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

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<td>Accuracy of Assessments</td>
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Surveyor: 16385
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/22/19 through 7/24/19. Diamond Care Center was found not in compliance with the following requirements: F641, F660, F679, F689, F744, F812, and F880.

### F 641 Accuracy of Assessments

CFR(s): 483.20(g)

§483.20(g) Accuracy of Assessments.
The assessment must accurately reflect the resident's status.

This **Requirement** is not met as evidenced by:

Surveyor: 35237
Based on interview, record review, and manual review, the provider failed to ensure one of one sampled resident (21) who had falls with injury had been accurately recorded on the Minimum Data Set (MDS) assessment. Findings include:

1. Interview and fall log review on 7/22/19 at 4:44 p.m. with licensed practical nurse J regarding resident 21's falls revealed:
   * The resident had a few recent falls with injuries.
   * She had fallen:
     - On 5/3/19 and caused an abrasion to her forehead and a hematoma to her right wrist and hand.
     - On 5/9/19 and caused a bump on her head.
     - On 6/29/19 and caused a bump on her head and a "strain" to her right wrist.
   * Prior to the above falls her last fall had been in 2017.

### LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Byron A. Shakespeare  
Executive Director  
8/15/2019

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.

RECEIVED
AUG 29 2019
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinic Identification Number:** 435114

**Multiple Construction**

**Building:**

**Wing:**

**Date Survey Completed:** 07/24/2019

**Name of Provider or Supplier:** DIAMOND CARE CENTER

**Street Address, City, State, Zip Code:**

901 N MAIN ST POST OFFICE BOX 300
BRIDGEWATER, SD 57319

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<tr>
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<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
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| F 641 | | Continued From page 1  
Review of resident 21's medical record, fall incident reports, and investigations revealed:  
*The same information related to the falls with injury as noted above.  
*Her most recent 6/18/19 annual MDS assessment had been coded to reflect the two falls in May 2019.  
*Those falls were coded as falls with no injury which had not matched the documented injuries the resident had obtained.  

Interview on 7/24/19 at 1:52 p.m. with the MDS assessment coordinator regarding resident 21's MDS and documented falls as noted above revealed:  
*She confirmed the above 6/18/19 MDS had not been coded accurately.  
*The falls should have been coded as falls with injury except major since her falls had involved minor injuries.  
*The Resident Assessment Instrument (RAI) manual was the reference she used for completing MDS assessments.  
*That had not been followed for coding the resident's falls.

Interview on 7/24/19 at 2:40 p.m. with the administrator, director of nursing, and registered nurse C regarding resident 21's above MDS assessment and coding confirmed the falls with injury had not been coded accurately and should have been. They expected the RAI manual to have been followed for MDS coding.

*Pages J-27 through J-37 related to section...
**F 641**
Continued From page 2
J1700 through J2000 related to falls included:
- Code falls as injury except major for any of the following: "skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain."
- "It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD [assessment reference date] to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS."

**F 660**
Discharge Planning Process
SS=0
CFR(s): 483.21(c)(1)(i)-(ix)

§483.21(c)(1) Discharge Planning Process
The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and:
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability

1. The discharge planning and care plan has been updated for #7. Follow up was made with Dakota at Home and documented that they are looking for additional resources to assist #7 at home. Facility will continue to follow up with agencies that may be able to provide services for #7 in a home situation

2. All residents will be reviewed for discharge planning including documentation. ED will re-educate the IDT to the discharge planning process with special emphasis on documentation of education to resident and resident progress, follow-up with other home services and updating of discharge plan.
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<th>COMPLETION DATE</th>
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<td>F 660</td>
<td>Continued From page 3 and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment.</td>
<td>F 660</td>
<td>3. DNS and/or her designee will monitor through IDT process and audited review of two resident records per week for one month and one resident record per week for two months for documentation, home resources and updating of discharge planning and education, etc. 4. The data collected will be taken to the QAPI Committee at least quarterly by the Director of Nurses or designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies.</td>
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preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Surveyor: 35237
Based on observation, interview, record review, and policy review, the provider failed to ensure one of two sampled resident's (7) discharge planning had been completed and documented to support his desire to go home. Findings include:

1. Review of resident 7's medical record revealed:
*He had been admitted on 2/11/19.
*He was alert and oriented to person, place, situation, and time.
*His 2/18/19 admission Minimum Data Set (MDS) assessment indicated he expected to be discharged to the community with active discharge planning occurring.
*His most recent 5/21/19 quarterly MDS assessment indicated:
-He was independent with most of his activities of daily living (ADL).
-He was totally dependent on staff assistance for eating related to his tube feeding.
-No active discharge planning was occurring.
-No was the response for the questions of if he wanted to talk to someone about leaving the facility or be asked about discharge on future
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Location Identification Number:**

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<td>435114</td>
<td>Diamond Care Center</td>
<td>B. Wing</td>
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**Date Survey Completed:** 07/24/2019

### Summary Statement of Deficiencies

**ID:** F 660

**Tag:** Continued From page 5 assessments.

Review of resident 7's 7/23/19 printed care plan related to discharge revealed:

- "A focus of: "Discharge plan undetermined at this time."
- "A goal of: "Discharge planning decision will be reached by end of review period." "
- "Interventions/Tasks of: "Assist resident and family in decision making process based on home situation and residents needs" and "Dakota at Home services about services and if he would be appropriate to live on own."
- "All those items had been initiated at the time of his admission on 2/11/19."
- "There had been no revisions or updates regarding his discharge plan or desire to go home."

Observation and interview on 7/22/19 at 1:32 p.m. with resident 7 in his room revealed:

- "He had been admitted about six months ago."
- "He had an apartment in another town he was still paying rent for and would like to get back to."
- "He felt he was able to do everything for himself other than his feeding tube."
- The tube feeding ran overnight from 9:00 p.m. through 9:00 a.m. and medications were given at those times along with one other time in the afternoon.
- "He asked if it would be possible to go home with the feeding tube and have someone come in to assist with that three times a day."
- Someone had told him that was not an option, but he thought it might still be a possibility.
- "Staff were aware of his desire to go home, and he had worked with therapy in the past."
- "Just recently he had a scope procedure and swallow study done to see if he could try eating..."
**continued from page 6**

The speech therapist would be coming later that day to see him.

*He was hopeful after working with speech therapy he might be able to get back home again.*

Interview on 7/23/19 at 9:05 a.m. with registered nurse (RN) A regarding resident 7 revealed:

*She was aware he wanted to get back home. She was unsure if there was any discharge planning for him currently.

*He required staff assistance with all his tube feeding care.

*Sentence cut off before completing thought.*

Review of resident 7’s progress notes from his admission on 2/11/19 through 7/23/19 revealed:

*There was minimal documentation addressing his discharge planning.

*On 2/11/19 at 10:13 in the nursing admission note: "...Discharge Planning: Unknown or uncertain at this time..."

