

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

ORIGINAL

PRINTED: 04/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/06/2016
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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F 000	INITIAL COMMENTS Surveyor: 35237 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/4/16 through 4/6/16. Diamond Care Center was found not in compliance with the following requirements: F176 and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/4/16 through 4/6/16. Areas surveyed included nursing services. Diamond Care Center was found not in compliance with the following requirement: F246.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, record review, interview, and policy review, the provider failed to ensure one of one legally blind resident (6) was found competent to self-administer medication during one of one random observation. Findings include: 1. Observation and interview on 4/6/16 at 9:15 a.m. of resident 6 sitting in the dining room eating his breakfast revealed: *A medicine cup filled with unattended medication had been left beside the resident's plate.	F 176	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: 1. Resident 6 will not be self-administering medications at this time. No other resident who does not have an order or successfully completed the self administration assessment will be self-administering their own medication. 2. All staff responsible for medication administration were re-educated to the policy regarding proper medication administration by 4/30/2016. 3. Director of Nursing/Designee will conduct Medication Administration Audit 1 time per week for 3 months. The data collected will be taken to the QAPI Committee at least quarterly by the Director of Nursing/Designee for discussion and review. At this time the committee will make the decision for any necessary follow up studies. 4. Completion Date 4/30/2016.	4/30/16

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

TITLE

(X6) DATE

Kimberly [Signature]

Executive Director

4/27/2016

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.

APR 29 2016

SD DOH L&C

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F 176	<p>Continued From page 1</p> <p>*He was the only resident at the table. *He was unable to see what he was eating for breakfast. *He was unaware there were medications left by his plate.</p> <p>Review of the medical record for resident 6 revealed no physician's order or nursing assessment for self-administration for medication.</p> <p>Interview with the director of nursing immediately following the above observation revealed she agreed: *There was no order for self-administration of medication for the resident. *It was her expectation medication was to be witnessed by the nurse unless there was a physician's order for self-administration.</p> <p>Interview on 4/6/16 at 12:10 p.m. with medication aide E regarding the above observation revealed: *She left the medication on the table unattended for the resident to self administer because a co-worker needed assistance. She had to leave the dining room. *She agreed that was not an appropriate practice of medication administration.</p> <p>Interview on 4/6/16 at 12:20 p.m. with resident 6 regarding staff's usual medication administration practice revealed: *Staff would leave medication at his table for him to self-administer. *When asked how he would have known if he would have taken all his pills or if one would happen to fall out he replied, "I would not be able to see it...good point."</p>	F 176		

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F 176	Continued From page 2 Review of the provider's undated Self Administration Policy revealed: *Residents may administer their own medications if they have been found safe to do so. *An assessment should have been completed by an registered nurse (RN), physician, and pharmacist.	F 176		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and resident's rights review, the provider failed to make an assistive device available upon request to promote the resident's independence and highest well-being for one of one sampled resident (6) who was legally blind. Findings include: 1. Observation on 4/4/16 from 5:50 p.m. through 6:15 p.m. of resident 6 in the dining room revealed he: *Was escorted to the dining room using a walker and a gait belt assisted by one staff member (used by staff for safety when assisting residents). *Was able to see colors but not identify what had	F 246	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: 1. Resident #6 had a care conference with IDT on 4/6/2016. At this time it was decided that PT would eval and measure for an appropriate wheelchair. Wheelchair was ordered and arrived on 4/13/2016. Resident has been using wheelchair at his leisure and continues to ambulate to meals with 1 assist. All residents were reviewed for their need for assistive devices by the IDT team. 2. All staff were re-educated to the guidelines in regards to communicating and providing reasonable accommodation of needs and preferences to the charge nurse to be added to the 24 hour report by Director of Nursing on 4/30/2016. This training will be included with Resident Rights training for all new hire orientation.	

