for the coming week. The day shift nurses are to check that report daily and work with the hospital outpatient coordinators to get labs completed and results. DON educated the nursing staff at the 2/23/16 nursing meeting on the importance of following the lab report daily for ensuring labs are done and results are obtained. Lab orders will be audited bi-weekly by DON or designee to ensure they are performed within timeframe of physician</p>		

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F 281	<p>Continued From page 2</p> <p>anemia) yearly. *Thyroid stimulating hormone (TSH) and thyroid hormone (T4) (laboratory tests for thyroid) every six months. *See psychiatrist every two to three months and as needed.</p> <p>Review of resident 1's medical record revealed the last: *TSH/T4 had been done on 10/9/14. *Psychiatry visit had been done on 8/9/15.</p> <p>Interview on 2/18/16 at 8:30 a.m. with LPN A and the director of nursing regarding resident 1 revealed: *They had a new psychiatrist from out of town who saw four to five residents each month. *The residents were seen depending on their needs. *Resident 1's mood and behavior were stable now. *They should have gotten a new physician's order to change the frequency of her psychiatry visits. *The TSH/T4 should have been drawn two times in 2015. *The laboratory tests had been overlooked. *Reoccurring laboratory orders needed a new physician's order each year to be drawn.</p> <p>Surveyor: 32332 3. Review of resident 9's medical record revealed: *She had been admitted on 1/22/16 from another nursing facility. *Medical records received from that nursing facility had indicated she had "do not resuscitate" (DNR) orders previous to admission. *Her 1/22/16 physician's admission orders had</p>	F 281	<p>order. Psych audit and Lab audit results will be reported by the DON to the Care Center's CQI committee quarterly beginning with the next meeting on 4/29/16 for discussion of further education or needs.</p> <p>3. An order for DNR status for Resident #9 was obtained by resident's primary physician on 2/18/16. MDS Coordinator is educating physicians at time of admit of new residents that they will need to address the code status with their history and physical documentation until all PCP's have been educated. DON educated nursing staff to ensure there is a code status for new residents on their admit orders at the 2/23/16 nurses meeting. She also educated the 3 nurses who were not at the meeting on 2/29/16 to 3/1/16 on this. DON or designee will perform a bi-weekly audit of newly admitted</p>		

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F 281	<p>Continued From page 3 not included orders for DNR code status.</p> <p>Interview on 2/17/16 at 3:45 p.m. with licensed practical nurse D revealed: *It was the provider's policy to obtain a physician's order for code status on admission. *She agreed there was no physician's DNR order.</p> <p>Interview on 2/18/16 at 9:30 a.m. with the director on nursing revealed: *Resident 9 had a DNR order when she lived at the previous facility. *The resident's physician had not given orders for DNR when the resident was admitted to the current facility. *Her expectation was the physician would give DNR orders, or the nurse admitting the resident would ask the doctor for a DNR order.</p> <p>Review of the provider's November 2015 Do Not Resuscitate policy revealed: **"In the absence of a "DO NOT RESUSCITATE" (DNR) order, CPR [cardiopulmonary resuscitation] must be initiated." **"The attending physician, or the physician covering for the attending physician, shall communicate the decision not to resuscitate in the form of a physician's order." **"The RN [registered nurse] may take a verbal order or transcribe a nursing home DNR order if nursing home orders are to be continued. Any verbal DNR order requires a second RN to witness the order. The physician must cosign these orders within 24 hours or the next visit."</p>	F 281	<p>residents to ensure there is a physician order for code status. Results of this audit will be reported by the DON to the Care Center's CQI committee quarterly beginning with the next meeting on 4/29/16 for discussion of further education or needs.</p> <p>*All bi-weekly audits will continue until the April 29, 2016 Care Center CQI meeting. The results of the audits will be reviewed at that CQI meeting and all quarterly CQI meetings how often the audits will be done will be determined on their compliance. Audits will be done for one year but frequency will be decided at quarterly CQI meetings.</p>	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an</p>	F 441		3/03/16