*On 2/21/19 at 1:31 p.m.: "Dakota at home was onsite this afternoon to visit with Resident regarding his options for returning back to private home setting. Dakota at Home staff was [name] who came onsite; [name] spent approximately 1 1/2 hours with Resident. Upon completion of meeting with Resident, [name] then spoke with DNS [director of nursing service] and BOM [business office manager]. [Name] stated at this time there are not enough services available to meet his PEG [tube] feeding needs. She advised Resident that he should continue to work with therapy on daily living skills as well as training on PEG tube. [Name] stated if she does not hear back from us in approximately 3 months she would follow back up with us to see how Resident...
Continued From page 7

is progressing. [Name] stated that she also advised Resident that his PCP [primary care practitioner] would also have to agree that it would be safe for him to return to his private home.

"On 3/7/19 at 1:35 p.m. by nursing: "Assisted resident in G-tube med [medication] administration at 1330 [1:30 p.m.]. Educated resident on process, resident was able to remove clip from tubing with difficulty, explanation with visual aide of how clip goes together was needed. Not able to kink tubing on own without assistance, causes some leakage of medication and stomach contents, this caused distraction as resident was trying to clean this up before continuing medication administration. Resident is able to open tubing after many attempts, and insert syringe, noted when resident is pushing water and meds through tubing is being kinked, intervention required. Resident understands that 30cc flushes must be done before and after meds, is unable to draw up all meds with syringe without assistance. Resident states is unable to attempt care without standing therefore syringe is hanging down towards floor when attempting to apply tube was missing tube all together, questioning if visual impairment is more of a factor, coupled with residents decreased dexterity. Will continue to work with resident."

"On 3/7/19 at 2:22 p.m. by the dietitian: "...Resident is anxious to return to his own home to administer feeding independently. Staff are currently training him on the TF [tube feeding] administration."  

"On 3/8/19 at 1:41 p.m. a nursing note: "Resident has talked quite a bit today about do his own GT [gastrostomy tube feeding] cares, hooking up feeding, and flushing with H2O [water]. When writer walked in room this morning, resident had
Continued From page 8

his GT clamp in his hand. he was excited because he had been working for 30 min to get it open and [preacher name] on TV preached about it being able to be done and then he all of sudden did it. Resident has put clamp on and off GT today with minimal difficulty. Will monitor."

"There were no further notes about staff teaching him how to do his tube feeding care independently.

"A note on 3/28/19 at 2:31 p.m. by social services: "...[Resident] has no family that are involved in his care. He is able to make most of his decisions. At this time he will remain in the facility."

-It had not mentioned if remaining in the facility was the resident's preference or how that decision had been made.

-There was no further documentation related to:
  -Overall discharge planning.
  -If the resident still wanted to go home.
  -If teaching had continued for him to do his own feeding tube care or how he handled that teaching.
  -If Dakota at Home had been back in three months as indicated in the note on 2/21/19.

Review of resident 7's Care Conference Summary reports revealed:

"On 2/13/19:
-He planned to be discharged to home with a comment of "wants to go home if able with nurse to do feeding."

-The summary included: "...He does wish to return to his apartment if he could find someone to help with his feeding tube with the feedings. Social worker did call Dakota at home and they will be out sometime in the next two weeks to assess [resident] and talk with [resident] about going back home in his apartment and services..."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

DIAMOND CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

901 N MAIN ST POST OFFICE BOX 300
BRIDGEWATER, SD 57315

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<td>F 660</td>
<td>Continued From page 9 they provide. Will see what Dakota at home has to say and look into options after they have visited.&quot;</td>
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|                    | "*On 2/28/19:  
-For his therapy program: "Working on skilled to be able to go home with the feeding tube. They also working on how to use the feeding tube."  
-His discharge plan was marked as "Unknown at this time."  
-The summary included: ",....[Resident] was told that we would talk again about how things are going in the next week. [Resident] has no other concerns at this time. Dakota at Home also has been out to assessment [assess] resident and right now they can't help him and will contact the facility in three months if they have not heard from the facility. Will continue to work with [resident] on skills to be able to go back to his apartment." |                                                                 |                     |
|                    | *On 5/30/19:  
-He was not on a therapy or restorative program.  
-His discharge plan was marked as "Unknown at this time."  
-The summary had not mentioned discharge planning at all.  
Interviews on 7/24/19 at 8:00 a.m. and at 10:20 a.m. with occupational therapy (OT) assistant D regarding resident 7's therapy and discharge goals revealed:  
*He had worked with OT when he had first been admitted.  
*They worked on getting him more independent related to his goal of going home.  
*They also had worked on some teaching for him to be able to complete his own tube feeding care.  
-Nursing was supposed to have worked on most of the tube feeding teaching with him since OT only saw him for a brief period of time. |                                                                 |                     |
**DIAMOND CARE CENTER**

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<td>&quot;OT staff had concerns with him completing his own tube feeding care, and he was discharged from their services on 3/12/19. At that time nursing was completing all of his tube feeding care. Review of the resident 7’s OT plan of care, discharge summary, and treatment notes revealed: A 3/12/19 daily treatment note of: ‘...At functional level for SNF [skilled nursing facility] with recommendation of LTC [long term care] placement at this juncture due to safety concerns and need for nursing to set up food for tube feed, improved bimanual dexterity and ADL I [activities of daily living independence].’ Interview on 7/24/19 at 5:11 a.m. with the licensed social worker regarding resident 7’s discharge planning revealed: *She was aware of his desire to get back home to his apartment. *She would have been involved in discharge planning along with the interdisciplinary team. *They had worked on him being able to complete his own tube feeding care, and he was not able to do that. *In February they had contacted Dakota at Home to see if there were any resources for him to be able to get back home with help for his tube feeding. At that time his discharge was not a possibility, and they were supposed to return in three months. —That follow-up had not occurred, and she was not sure why. *She confirmed there was minimal documentation in his record to support discharge planning had been completed as it should have been. After March 2019 there was no further</td>
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<td>F 660</td>
<td>Continued From page 11 documentation related to his discharge plan. *She confirmed his care plan had not been updated related to his discharge goals and should have been. Interview on 7/24/19 at 9:26 a.m. with licensed practical nurse B regarding resident 7 revealed: *She was aware he wanted to go home. *The nurses had worked with him on tube feeding teaching, and that had not gone well. *She confirmed the teaching by nursing staff was not documented well and should have been to support it had been done. *Discharge planning should have been documented in his record. *His care plan had not been updated related to discharge planning. Interview on 7/24/19 at 10:02 a.m. with the director of nursing, administrator, and RN C regarding resident 7's discharge planning revealed: *They confirmed the documentation in his medical record had not supported all the discharge planning that had occurred. *His care plan had not been updated since admission related to discharge planning, and it should have been. *The three month follow-up by Dakota at Home staff had not occurred and should have. *Discharge planning and documentation should have been completed by the interdisciplinary team. Review of the provider's March 2019 Discharge Planning and Transfer Process policy revealed: *Discharge planning should have begun upon admission and involved the resident. *Discharge planning should have been</td>
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<td>F 679</td>
<td>Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)</td>
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§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

This REQUIREMENT is not met as evidenced by:

Surveyor: 40771

Based on observation, interview, and record review, the provider did not ensure activities were offered to one of one sampled resident (1) who had dementia. Findings include:

1. Review of resident 1's medical records revealed she:
   * Had a Brief Interview of Mental Status assessment score of three meaning she had severe cognitive impairment.
   * Had diagnoses of dementia, anxiety disorder, and generalized muscle weakness.
   * Needed extensive help of staff to ambulate with the aid of a walker or wheelchair.