(Cont. ->)

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F 246	<p>Continued From page 3 been served to him. *Waved and called out to a resident he thought was sitting at a table approximately ten feet away. There was no resident there at that time.</p> <p>Review of resident 6's medical record revealed: *He was legally blind. *His most recent history of falls were on 2/13/16, 2/26/13, and 3/9/16. *An Minimum Data Set (MDS) Summary: nursing note dated 3/28/16 revealed: -"He was able to clearly make himself known." -He "is highly visually impaired and has a diagnoses of legally blind." -Therapy was aware of increased weakness and difficulty walking. *An MDS note dated 3/29/16 revealed: -His Brief Interview for Mental Status (BIMS) score (shows mental awareness) was 13 out of 15. -That score showed he was capable of making independent decisions. -Documentation at that time showed he enjoyed sitting by the window, watching the outside, and visiting with others. *A Community Life Progress note dated 3/31/16 revealed he was to have used glasses, a wheelchair, and a walker as assistive devices. *Review of the resident's current care plan at the time of the survey revealed he was to have had a "pressure relieving cushion in wheelchair" to prevent skin breakdown. *Review of the 4/1/16 Nursing Assistant Care Plan revealed staff were to have provided stand-by assistance only to the resident with the use of the walker.</p> <p>Observation and interview on 4/5/16 at 11:30 a.m. with resident 6 in his room revealed he:</p>	F 246	<p>3. Executive Director/Designee will audit IDT Meeting minutes 3 times per week to ensure that when residents make a request for equipment it is being addressed and documented. The data collected will be taken to the QAPI Committee at least quarterly by the Executive Director/Designee for discussion and review. At this time the committee will make the decision for any necessary follow up studies.</p> <p>4. Completion Date 4/30/2016.</p>	4/30/16	

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F 246	<p>Continued From page 4</p> <ul style="list-style-type: none"> *Had no wheelchair in his room for his use with ambulation. *Had used a wheelchair in the past, but it was taken away from him by staff because his daughter had not wanted him to have it. *Stated he was very tall and had previously tipped his walker to one side while ambulating down the hallway. *Was often afraid of falling because of his limited vision and increased weakness. *Often chose to remain in his room, because he was not able to move independently without the assistance of staff. *Was not able to see anything other than vague objects or colors. *He felt using a walker with his limited vision would put him at a higher risk for falls. *Had told staff on many occasions he wanted to use a wheelchair to move independently, but staff would tell him no. *Liked to go to the big window and see the sunshine and felt he was not able to that safely on his own or at his leisure. <p>Interview on 4/5/16 at 2:00 p.m. with certified nursing assistant (CNA) F regarding resident 6 revealed:</p> <ul style="list-style-type: none"> *He was legally blind. *She used a gait belt and a walker to assist him with ambulation to dine or therapy. *He often declined activities due to his blindness. *He was dependent on staff for ambulation due to his blindness. *He had a wheelchair at one time, but his daughter told staff he was not to use one and had removed it from his room. *His daughter told staff it would affect her ability to take him to another town on outings if she was not able to use a walker. She forbade staff from 	F 246			

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F 246	Continued From page 5 allowing the resident to use it at any time. *She agreed staff should not have removed the wheelchair from the resident's use without his permission since he had been capable of making his own decisions independently. *They (staff) had not been advised by the charge nurse or director of nursing (DON) otherwise. Interview on 4/6/15 at 11:00 a.m. with the DON regarding resident 6's choice in using a walker revealed: *The resident's daughter had advised staff not to give the resident a wheelchair to ambulate throughout the facility. *She felt that would limit her ability to assist the resident on outings to other towns if he would become incapable of using a walker. *She agreed the resident's BIMS score indicated he was capable of making independent choices about his life. *She agreed by not allowing him to exercise his right of choice with regard to wheelchair use they failed to accommodate his need of independence and well-being.	F 246			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441			

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F 441	<p>Continued From page 6</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: 33488 Based on observation, interview, manufacturer's guideline review, and policy review, the provider failed to ensure appropriate infection control was followed by ensuring:</p>	F 441	<p>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:</p> <ol style="list-style-type: none"> 1. The whirlpool tub is being disinfected per manufacturer's recommendations. No toilet paper or personal care wipes will be stored on or behind plumbing pipes. Shower room was emptied of non-shower related items on 4/7/2016. The mechanical lifts will be cleaned between each use per policy. Store Room in South Hall was emptied and organized on 4/7/2016 to prevent comingling of linen, food items, and activity items. Two (2) new AC Window Units were installed in the end of 200 hall on 4/28/2016 and cleaning of the Window AC units was added to the monthly TELS preventative maintenance program. 2. All staff responsible for cleaning, care, and operation of the whirlpool tub were re-educated to the policy for disinfecting the whirlpool tub on 4/26/2016 by the Director of Nursing. All staff were re-educated to the Infection Control Policy and Procedure by the Director of Nursing and Executive Director on 4/29/2016. <p>(Cont. →)</p>	