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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 441	<p>Continued From page 4</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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 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: 35237</p>	F 441	<p><u>F441 PLAN</u></p> <p>1. The filters for oxygen concentrators for residents 2, 9, 16, 17 and 18 were replaced by the night nurse on 2/17/16. It is the responsibility of the night nurse to clean the filters and document in the nightly task duty book. DON educated the 3 night charge nurses on their role in ensuring that all the tasks in the night task book including cleaning all residents' oxygen concentrator filters are completed by the night staff before signing off on the task list. All other nurses were educated by the DON at the 2/23/16 nursing meeting on cleaning the filters. The Infection Control in Care</p>		

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

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NAME OF PROVIDER OR SUPPLIER  <b>SANFORD CARE CENTER VERMILLION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>20 S PLUM STREET VERMILLION, SD 57069</b>		
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F 441	<p>Continued From page 5</p> <p>Based on observation, interview, and policy review, the provider failed to maintain sanitary conditions for:</p> <p>*Five of nine randomly observed residents' (2, 9, 16, 17, and 18) oxygen concentrator filters had dust and foreign particles on them.</p> <p>*Two of four sampled residents' (3 and 7) wheelchairs in the north wing had been dirty.</p> <p>Findings include:</p> <p>1. Random observations from 2/16/16 at 4:00 p.m. through 2/17/16 at 5:50 p.m. throughout the facility revealed:</p> <p>*Residents 2, 9, 16, 17, and 18 had oxygen concentrators in their rooms.</p> <p>*The oxygen concentrator filters were dusty with a whitish powder on them.</p> <p>*Some of those oxygen concentrator filters had white and gray particles attached to them.</p> <p>Interview on 2/17/16 at 5:25 p.m. with licensed practical nurse (LPN) A regarding the oxygen concentrator filters revealed:</p> <p>*All the filters should have been cleaned weekly by the night staff.</p> <p>*They had spare sets of filters ready-to-use, so staff could put them into the concentrators right away while they washed and let the dirty filters air dry.</p> <p>*The night staff had a cleaning duty book with a task sheet they signed off on when the filter cleaning was completed.</p> <p>Observation of resident 16's oxygen concentrator filter and interview with the infection control nurse on 2/17/16 at 5:40 p.m. revealed:</p> <p>*She confirmed the filter was dusty with foreign particles on it. She agreed it appeared to not have been cleaned recently or within the last week.</p>	F 441	<p>Center Nursing Services policy was updated to include cleaning or replacing filters weekly. DON or designee will audit 5 concentrator filters for cleanliness bi-weekly and report results reported by the DON to the Care Center CQI committee quarterly beginning at the next meeting on 4/29/16 for discussion of further education and/or needs.</p> <p>2. Resident # 3 and #7's wheelchairs were cleaned on 2/17/16 by CNA staff. *All residents with wheelchairs were checked for need of cleaning by CNA staff. Education regarding cleaning wheelchairs after meals as needed and PRN was done with CNA staff at meeting</p>		

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F 441	<p>Continued From page 6</p> <p>*Night staff were responsible for cleaning the filters weekly according to their task schedule. *She agreed there was a risk to the residents if the oxygen concentrator filters were not cleaned appropriately.</p> <p>Interview on 2/17/16 at 6:00 p.m. with the director of nursing (DON) revealed: *She confirmed the oxygen concentrator filters were dirty and needed cleaning. *The night staff had been expected to clean the filters weekly according to their task sheet. *The task sheet had been initialed by the nursing staff as completed, but the filters did not appear to have been cleaned within the last week. *There was no specific policy on oxygen concentrator filter cleaning. *The expectation was to clean them weekly and follow the task schedule.</p> <p>2. Observation on 2/17/16 at 10:00 a.m. of resident 7's wheelchair revealed: *On the inside of both arm rests there was a brownish residue. *The vinyl cover on the right arm rest was cracked with the inner padding showing through.</p> <p>Interview with certified nursing assistant (CNA) C on 2/17/16 at 12:20 p.m. and observation of resident 3's wheelchair at that same time revealed: *The resident's wheelchair had been dirty with food debris inside both arm rests and on the seat cushion. *There were also two dirty tissues tucked in-between the cushion and the arm rest. *She stated the CNAs did the wheelchair cleaning. *They had a special wheelchair washing machine</p>	F 441	<p>2/24/16 by Education Coordinator and by DON at nurses meeting on 2/23/16 as well as one on one education with the 3 nurses who were absent from the 2/23/16 meeting by DON 2/29/16 to 3/1/16. An audit of 5 wheelchairs will be done by the DON or designee bi-weekly with results reported by the DON to the Care Center CQI committee quarterly beginning at the next meeting on 4/29/16 for discussion of further education and/or needs.</p> <p>*All bi-weekly audits will continue until the April 29, 2016 Care Center CQI meeting. The results of the audits will be reviewed at that CQI meeting and all quarterly</p>	