2. Review of resident 1's 1/25/19 care plan revealed the following interventions:
   * Will attempt to divert [name] away from loud/busy areas and place in more calm/quiet

3. 1. Resident 1's chart was reviewed for history of activities she enjoyed prior to being admitted to facility. The previous activities she enjoyed such as knitting, manicures, playing bingo, and gospel music will be incorporated into an individualized activity plan for her.

4. Care plan was updated to reflect current likes and dislikes and the new individualized activity plan.

5. Resident care plans will be reviewed to assure individualized activities of their choice are incorporated into the care plan. Audit tool will be implemented following staff education which will be done by 8/29/19 to record behaviors and interventions offered to resident morning and afternoon.

6. 3. ED/designee will audit activity attendance and behavior interventions for effectiveness utilizing the audit tool. The monitoring will be completed three times per week for one month. Results will be reviewed and changes will be made based on resident participation and refusal of activities.

7. 4. The ED or designee will report findings at IDT meetings, behavior rounds, and results will be reviewed quarterly at the facility's QAPI meeting. At this time, the committee will make the decision for any necessary follow up studies.
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| **SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)** | Environment.*  
**"Attempt non-pharmacological interventions such as one to one visits, soft music, massage with lotion to hands and observe effectiveness."**  
**"Offer non-pharmacological interventions for pain relief such as rest periods, repositioning, hand massage, and soft music."** |
| **Review of resident 1's undated All About Me document revealed:** |  
*When she was anxious staff should have tried hand massages and going outside if the weather was nice.*  
*She took a nap after lunch.*  
*Her favorite music had "nothing particular" documented, but then had hymns listed.*  
*Listed several television shows she liked.* |
| **Review of resident 1's 3/30/17 recreation/wellness document noted her current interests were:** | Bingo, car rides/sightseeing, movies/plays/theatre, exercise, walks, biking, trivia, crosswords/word searches/sudoku. There had been any updates since 2017. |
| **Random observations of resident 1 revealed her seated in front of the nurses station in her wheelchair at the following times:** |  
*7/22/19 between 1:30 p.m. and 6:00 p.m. on four occasions with no interaction with other residents or staff during those times.*  
*7/23/19 between 8:00 a.m. and 5:00 p.m. on six occasions:*  
-She was talking to herself and refused several staff offering to take her to the dining area for lunch.  
-She had her eyes closed and head leaning forward at times.  
*7/24/19 between 7:45 a.m. and 4:00 p.m. on ten* |

*FORM CMS-2567(02-99) Previous Versions Obsolete  
Event ID: GF11  
Facility ID: 0095  
If continuation sheet Page 14 of 41*
**Continue from page 14**

- She was rocking her wheelchair by moving her feet.
- She was shaking and rubbing her hands.
- During the music activity she was not taken into the area with the other residents. Instead she was left in the same location by the nurses station.

Observation throughout the survey from 7/21/19 through 7/24/19 of the area outside the nurses station revealed:
- Periodically there would be up to ten residents seated in that area.
- One resident would talk loudly and consistently while seated there.
- It was the intersection to the dining room hallway, and the two hallways used to get to residents' rooms.
- There were also four administrative offices around that area.
- There was continuous traffic and noise.

Interview on 7/24/19 at 10:03 a.m. with the director of nursing regarding resident 1 revealed she:
- Was best with one-to-one interaction.
- Did not do well in big groups.
- Did not like Bingo, naps, or to go outside.
- Was in the area by the nurses station, so they could watch her and keep her safe.
- Would be aggressive by hitting or tripping staff or other residents when they would walk by her.
- Would get agitated and would refuse activities.

Interview on 7/24/19 at 10:47 a.m. with certified nursing assistant (CNA) F regarding resident 1 revealed:
- She had been the activity director but taken the summer off to work as a CNA.
Continued From page 15

*She would be going back into that position on 8/8/19.
*She needed to update the resident's activity preferences.
*She documented all refusals when the resident was offered an activity and refused.
*The resident did not like big groups or large group activities.
*She liked going outside when it was nice.
*She would do better with one-to-one interaction.
*She enjoyed music when someone came to sing or play music.
*She needed staff to move her from place-to-place as she was unable to move herself.

Observation on 7/24/19 at 1:10 p.m. revealed she was seated in her wheelchair in the dining room. She was one of two residents left in the dining area after the noon meal was finished. She was speaking to herself and looked at staff as they passed her and followed them with her eyes while talking. No staff interaction was observed during the twenty minutes she was sitting there. After twenty minutes she was moved from the dining area into the hallway by the nurses station and left there.

Interview on 7/24/19 at 1:29 p.m. with CNA 1 revealed she had not been told any special activities that interested resident 1.

Interview on 7/24/19 at 1:38 p.m. with licensed practical nurse B regarding resident 1 revealed:
*She sat in front of the nurses station, because they wanted to keep an eye on her and prevent falls.
*She reacted to the setting around her, so if it was chaotic she would get agitated.
**F 679** Continued From page 16

- No music was played around the nurses station where resident 1 was sitting.
- After she became agitated they would move her to a quieter location.
- She did not have a radio in her room, and music had been listed as an intervention on her 1/25/19 care plan.

Interview on 7/24/19 at 1:57 p.m. with community assistant K revealed she was aware resident 1 liked music. She was told when resident 1 was speaking to "go along" with what she was saying so not agitate her. She had received no other training on working with residents with dementia.

Review of resident 1's community life documentation between 6/25/19 and 7/24/19 revealed:
- She had refused to take part in activities on 6/30/19 (two times), 7/21/19, and 7/23/19; a total of four refusals.
- She attended two of the seventeen types of activities that had been offered.
- She attended devotions/sermon on twenty-four days.
- She only attended one exercise activity.
- No other activities were documented as offered or refused.