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F 441	<p>Continued From page 7</p> <ul style="list-style-type: none"> *One of one whirlpool tub was disinfected between resident use. *Personal care wipes and toilet paper in all residents' rooms were not stored on or behind plumbing pipes behind the toilets. *One of one shower room was not used to store non-bathing related items. *One of one randomly observed stand-up lift (mechanical device used to assist residents with standing) had been clean and did not have visible dirt and debris on it. *One of one store room in the 200 hall had not co-mingled residents' linen, food items, chemicals, and activity equipment together on shelving units and in cupboards. <p>Findings include:</p> <p>1. Observation on 4/4/16 at 4:25 p.m. of certified nursing assistant (CNA) G in the whirlpool tub room preparing to clean it revealed:</p> <ul style="list-style-type: none"> *She had a laminated photocopy of the Apollo bath cleaning/bath disinfecting process she used for instruction on how to clean and disinfect the whirlpool tub. *On the left side of the page were instructions for a cleaning process only. <ul style="list-style-type: none"> -That process used a cleanser that removed excess dirt and grime. *On the right side of the page were instructions for the disinfection process. <ul style="list-style-type: none"> -That process used a separate disinfectant chemical. *She would use the cleaning process using the cleanser in-between resident use, and the disinfectant process using the disinfectant chemical at the end of each day. *She demonstrated each process. *She was unaware the chemical used to clean the tub was not the same as a disinfectant. 	F 441	<ul style="list-style-type: none"> 3. Director of Nursing/Designee will audit the disinfection of the Whirlpool Tub one time per week for 3 months. The data collected will be taken to the QAPI Committee monthly by the Director of Nursing/Designee for discussion and review. Director of Nursing/Designee will do an audit of Infection Control 1 time per week for 3 months. At this time the committee will make the decision for any necessary follow up studies. 4. Completion Date: 4/29/2016 	4/29/16

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F 441	<p>Continued From page 8</p> <p>*She was the main bath aide, and provided most of the residents' baths.</p> <p>*All but one of thirty-seven residents received whirlpool tub baths.</p> <p>Interview on 4/4/16 at 5:30 p.m. with the administrator regarding the above observation revealed both processes were to have been followed to ensure the tub had been disinfected appropriately.</p> <p>2. Random observations beginning on 4/4/16 from 3:30 p.m. through 4/6/16 at 11:00 a.m. in numerous residents' rooms revealed: *Personal care wipes were being stored on the back of the toilet on top of the exposed metal plumbing pipe by the flush handle. *Extra toilet paper rolls were pushed into the space between the metal plumbing pipe and the wall behind the toilet for storage.</p> <p>Interview with the maintenance supervisor on 4/5/16 at 3:00 p.m. with the maintenance supervisor and again on 4/6/16 at 11:00 a.m. with the director of nursing (DON) regarding the above observations revealed: *They agreed storing personal care wipes and toilet paper on or around the plumbing pipe was not an appropriate infection control measure and would contaminate clean items. *Those items would be exposed to bacteria from the damp metal plumbing pipe. *Shelving was needed in all residents bathrooms for storing personal care items and extra toilet paper rolls.</p> <p>3. Random observations beginning on 4/4/16 from 3:30 p.m. through 4/6/16 at 11:00 a.m. in the 200 hallway shower room revealed:</p>	F 441			

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F 441	<p>Continued From page 9</p> <ul style="list-style-type: none"> *Directly next to the shower stall area was a cloth lazy-boy recliner. *Two bedpans were on top of an isolation cart. *The respiratory care cart that contained one oxygen tank, a suction machine, and sterile supplies was kept in that shower room. *Clean resident care items (disposable undergarments, linens, shower supplies, toothettes (used instead of toothbrush) were uncovered and exposed to the surrounding environment. *One stand-lift with heavily soiled foot pedals with dirt and food-like substances, and one small spot that was stained yellow. <p>Interview on 4/5/16 at 9:45 a.m. with CNA G regarding the above shower room revealed she had given a resident a shower less than one hour before this interview.</p> <p>Interview with the maintenance supervisor on 4/5/16 at 3:00 p.m. with the maintenance supervisor and again on 4/6/16 at 11:00 a.m. with the DON revealed:</p> <ul style="list-style-type: none"> *They had minimal storage capabilities in the facility. *They agreed a shower was not an appropriate storage room. *Appropriate infection control was not maintained by storing the above mentioned items that were not shower related, in the shower room. <p>4. Random observations beginning on 4/4/16 from 3:30 p.m. through 4/6/16 at 11:00 a.m. in the 200 hallway storage room revealed:</p> <ul style="list-style-type: none"> *Residents' linen were kept in a closet co-mingled with staff coats, a toilet brush, and an electronic keyboard. *In another cupboard were residents' activity 	F 441			