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F 441	<p>Continued From page 7 on another unit.</p> <p>-The machine took about five minutes to wash a wheelchair.</p> <p>*She was not aware of a specific schedule to clean the wheelchairs.</p> <p>Interview on 2/17/16 at 5:25 p.m. with LPN A regarding residents' wheelchairs revealed: *All residents' wheelchairs should have been cleaned weekly by the night staff. *The night staff had a cleaning duty book with a task sheet they signed off on when the wheelchair cleaning was completed.</p> <p>Interview on 2/17/16 at 5:40 p.m. with the infection control nurse revealed: *Night staff were responsible for cleaning residents' wheelchairs weekly according to their task schedule. *She had personally cleaned the residents' wheelchairs for south and west wings last week. *She confirmed some residents' wheelchairs got more dirty than others and should have been cleaned as needed along with weekly cleaning. *She stated resident 7's right arm rest was uncleanable and needed to be replaced.</p> <p>Interview on 2/17/16 at 6:00 p.m. with the DON revealed: *The night staff had been expected to clean residents' wheelchairs weekly according to their task sheet. *The facility had purchased a wheelchair washing machine that had made it easier to wash the wheelchairs. *Staff should have cleaned the wheelchairs as needed if they were dirty. *She expected residents' wheelchairs to be been kept clean.</p>	F 441	<p>CQI meetings how often the audits will be done depending on their compliance. Audits will be done for one year but frequency will be decided at quarterly CQI meetings.</p>	3/03/16	

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NAME OF PROVIDER OR SUPPLIER  <b>SANFORD CARE CENTER VERMILLION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>20 S PLUM STREET VERMILLION, SD 57069</b>		
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F 441	<p>Continued From page 8</p> <p>*There was no specific policy on wheelchair cleaning. The expectation was to clean them weekly and follow the task schedule.</p> <p>3. Review of the February 2016 Night Shift Cleaning Duties sheets revealed: *For all wings the wheelchairs should have been cleaned weekly on Sunday nights. *For all wings the oxygen concentrator filters should have been cleaned weekly on Monday nights. *There were staff initials indicating the tasks had been completed for the first three weeks in February.</p> <p>Review of the provider's revised February 2016 Infection Control in Care Center Nursing Services policy revealed: *The purpose was "To define procedures for cleaning, storage and handling of equipment and supplies and the maintenance of a sanitary environment." *"There will be established cleaning protocols for the general department environment and equipment and for safe storage and handling of equipment and supplies." *"For wheelchairs "During resident use, these items should be washed, disinfected and dried on a weekly basis."</p>	F 441			

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

**ORIGINAL**

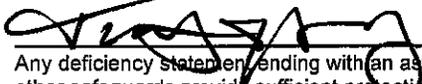
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NAME OF PROVIDER OR SUPPLIER  <b>SANFORD CARE CENTER VERMILLION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>20 S PLUM STREET VERMILLION, SD 57069</b>	
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/17/16. Sanford Care Center Vermillion was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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

TITLE

(X6) DATE



**CEO**

**3/9/16**

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.