Review of resident 1's 1/21/19 Minimum Data Set (MDS) assessment revealed she was not able to be understood, so staff had completed the questions. The selections for activity preferences only revealed the following:
- Receiving tub bath.
- Snacks between meals.
- Family or significant other involvement in care decisions.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<tbody>
<tr>
<td>F 689</td>
<td>Continued From page 17</td>
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<tr>
<td>F 689</td>
<td>Free of Accident Hazards/Supervision/Devices</td>
</tr>
<tr>
<td>SS=D</td>
<td>§483.25(d)(1)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to implement interventions and update the resident's care plan following falls with injury for one of four sampled residents (21) to potentially prevent future falls. Findings include: 1. Review of resident 21's medical record revealed: -She had been living there since 2015. -Her diagnoses included: dementia with behavioral disturbance, mood disorder, insomnia, major depressive disorder, and restless leg syndrome. -Her most recent 6/18/19 annual Minimum Data Set assessment indicated she: -Was independent with walking and transferring herself. -Required limited assistance of one staff person with using the toilet. -Was not steady but able to stabilize without human assistance. -Had two falls with no injury during that lookback period. --Those had been coded inaccurately. Refer to F689</td>
</tr>
<tr>
<td>F 689</td>
<td>1. Resident 21 continues to be observed daily for falls. Care plan has been updated regarding fall prevention. Resident will be provided with a bed-side table that will be placed in front of her to rest her head on should she be tired and refuses to lie down. She may also use the table for other activities such as coloring and drawing which she has enjoyed in the past. This table will be used in all areas that she sits upright and falls asleep, such as, resident's room and the area by the nurse's station. 2. Residents with history of falls will be Reviewed and care plans updated as needed. 3. The DNS or designee will be responsible for monitoring and auditing three residents per week for one month for following the fall prevention in place and resident response to interventions. 4. The Director of Nursing or designee will monitor and audit three residents per week for one month. The collected data will be included in the fall/incident data reported in the monthly Quality Assurance and Performance Improvement meeting.</td>
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</table>
F 689  Continued From page 18

F641, finding 1.

*Her Morse fall scale assessments for predicting her risk of falls had been done on 6/29/18, 3/19/19, and 6/18/19.

*Those scores indicated she was at a high risk for falling.

Interview and fall log review on 7/22/19 at 4:44 p.m. with licensed practical nurse (LPN) J regarding resident 21's falls revealed:

*The resident had a few recent falls with injuries.

*She had fallen:

-On 5/3/19 by the nurses station and caused an abrasion to her forehead and a hematoma to her right wrist and hand.

--No new intervention was listed.

-On 5/9/19 by the nurses station and caused a bump to her head.

--Physical therapy to evaluate and treat was the intervention.

-On 6/29/19 in her bathroom and caused a bump on her head and a "strain" to her right wrist.

--The intervention was her being sent to the clinic for an x-ray of her wrist.

--Prior to the above falls her last fall had been in 2017.

*Her falls were from her falling asleep when sitting in a chair or on the toilet, and then falling forward.

*She had the behavior of talking to herself most of the day and night, and she did not sleep well at night.

*She frequently dozed off during the day while sitting by the nurses station.

Observations of resident 21 throughout the survey on 7/22/19 from 1:15 p.m. through 7:00 p.m., on 7/23/19 from 7:45 a.m. through 5:00 p.m., and on 7/24/19 from 7:45 a.m. through 5:00 p.m.
Continued From page 19

p.m. revealed:
*She ambulated independently with a four-wheeled walker.
*Her gait has appeared steady.
*When she was not in the dining room eating she spent a majority of her time sitting in a stationary chair by the nurses station.
*While sitting in the chair she would talk loudly to herself most of the time, but at other times she would also fall asleep.

Review of resident 21's 5/6/19 fall incident report and investigation revealed:
*At 7:50 a.m. she had fallen near the nurses station.
*The incident report description was "resident sitting @ RN station. CNA et [and] writes only several feet from resident. Writer saw resident fall out of chair onto hands/wrist and head. Resident stated she had dozed off. Abrasion [with] goose egg to L [left] forehead. Area cleansed & bacitracin applied. Also, tennis ball sized hematoma to R [right] wrist/hand. Sm. [small] bruise also noted to L hand. Resident denies any pain."
*NA(nct applicable) was checked for if the problem was addressed on her care plan.
*Immediate intervention implemented was left blank.
*The fall investigation included:
*The cause of the fall was: "resident had dozed off & fell out of the chair."
*Intervention to prevent future falls was left blank.
*The fall risk analysis included:
*Her "last fall was documented in 2017."
*Risks and interventions were: "res [resident] will at times doze in stationary chair @ RN station. Staff attempts to have resident rest in bed [with] resident generally replying to go 'jump in a creek"
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DIAMOND CARE CENTER**

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<tr>
<th>(X4) ID PREFIX TAG</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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| F 689              | Continued From page 20 and die."
-Describe effectiveness and/or changes to plan of care was: "staff were near resident at time of fall but unable to intercept fall. Resident was able to state that she had fallen asleep in chair & fell. Care plan interventions in place. No new interventions at this time."
*There was no mention of implementing a new or different fall prevention intervention. Review of resident 21's 5/9/19 fall incident report and investigation revealed:
*At 11:55 a.m. she had fallen near the nurses station again.
*The incident report description was: "Writt er was turning corner by RN station et saw resident falling to ground [with] head hitting floor. Resident denies pain. "d [questioned] res if she was sleeping or standing [up] @ time of fall, res unable to say. Noted goose egg to R forehead. No further injuries noted. Resident assisted [up] [with] [three] assist & gaitbelt."
-ProBLEM addressed on care plan was left blank.
-Immediate intervention implemented was listed as "PT [physical therapy] screened & orders rec'd [received]."
*The fall investigation included:
- The cause of the fall was: "yes has been known to sleep in chairs by RN station. Likely fell asleep & slipped from chair."
-Intervention to prevent future falls was: "Nursing asked that PT screen resident d/t [due to] recent falls. On 5/13/19 order rec'd for PT eval & treat for seating/walker evaluation r/t [related to] falls."
--The order for PT was four days after the fall with injury had occurred.
*The fall risk analysis included:
-"Resident's last fall was 5/3/19."
-Risks and interventions were: "Resident has
Continued From page 21

history of falling asleep while sitting up in chairs or on bedside. Resident is known to refuse/argue with staff when staff approach when note dozing off or sleeping in chairs & will refuse to go & lay down. Fall on 5/3/19 & this fall both rt falling asleep in chair."

-Describe effectiveness and/or changes to plan of care was. "Discussed fall with PT & screen was completed. Discussed possibly looking at different walker w/ [with] a seat so if resident would lean forward when dozing could lean into walker since she generally refuses to lay down. PT orders were rec'd on 5/13/19 for seating/walker eval R/T falls. Pt did feel that a walker w/ seat (example: 4WW) would not be safe. Resident did not comply [with] therapy as refused treatments & PT was discontinued."

--There were no further interventions tried or documented for fall prevention when the resident refused PT.

Review of resident 21's 6/29/19 fall incident report and investigation revealed:

"At 10:00 p.m. she had fallen in her bathroom off the toilet."

"The incident report description was: "CNA reports resident on the floor. This RN to residents room - BR [bathroom]- saw resident laying face down on BR floor with head up against door frame and she's on her knees yelling to help her up. Previously had been sleeping in her bed. 3 assist and gait belt to get her on her knees and then to stand up and sit down on toilet. When asked how/why she was on the floor states I was sitting here on the toilet and then I was on the floor, I don't remember. Face and forehead red. Noted bruise and swelling to top of R hand by knuckle. No other injuries noted. When done on toilet, walked back to bed. Able to move all
Continued From page 22

-Problem addressed on care plan was left blank.
-Immediate intervention implemented was left blank.
-"The fall investigation included:
- The cause of the fall was: "Resident had been on toilet & then fell to the floor. Resident was not able to state if she had fallen asleep. She has a history of falling due to this in recent months."
- Intervention to prevent future falls was: "Staff continue to remind her to lie down when note her sleeping on edge of bed or chairs and offer assistance if note resident on toilet but she does take herself to the restroom throughout the day & night."
- The fall risk analysis included:
- Her fall history was: "5/3, 5/9, 6/29 all caused her to fall forward hitting head."
- Risks and interventions were: "Resident falls asleep with majority of [upper] half of body leaning forward. Becomes angry yells at staff when attempt to intervene."
- Describe effectiveness and/or changes to plan of care was: "Will continue to cue; offer, assistance when note resident sleeping or in BR."
- It did not appear there was a change or new intervention implemented for fall prevention.

Review of resident's 21's 7/24/19 care plan related to falls revealed:
* Focus area: "[Name] has limited physical mobility rft. Dementia with history of falls and unsteady on feet at times.
- That had not included her falls being caused by
Continued From page 23

falling asleep and falling off the chair or toilet as indicated above.
*Goal was: "will have no major injury related to fall."
*Interventions included:
  - "Ambulation: Independent with walker."
  - "[Name] does need supervision/set-up help with getting in and out of bed at times."
  - "Ensure night-light always on especially [especially] at HS [bedtime] to provider [provide] dim lighting for visual with ambulating to/from bathroom."
  - "Ensure that [name] is wearing appropriate footwear and utilizing walker when ambulating."
  - "If [name] sitting up on edge of bed or in chair dozing, please arouse her and ask her to lay down to attempt her from falling forward. Recliner was tried in [name] room so that she could lean back while in chair. [Name] refused to sit in recliner."
  - "[Name] may refuse or argue when asked to lie down."
  - "Locomotion: supervision/set-up outside of room where to go at times."
  - "Offer to assist to bed if [name] appears to be sleeping on edge of bed while reading books."
  - "Recliner was tried in room. [Name] refused to sit in recliner."
  - "Transfer: Independent with walker. [Name] agreed to turn call light on when going into restroom to alert staff that she is there so they can assist safely back out of the restroom."
  - A handwritten entry from 7/2/19 of "If note [name] sitting on toilet, intervene to assist to prevent falling in BR [bathroom] or falling asleep on toilet."
  - The above interventions other than the handwritten entry had been implemented prior to the above falls in May and June.
Continued From page 24

Most of the above interventions had been from 2017 and 2018.

Interview and record review on 7/24/19 at 1:52 p.m. with the MDS assessment coordinator nurse regarding resident 21 and her falls revealed:

* She was aware of the resident's recent falls with injury.
* The interdisciplinary team (IDT) reviewed and discussed all residents' falls daily with their meetings.
* At that time they talked about potential interventions to implement for fall prevention if the nurse had not already done so.
* She stated the resident frequently liked to sit in the chairs outside the nurses station.
* Most of the time she would be talking to herself, but she also often fell asleep too.
* She confirmed:
* There was no documentation to support a new intervention having been tried following the resident's 5/3/19 fall.
  -- The resident ended up having a similar fall six days later.
  -- Both of those falls had resulted in injuries.
* The PT evaluate and treat intervention after the 5/6/19 fall was days later on 5/13/19, and the resident had refused to participate.
* No other interventions had been tried after that.
* The 7/2/19 intervention on the resident's care plan following her 6/29/19 fall off the toilet was not a new intervention.
* It duplicated the several other entries on the resident's fall interventions from 2017 and 2018.
* She agreed the goal was to review the potential cause of a resident's fall and review their current interventions to adjust and/or add a new intervention to hopefully prevent another fall.
* She confirmed most of the resident's fall
Continued From page 25
interventions had been in place for months or years prior to her recent falls in May and June 2019.

Interview on 7/24/19 at 2:14 p.m. with licensed practical nurse B regarding residents' falls revealed:
*When a resident fell the charge nurse was responsible for the initial assessment and investigation to attempt to figure out the cause of the fall.
 -Then they should have attempted to put in place a new intervention for preventing future falls.
 *The new intervention should have been documented on the incident and investigation reports, and then put onto the resident's care plan.
 *If the nurse could not identify a new intervention then the interdisciplinary team would assist when they did their final review.
 -The IDT should have then added a new intervention for fall prevention on the care plan.

Interview on 7/24/19 at 2:40 p.m. with the administrator and director of nursing (DON) regarding the above findings for resident 21 revealed:
*They confirmed the documentation had not supported new or changed interventions for the resident's falls.
*They felt they had attempted everything they could to prevent her falls, and they were out of options.
*They agreed anytime a resident fell the IDT was to have investigated to attempt to find out the root cause of the fall.
 -After they knew the cause they could review and/or adjust their fall prevention interventions in hopes of preventing future falls.
<table>
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<th>F 689</th>
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<td>&quot;The above incidents seemed to revolve around the resident falling asleep, and the interventions had not changed related to that. They confirmed her care plan fall prevention interventions had not been revised following her two falls in May 2019. Most of those interventions had been in place for several months or years. If they had not been effective they should have been reviewed and revised. Review of the provider's revised February 2019 Fall Risk and Prevention Guidelines policy revealed: <em>The purpose was &quot;To ensure adequate interventions are in place to decrease, limit and prevent resident falls and ensure resident safety while maintaining their dignity and highest practical level of abilities.&quot;&quot;</em> Once established, all interventions are to be listed on the SNF [skilled nursing facility] care plan...&quot;* The Action Plan Response included: &quot;...Investigations should be thorough, accurate, fact based, be well documented, concise and understandable.&quot; <em>&quot;The DNS [director of nursing service (DON)] must monitor the fall tracker routinely to assure that all falls have been logged and an appropriate intervention are documented on the Care Plan and NAR [nursing assistant registered/CNA] Care Plan for each fall.&quot;</em> <em>&quot;The ED [executive director (administrator)] and/or DNS are responsible for ensuring that IDT is reviewing and monitoring the fall tracker.&quot;</em></td>
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<tr>
<td>F 744</td>
<td>Treatment/Service for Dementia</td>
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<tr>
<td>SS=D</td>
<td>CFR(s): 483.40(b)(3)</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<tr>
<th>(X1) PROVIDER/SUPPLIER/CCLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tr>
<td>435114</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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**NAME OF PROVIDER OR SUPPLIER**

DIAMOND CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

901 N MAIN ST POST OFFICE BOX 300  
BRIDGEWATER, SD  57319

**DATE SURVEY COMPLETED**

07/24/2019

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<td>F 744</td>
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§483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by:

Surveyor: 40771  
Based on observation, interview and record review, the provider failed to ensure one of one sampled resident (1) with dementia had received appropriate and demonstrated effective interventions to support her psychosocial wellbeing. Findings include:

1. Review of resident 1's medical records revealed she:
   * Had a Brief Interview for Mental Status score of three meaning she had severe cognitive impairment.
   * Had diagnosis of dementia, anxiety disorder, and generalized muscle weakness.
   * Required extensive assistance from staff to ambulate with the aid of a walker or for the wheelchair.