**MAR 10 2016**

**SD DOH L&C**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10697	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  02/18/2016
NAME OF PROVIDER OR SUPPLIER  SANFORD CARE CENTER VERMILLION		STREET ADDRESS, CITY, STATE, ZIP CODE 20 S PLUM STREET VERMILLION, SD 57069		
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S 000	Compliance/Noncompliance Statement  Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/16/16 through 2/18/16. Sanford Care Center Vermillion was found not in compliance with the following requirements: S169 and S236.	S 000	S169 – PLAN	
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 one of one main entrance door. Findings include:  1. Observation on 2/16/16 at 3:45 p.m. revealed the main entrance door was equipped with an	S 169	1. On 2/18/16 the front door alarm was turned on at all times except when staff member is sitting at the front reception desk. Even though the alarm had been turned off during the day shift previous to 2/18/16, there had not been any resident elopements. DON provided	

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

TITLE

CEO

(X6) DATE

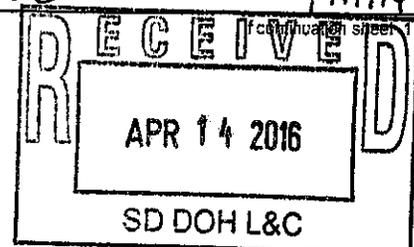
4/14/16

STATE FORM

8889

RFQT11

Continuation sheet 1 of 5



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10697</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/18/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SANFORD CARE CENTER VERMILLION</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>20 S PLUM STREET VERMILLION, SD 57069</b>
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S 169	<p>Continued From page 1</p> <p>audible alarm. The alarm was not activated at the time of the observation. The main entrance door was within sight distance of the health information management (HIM) clerk/nurses station desk when staff were present.</p> <p>The main entrance door was observed not activated and not monitored on:                      *2/16/16 at 6:15 p.m.                      *2/17/16 at 5:40 p.m.                      *2/17/16 at 6:15 p.m.                      *2/18/16 at 7:20 a.m.                      *2/18/16 at 11:50 a.m.</p> <p>Observation of the door alarm panel on 2/17/16 at 5:40 p.m. revealed the main entrance door alarm switch had been in the off position.</p> <p>Interview on 2/18/16 at 8:10 a.m. with HIM clerk (B) revealed she had worked from 8:00 a.m. to 4:30 p.m. with a half hour lunch. She had monitored the door during her scheduled hours.</p> <p>Interview on 2/18/16 at 11:15 a.m. with the director of nursing (DON) confirmed the main entrance door alarm switch had been in the bypass alarm position during the hours of 6:00 a.m. to 8:00 p.m.</p> <p>Review of the provider's Security - Locking of Doors policy number S 107 dated January 1990 revealed:                      "2.2 The Care Center Main Entrance is alarmed at all times. During the hours of 6:00 am to 8:00 pm, the alarm is silenced for visitors. At 8:00 pm to 6:00 am the door is automatically locked."                      "2.2.1 The Care Center HIM Clerk and Charge Nurse will monitor the Main Entrance during the hours the alarm is silenced (6:00 am to 8:00 pm)."</p>	S 169	<p>Staff education on ensuring alarm is turned on at all times unless staff is sitting at the front reception desk at the 2/23/16 nurses meeting and to the 3 nurses that were absent by 3/3/16. A note was placed at the nurses' station behind the front reception desk that states the</p>	

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NAME OF PROVIDER OR SUPPLIER  
**SANFORD CARE CENTER VERMILLION**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**20 S PLUM STREET  
VERMILLION, SD 57069**

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S 169	<p>Continued From page 1</p> <p>audible alarm. The alarm was not activated at the time of the observation. The main entrance door was within sight distance of the health information management (HIM) clerk/nurses station desk when staff were present.</p> <p>The main entrance door was observed not activated and not monitored on:                      *2/16/16 at 6:15 p.m.                      *2/17/16 at 5:40 p.m.                      *2/17/16 at 6:15 p.m.                      *2/18/16 at 7:20 a.m.                      *2/18/16 at 11:50 a.m.</p> <p>Observation of the door alarm panel on 2/17/16 at 5:40 p.m. revealed the main entrance door alarm switch had been in the off position.</p> <p>Interview on 2/18/16 at 8:10 a.m. with HIM clerk (B) revealed she had worked from 8:00 a.m. to 4:30 p.m. with a half hour lunch. She had monitored the door during her scheduled hours.</p> <p>Interview on 2/18/16 at 11:15 a.m. with the director of nursing (DON) confirmed the main entrance door alarm switch had been in the bypass alarm position during the hours of 6:00 a.m. to 8:00 p.m.</p> <p>Review of the provider's Security - Locking of Doors policy number S 107 dated January 1990 revealed:                      **2.2 The Care Center Main Entrance is alarmed at all times. During the hours of 8:00 am to 8:00 pm, the alarm is silenced for visitors. At 8:00 pm to 6:00 am the door is automatically locked."                      **2.2.1 The Care Center HIM Clerk and Charge Nurse will monitor the Main Entrance during the hours the alarm is silenced (6:00 am to 8:00 pm)."</p>	S 169	<p>door alarm is to be on at all times unless staff member is sitting at the main desk/front reception desk. Also DON provided one on one education with the HIM clerk on 2/18/16. A door alarm weekly audit will be performed by the DON or designee to ensure the alarm is on when staff is not sitting at the front reception</p>	

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S 169	<p>Continued From page 1</p> <p>audible alarm. The alarm was not activated at the time of the observation. The main entrance door was within sight distance of the health information management (HIM) clerk/nurses station desk when staff were present.</p> <p>The main entrance door was observed not activated and not monitored on:                      *2/16/16 at 6:15 p.m.                      *2/17/16 at 5:40 p.m.                      *2/17/16 at 6:15 p.m.                      *2/18/16 at 7:20 a.m.                      *2/18/16 at 11:50 a.m.</p> <p>Observation of the door alarm panel on 2/17/16 at 5:40 p.m. revealed the main entrance door alarm switch had been in the off position.</p> <p>Interview on 2/18/16 at 8:10 a.m. with HIM clerk (B) revealed she had worked from 8:00 a.m. to 4:30 p.m. with a half hour lunch. She had monitored the door during her scheduled hours.</p> <p>Interview on 2/18/16 at 11:15 a.m. with the director of nursing (DON) confirmed the main entrance door alarm switch had been in the bypass alarm position during the hours of 6:00 a.m. to 8:00 p.m.</p> <p>Review of the provider's Security - Locking of Doors policy number S 107 dated January 1990 revealed:                      ""2.2 The Care Center Main Entrance is alarmed at all times. During the hours of 6:00 am to 8:00 pm, the alarm is silenced for visitors. At 8:00 pm to 6:00 am the door is automatically locked."                      ""2.2.1 The Care Center HIM Clerk and Charge Nurse will monitor the Main Entrance during the hours the alarm is silenced (6:00 am to 8:00 pm)."</p>	S 169	<p>will be reported by the DON to the Care Center CQI committee quarterly beginning at the next meeting on 4/29/16 for discussion of further education and/or needs. *Weekly audits will continue until the April 29<sup>th</sup>, 2016 Care Center CQI meeting. The results of the audits will be reviewed at that meeting</p>	

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER  SANFORD CARE CENTER VERMILLION		STREET ADDRESS, CITY, STATE, ZIP CODE 20 S PLUM STREET VERMILLION, SD 57069		
(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>audible alarm. The alarm was not activated at the time of the observation. The main entrance door was within sight distance of the health information management (HIM) clerk/nurses station desk when staff were present.</p> <p>The main entrance door was observed not activated and not monitored on:                      *2/16/16 at 6:15 p.m.                      *2/17/16 at 5:40 p.m.                      *2/17/16 at 6:15 p.m.                      *2/18/16 at 7:20 a.m.                      *2/18/16 at 11:50 a.m.</p> <p>Observation of the door alarm panel on 2/17/16 at 5:40 p.m. revealed the main entrance door alarm switch had been in the off position.</p> <p>Interview on 2/18/16 at 8:10 a.m. with HIM clerk (B) revealed she had worked from 8:00 a.m. to 4:30 p.m. with a half hour lunch. She had monitored the door during her scheduled hours.</p> <p>Interview on 2/18/16 at 11:15 a.m. with the director of nursing (DON) confirmed the main entrance door alarm switch had been in the bypass alarm position during the hours of 6:00 a.m. to 8:00 p.m.</p> <p>Review of the provider's Security - Locking of Doors policy number S 107 dated January 1990 revealed:                      **2.2 The Care Center Main Entrance is alarmed at all times. During the hours of 6:00 am to 8:00 pm, the alarm is silenced for visitors. At 8:00 pm to 6:00 am the door is automatically locked."                      **2.2.1 The Care Center HIM Clerk and Charge Nurse will monitor the Main Entrance during the hours the alarm is silenced (6:00 am to 8:00 pm)."</p>	S 169	<p>and all</p> <p>quarterly CQI meetings how often the audits will be done depending on their compliance. Audits will be done for one year but frequency will be decided at quarterly CQI meetings.</p>	3/03/16