Refer to F679

Review of the 11/1/18 facility assessment revealed the average number of residents requiring dementia care was greater than fifty percent.

Interview on 7/24/19 at 10:03 a.m. with he administrator revealed:
* They had a computer training program on dementia through Relias that staff were to have completed by 12/31/18.
* Many of the staff had not completed that training.

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F 744  
1. Resident #1 has been reviewed by Physician and started on a new medication Nussexta one capsule every AM with increasing doses. Resident's behaviors will be monitored for uncontrollable crying, physical aggression and verbal aggression. These target behaviors will be documented in the medication administration record. Care plan will be updated as needed.  
2) Resident care plans will be reviewed/revised as needed. Staff will monitor the residents behaviors through use of a daily flowsheet. Staff education will be provided by the DNS and completion of dementia training.  
3) DNS or her designee will monitor compliance for dementia training weekly and data from flow sheet regarding resident response to interventions. Changes will be made based on resident need and response.
4) The data collected will be reported by the Director of Nursing or designee in the facility's quality assurance and performance improvement meeting quarterly.

**COMPLETION DATE**

9/12/2019
**F 744** Continued From page 28
-That was something they had identified in their quality assurance program meetings.
--There was not a process improvement plan developed for it to be monitored.
*In a follow-up interview at 2:00 p.m. the administrator revealed fifteen of the scheduled CNAs had not completed that training.
-Of the fifteen CNAs, seven had worked the week of 7/14/19 through 7/24/19.
-Those CNAs could have worked with resident 1 during that time.
*The facility had no policy specific to dementia care.

**F 812** Food Procurement, Store/Prepare/Serve-Sanitary
CFR(s): 483.60(l)(1)(2)

§483.60(l) Food safety requirements.
The facility must -

§483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Surveyor: 41088

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**SUMMARY STATEMENT OF DEFICIENCIES**
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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</table>
| F744 | 483.60(l)(1)(2) | Continued From page 28
-That was something they had identified in their quality assurance program meetings.
--There was not a process improvement plan developed for it to be monitored.
*In a follow-up interview at 2:00 p.m. the administrator revealed fifteen of the scheduled CNAs had not completed that training.
-Of the fifteen CNAs, seven had worked the week of 7/14/19 through 7/24/19.
-Those CNAs could have worked with resident 1 during that time.
*The facility had no policy specific to dementia care. |
| F812 | 483.60(l)(1)(2) | Food Procurement, Store/Prepare/Serve-Sanitary |
| | 9/12/2019 | 1. Glove Use and Hand Hygiene will be performed per facility handwashing policy.
2. All Dietary staff will be re-educated to the handwashing policy and procedure including completion of competencies. To be completed by the Dietary Supervisor or designee.
3. Re-education will be completed by 9/20/2319.
3) Handwashing audits, including meal service will be completed by the Dietary Manager or designee three times per week for one month.
4. The data collected will be taken to the QAPI Committee at least quarterly by the Dietary Manager or designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies. |
Based on observation, interview, and policy review, the provider failed to ensure one of one dietary personnel M followed the handwashing and glove use policy after meal service. Findings include:

1. Observation on 7/22/19 at 1:14 p.m. of dietary aide M clearing off dishes after the noon meal revealed he:
   *Was already wearing off gloves.
   *Took dirty dishes off the tables and put them in a tub on a rolling cart.
   *Touched salt and pepper shakers and moved them to the center of table with other items with his same gloved hands.
   *Grappled door knobs to the kitchen area with those gloved hands.
   *After returning the cart to the kitchen he was not observed performing hand hygiene after removing his gloves.

Interview on 7/24/19 at 1:09 p.m. with the certified dietary manager regarding hand hygiene for kitchen staff revealed:
*The dietary aid had been working at the facility for about a year.
*He had been trained on proper hand and glove hygiene practices.
*His training was current, and he should have known the correct procedure for glove use.
*She would have expected the dietary staff to follow proper policy and procedures regarding glove use and hand washing.

Interview on 7/24/19 at 1:56 p.m. with the administrator regarding hand hygiene practices in the kitchen revealed she:
*Had been aware of the above observation of the glove use with the dietary aide.
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| F 812 |        |     | **Continued From page 30**  
*Would expect all staff to follow proper hand hygiene and glove use policy and procedures.*  
*Stated they had been working hard on that issue, as they had been cited in the past for it and would continue to work on it.*  

Review of the provider's January 2019 Glove Use in the Dietary Department policy revealed:  
""'It is the policy of the Dietary Department to wear gloves to protect both patrons and employees from contagious and foodborne illnesses."  
*Employees will:  
-Wash their hands thoroughly before and after wearing or changing gloves.  
-Choose the correct size gloves to fit their hands from the variety of glove sizes that the facility provides.  
-Change disposable gloves between tasks and not wear them continuously. If raw meats, poultry, or seafood is handled with gloves on, employees will not handle ready-to-eat and cooked foods without washing their hands and changing their gloves.  
-Change gloves if they rip or become soiled.  
-Change gloves if they are in continual use for 4 hours, even if performing a single task.  
-Change gloves after sneezing, coughing, or touching their hair and/or face.  
-Not use food contact gloves for nonfood tasks, including cleaning, handling money, etc.  
-Remove disposable gloves by grasping at the cuff and peeling them off inside out.  
-Wear gloves with handling salad bar items, fruits, sandwiches, cooked foods, deli meats, cheeses, breads, and ice.  
-Wear vinyl or synthetic gloves when food is handled near a heat source. Poly gloves are not heat resistant.  
-Wear disposable gloves at all times if they are
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| F 812  |        |     |    |        |     | Continued From page 31
- wearing artificial nails or fingernail polish.
- Find gloves conveniently located in racks and hand sinks and near workstations."
Review of the provider's December 14, 2011 Procedure for Hand Washing policy reveals:
"When to Wash Hands (at a minimum):
- When reporting to work and before going home.
- Before eating and drinking.
- Before and after using the toilet.
- After sneezing, coughing, or blowing your nose.
- After touching your hair, face, etc.
- After smoking cigarettes.
- Before and after each resident contact.
- Whenever hands are obviously soiled.
- After contact with any body fluids.
- After handling any contaminated items (linens, soiled diapers, garbage, etc.).
- After changing gloves."
| F 880  | SS=E   |     |    | F 880  |     | Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f)
§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.
§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:
§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections | 9/12/19 |
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<td>F 880</td>
<td>Continued From page 32 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(a) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.</td>
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<td>F 880</td>
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<td>$483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</td>
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| $483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, and policy review, the provider failed to ensure proper hand hygiene and glove use had been followed during personal care for six of nine randomly observed residents (6, 10, 11, 20, 21, and 27) by six of six certified nursing assistants (CNA) (E, F, G, H, I, and L). Findings include: Surveyor: 41088 1. Observation on 7/22/19 at 2:58 p.m. during resident 8's personal care by CNA's F and G revealed: *CNA G pushed a total mechanical lift into the resident's room and closed the door. *Neither of the CNAs performed hand hygiene after entering the resident's room and prior to putting on gloves. *Both CNAs put on gloves to assist the resident with changing her incontinence brief and assisting her into her wheelchair. *CNA F opened two dresser drawers with her gloved hands, took out a container of powder, proceeded to do peri-care, and put powder on her with the same gloved hand. -She then took off her gloves, used hand sanitizer, and put on new gloves. -The incontinence brief tore while positioning the
Continued From page 34