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10697</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/18/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>SANFORD CARE CENTER VERMILLION</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>20 S PLUM STREET VERMILLION, SD 57069</b>		
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S 236	<p>44:73:04:12(1) Tuberculin Screening Requirements</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to: *Obtain the second step and assess the results of the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days after admission for 1 of 18 (6) sampled</p>	S 236	<p><b>S236 - PLAN</b></p> <p>1. Resident # 6 showed no signs or symptoms of TB. She was given a one-step TB skin test on 2/29/16 in the left forearm and it was read by staff on 3/2/16 with 0mm reaction. Resident 11 also showed no signs or symptoms of TB. He was given a one-step TB skin test on 2/29/16 in the left forearm and it was read by staff on 3/2/16 with 0mm reaction. DON is working with the Sanford Information Technology department to add standing orders in the electronic medical record for one or two step TB skin tests as appropriate upon admit of residents for staff to initiate for all newly</p>	

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S 236	<p>Continued From page 3</p> <p>residents.</p> <p>*Assess the result of the second step TB skin test for 1 of 18 (11) sampled residents. Findings include:</p> <p>1. Review of resident 6's medical record revealed: *She had been admitted on 6/26/15. *She was given her first TB skin test on 6/28/15, and the result had been documented as negative. *There was no record a second TB skin test had been completed.</p> <p>Interview on 2/17/16 at 1:30 p.m. with licensed practical nurse A revealed: *Resident 6 had been living at home prior to her admission. *No second step TB skin test had been completed. *The test should have been completed.</p> <p>2. Review of resident 11's medical record revealed: *He had been admitted on 7/31/15, *He was given his first TB skin test on 7/31/15, and the result had been documented as negative. *His second TB skin test had been documented as given on 8/6/15. *No result of the second TB skin test had been recorded.</p> <p>3. Interview on 2/18/16 at 9:55 a.m. with the director of nursing revealed: *Resident 6's second step TB test had not been completed. *There were no results documented of resident 11's second TB skin test. *The skin test should have been assessed and documented. *The provider had changed their medication</p>	S 236	<p>admitted residents DON</p> <p>educated the nursing staff on this process and requirement for all newly admitted residents to have documentation of two TB tests within 14 days of admission to the Care Center at the nursing staff meeting on 2/23/16 and provided one on one education for the 3 nurses that were absent from 2/29/16 to 3/3/16. DON or designee will audit bi-weekly all admits since 2/18/16 for documentation of two step TB test within 14 days of admit and all newly admitted residents for same. Results will be reported by the DON to the Care Center CQI committee quarterly beginning at the next meeting on 4/29/16 for</p>	

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S 236	Continued From page 4 documentation to an electronic medication administration record (MAR) last summer. *The new electronic MAR had not been set-up to alert the nurses to read the residents' TB skin tests, so some of the tests had been missed.  Review of the provider's March 2015 Tuberculosis Surveillance and Management for Healthcare Workers and Residents policy and procedure revealed the residents would be given a two-step TB skin test within fourteen days of admission. Test results were to have been received by the nursing staff from the laboratory.	S 236	discussion of further education and/or needs. *Bi-weekly audits will continue until the April 29, 2016 CQI meeting. The results of the audits will be reviewed at that CQI meeting and all quarterly CQI meetings how often the audits will be done depending on their compliance. Audits will be done for one year but frequency will be decided at quarterly CQI meetings.		
S 000	Compliance/Noncompliance Statement  Surveyor: 22452 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 2/16/16 through 2/18/16. Sanford Care Center Vermillion was found in compliance.	S 000		3/03/16	