She then took off her gloves, opened the drawer, and got a clean incontinence brief. They both placed the clean brief on her and continued to dress the resident.
*CNA G removed her gloves and did not perform hand hygiene.
*The resident was assisted into a lift sling and positioned into the wheelchair using the mechanical lift with neither CNA wearing gloves.
*CNAs F and G then put on new gloves without performing hand hygiene.
*CNA G used wipes to sanitize the lift.
*Both CNAs then discarded their gloves and left the room and no hand hygiene was completed before they left the room.

Interview on 7/24/19 at 1:30 p.m. with CNA F revealed:
*She had been aware of missed opportunities to perform hand hygiene while caring for resident 6.
*Acknowledged she had not used proper hand hygiene.
*She stated she had gone through training on the correct use of gloves and hand hygiene.

Surveyor: 35237
2. Observation on 7/22/19 at 3:38 p.m. during resident 27's personal care by CNAs E and F revealed:
*Upon entering the room neither CNA performed hand hygiene.
*They put on gloves and assisted the resident with incontinence care while he was in bed.
*Both CNAs assisted with his perineal (peri) care.
*After CNA E did his perineal peri-care she changed his gloves without performing hand hygiene.
-She then put protective barrier cream on his
Continued From page 35

buttocks and assisted with his dressing.
*After CNA F assisted with peri-care she removed her gloves, looked in his drawer for more supplies, and assisted with his dressing.
-After touching all of those surfaces with potentially contaminated hands she used hand sanitizer.
*CNA E bagged up the garbage and soiled linen and left the room going to the soiled utility room down the hall without performing hand hygiene.
-She had touched the resident’s door handle and soiled utility room door handle with potentially contaminated hands.

3. Observation and interview on 7/22/19 at 4:17 p.m. during resident 20’s personal care with CNAs E and G revealed:
*Neither CNA had performed hand hygiene when entering the resident's room and prior to his care.
*They put on gloves and assisted him to walk with a gait belt and walker to the bathroom.
*CNA E removed his soiled incontinence brief and changed her gloves without performing hand hygiene.
*After she assisted him with his peri-care they removed their gloves and without performing hand hygiene assisted him with his gait belt back to the chair.
*CNA G bagged the garbage and put sanitizer in her left hand prior to leaving his room but did not use it until after she put the garbage in the soiled utility room down the hallway.
-She had touched the resident’s door handle and soiled utility room door handle with her potentially contaminated right hand.
*CNA E used hand sanitizer prior to leaving the room.
*Both CNAs confirmed the above observation was their usual practice.
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<th>F 880 Continued From page 36</th>
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<td>4. Observation and interview on 7/22/19 at 4:52 p.m. during resident 27's transfer with CNAs E and G revealed:</td>
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<td>*Neither CNA had performed hand hygiene when they entered the resident's room and prior to his care.</td>
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<td>*They assisted the resident by placing a sling underneath him and using a total mechanical lift to transfer him from his bed to his wheelchair.</td>
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<td>*After completing the transfer CNA G used sani-cloth wipes to clean the lift, and CNA E used her bare hands to move and adjust his compression stocking around on his bare toes.</td>
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<td>*CNA E then wheeled the resident in his wheelchair to the dining room while CNA G moved the lift into a storage room across the hall.</td>
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<td>*Neither CNA had performed hand hygiene prior to leaving the resident's room.</td>
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<td>5. Observation on 7/23/19 at 9:20 a.m. during resident 21's personal care with CNA H revealed:</td>
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<td>*The CNA had not performed hand hygiene upon entry or prior to putting on gloves to assist the resident.</td>
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<td>*She assisted the resident to walk to the bathroom and removed her soiled incontinent brief.</td>
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<td>*She changed her gloves without performing hand hygiene and assisted the resident with peri-care and applying a new brief.</td>
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<td>-She did complete hand hygiene prior to leaving the room.</td>
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<td>6. Observation on 7/23/19 at 10:03 a.m. during resident 10's personal care with CNAs H and I revealed:</td>
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<td>*They assisted the resident to the bathroom using a stand lift.</td>
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Continued From page 37

*With gloves on CNA H removed his soiled incontinent brief, then touched the lift and drawers of his dresser to get a new brief, and then put that on him.

*With gloves on CNA I performed his peri-care.
- She then removed her gloves and without performing hand hygiene she:
  -- Pulled up his new incontinent brief and pants.
  -- Assisted CNA H to move him back into the chair.

* Following the lift transfer CNA H removed her gloves and without performing hand hygiene she pushed the lift out of the room into the hallway.
- She then came back and assisted him with his blanket.

* Prior to leaving the room CNA H used hand sanitizer and CNA I washed her hands.

Interview following the above observation with CNAs H and I revealed:

* The above had been their usual practice.
* They confirmed they should have performed hand hygiene:
  - Upon entering the room and prior to assisting the resident with personal care.
  - Prior to putting on gloves.
  - After removing gloves.
  - Prior to leaving the resident's room.

Surveyor: 40771
7. Observation on 7/23/19 at 1:49 p.m. of certified nursing assistants (CNAs) I and L helping resident 11 use the restroom revealed:

* No hand hygiene was done prior to putting gloves on to assist the resident to the bathroom.
* After removing her urine soaked brief CNAs assisted her to remove her pants and shoes with those same gloves on.
* Gloves were removed after helping her remove
Continued From page 38

her pants and shoes, but no hand hygiene was done and CNAs touched the wheelchair, closet door, and clothing in the closet.
*CNAs put on new gloves without doing hand hygiene and assisted the resident with peri-care. Removed the gloves and discarded them.
*CNAs assisted the resident into her bed and rearranged the wheelchair in her room and touched several surfaces in the room prior to washing their hands.

Interview with CNAs I and L immediately following the above observations revealed:
*They should have performed hand hygiene prior to and after putting gloves.
*They acknowledged they had not used proper hand hygiene.

Surveyor: 35237
8. Interview on 7/23/19 at 10:20 a.m. with registered nurse (RN) A regarding hand hygiene and glove use revealed:
*All staff should have performed hand hygiene at the appropriate times which included:
-Upon entering a resident's room and prior to assisting with personal care.
-When removing gloves and prior to putting on a new pair of gloves.
-Prior to leaving a resident's room.
*Potentially contaminated hands or gloves should not have touched other surfaces.

Interview on 7/23/19 at 1:48 p.m. with the director of nursing and RN C regarding the above hand hygiene concerns revealed:
*They confirmed hand hygiene and glove use should have been completed according to facility policy.
*Appropriate hand hygiene and glove use was an
F 880  Continued From page 39
essential part of infection control practices.
*Hand hygiene should have been done upon
entering a resident's room, when changing
gloves, and prior to leaving the room.
*Potentially contaminated hands or gloves should
not have touched other surfaces.
Surveyor: 41088
Interview on 7/24/19 at 1:56 p.m. with the
administrator revealed:
*The facility had gone through extensive training
on hand hygiene practices with the employees.
*She would have expected all of the staff to use
proper hand hygiene and sanitary practices along
with following their policy and procedure.
*They planned to continue to work on that issue
with staff as they had been cited for that in the
past.

Surveyor: 35237
Review of the provider's 12/14/11 Procedure for
Hand Washing policy revealed:
*Hand washing should have been done at the
following times:
- Before and after each resident contact.
- After contact with any body fluids.
- After handling any contaminated items (linens,
soiled diapers, garbage, etc.[did not list more
items]).
- After changing gloves.
*Hand sanitizer could have been used at the
following times versus hand washing:
- If there was no visible soil on hands.
- After contact with residents' intact skin.
- After contact with inanimate objects.
- Before entering the resident's room.
- Before exiting the resident's room.
- After changing gloves.

Review of the provider's January 2010 Glove
Techniques policy revealed: "Wear clean non-sterile gloves when touching blood, body fluids, secretions, excretions, other potentially infectious materials, and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change gloves between tasks and procedures on the same resident after contact with material than may contain a high-concentration of microorganisms. Always wash hands after removing gloves. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments."
DIAMOND CARE CENTER

SUMMARY STATEMENT OF DEFICIENCIES
(SUCH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LEG IDENTIFYING INFORMATION)

E 000 Initial Comments

Surveyor: 16385
A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 7/22/19 through 7/24/19. Diamond Care Center was found in compliance.
The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:

**K 000**

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<tr>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
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<td>Surveyor: 40506</td>
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<td>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/23/19. Diamond 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 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K522, K712, and K918 in conjunction with the providers commitment to continued compliance with the fire safety standards.</td>
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**K 522**

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<td>K 522</td>
<td>HVAC - Any Heating Device</td>
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<td>Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also:</td>
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<td>* is chimney or vent connected.</td>
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<td>* takes air for combustion from outside.</td>
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<td>* provides for a combustion system separate from occupation area atmosphere.</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Surveyor: 40506</td>
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<td>Based on testing and interview, the provider failed to maintain combustion (fresh) air in one randomly observed area (boiler room). Findings include:</td>
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<tr>
<td>K 522</td>
<td>9/12/19</td>
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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 residents. Provided, however, that in the above deficiencies, the findings stated above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. By signing below, the above findings and plans of correction are discloseable 14 days following the date these documents are made available to the facility. If deficiencies are found, an approved plan of correction is requisite to continued program participation.

Byron A. Shakespere
Executive Director 8/8/2019
K 522 Continued From page 1
1. Observation at 10:30 a.m. on 7/23/19 of the two commercial propane gas-fired boilers in the boiler room revealed the following:

There was not sufficient dedicated combustion (fresh) air for the operation of the propane gas-fired commercial boilers. Boilers had previously been connected, but the ductwork had rusted away.

Interview with the maintenance supervisor at the time of the observations confirmed those findings.

The deficiency affected one of several requirements for fuel fired devices.

K 712 Fire Drills
SS=D CFR(s): NFPA 101

Fire Drills
Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7
This REQUIREMENT is not met as evidenced by:
Surveyor: 40506
Based on observation, interview, and plan review, the provider failed to ensure staff were familiar with the provider’s fire drill procedures (acknowledging the flashing red light simulating a fire and rescuing the resident from the room).

1) Fire Drills will be performed per facility fire policy & procedure.

2) All staff will be re-educated to the fire policy & procedure by the Executive Director or designee. Re-education will be completed by 9/29/19.

3) Fire Drill Audits will be completed by the Maintenance Director two times a month after a fire drill for 1 month.

The data collected will be taken to the QAPI Committee at least quarterly by the Maintenance Director or designee for discussion and review. At this time, the committee will make the decision for any necessary follow up studies.
**Continued From page 2**

Findings include:

1. Observation at 11:00 a.m. on 7/23/19 revealed the staff member responding to the call light and simulated fire in resident room 105 entered the room in response to a call light, remained in the room, and closed the door immediately without further fire drill response. Maintenance supervisor told a second staff member who arrived ninety seconds later there was a fire drill in resident room 105. The remainder of the fire drill progressed appropriately. The all clear was called approximately eleven minutes after the nurse call and simulated fire scenario were activated.

   Interview with the maintenance supervisor at the time of the observation confirmed those findings.

The deficiency had the potential to affect 100% of the occupants of the smoke compartment.

**Electrical Systems - Essential Electric System CFR(s): NFPA 101**

Electrical Systems - Essential Electric System Maintenance and Testing

The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test
K 918

Continued From page 3

under load conditions include a complete simultaneous cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This REQUIREMENT is not met as evidenced by:

Surveyor: 40506

Based on record review and interview, the provider failed to perform appropriate testing for the emergency generator by not attaining the minimum thirty percent load in the required monthly load testing for seven of the past twelve months. Findings include:

1. Emergency generator maintenance record review for the twelve months prior to the survey on 7/23/19 at 1:45 p.m. revealed the provider did not attain the required thirty percent of the capacity of the generator being used during seven of the previous twelve monthly load run times. Further review revealed the maintenance supervisor was unable to provide documentation of a load bank test performed on the diesel generator.
**K 918**  
Continued From page 4

Interview on 7/23/19 at 3:00 p.m. with the administrator and the maintenance supervisor revealed they had not performed the required annual load bank test. The finding was acknowledged and verified at the exit interview.

The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has the capacity for 34 beds with a census of 31 on the day of survey.

Reference: NFPA Standard: NFPA 110: 8.4
Diamond Care Center
901 N Main St Post Office Box 300
Bridgewater, SD 57319

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 7/22/19 through 7/24/19. Diamond Care Center was found in compliance.

Compliance/Noncompliance Statement

Surveyor: 16385
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 7/22/19 through 7/24/19. Diamond Care Center was found in compliance.