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F 441	<p>Continued From page 10</p> <p>books along with a half empty bottle of Karo syrup.</p> <p>*In a third cupboard were seven bottles of Jevity (nutrition supplement given through a tube into the stomach) stored on the floor.</p> <p>Interview with the maintenance supervisor on 4/5/16 at 3:00 p.m. and again on 4/6/16 at 11:00 a.m. along with the DON revealed:</p> <p>*Resident linens were not to be co-mingled with staff clothing, activity, or toilet cleaning equipment.</p> <p>*The Karo syrup should have been discarded and was unsure how long it had been in the cupboard.</p> <p>*The Jevity supplement was no longer in use, as the resident that had used it had been discharged from the facility.</p> <p>*The DON agreed supplements no longer in service should have been stored appropriately in a clean manner off the floor in the kitchen store room.</p> <p>5. Random observations beginning on 4/4/16 from 3:30 p.m. through 4/6/16 at 11:00 a.m. at the far end of the 200 hallway revealed a small dining and activity room with the following:</p> <p>*The small dining room had a white air conditioner with a black mold-like substance in the vents and a large amount of dust and debris.</p> <p>*The activity room had a gray air conditioner with a large amount of dust and debris in the vents.</p> <p>Interview on 4/5/16 at 3:00 p.m. with the maintenance supervisor regarding the above air conditioners revealed:</p> <p>*The air conditioning units were not part of his preventative maintenance program.</p> <p>*They were not cleaned on a routine basis that he was aware of.</p>	F 441			

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

PRINTED: 04/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/06/2016
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		
(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 11</p> <p>*He agreed they needed to be cleaned regularly and become part of his preventative maintenance program.</p> <p>6. The provider had no specific policy on preventative maintenance when requested during the survey.</p> <p>Review of the provider's December 2010 Apollo whirlpool tub manufacturer's guidelines revealed after each bath the provider was to have followed the cleaning process listed, immediately followed by the disinfecting process, to effectively kill bath-borne bacteria, fungi, and viruses.</p> <p>Review of the provider's undated Environmental Rounds policy revealed: *The infection control (IC) nurse (the DON), her designee, charge nurse, and supervisors were to have completed environmental rounds on a regular basis. *Rounds were to have been part of the daily routine and regularly have been performed throughout the facility. *The IC nurse was to have generated reports identifying areas of non-compliance, and a corrective action form was to have been distributed to the supervisors of each area.</p> <p>Review of the provider's January 2010 Infection Control Program policy revealed: *Its purpose was to have developed and revised policies, procedures, and practices that promoted to evidence-based infection control practices. *One surveillance program activity was to perform environmental surveys.</p>	F 441			

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

ORIGINAL

PRINTED: 04/19/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435114	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/05/2016
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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
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/5/16. Diamond Care Center 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kimberly Jones* TITLE *Executive Director* (X6) DATE *4/27/16*

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.

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40597	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2016
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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
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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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 35237 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/4/16 through 4/6/16. Diamond Care Center was found not in compliance with the following requirements: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	<p>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:</p> <ol style="list-style-type: none"> Employee B, D, A, and C have been assigned all required orientation and annual training to be completed by 5/15/2016. All staff were audited by Executive Director and assigned any missing education required to be completed by 5/15/2016. All leadership was re-educated to the requirements of Orientation and Annual education requirements per 44:73:04:05 on 4/29/2016 by Executive Director. Education schedule was reviewed by Executive Director to ensure all Personnel Education topics are covered each calendar year. Executive Director will conduct a required education audit 1 time per week for 3 months. The data collected will be taken to the QAPI Committee at least quarterly by the Executive Director/Designee for discussion and review. At this time the committee will make the decision for any necessary follow up studies. Completion Date: 5/15/2016 	4/15/16

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

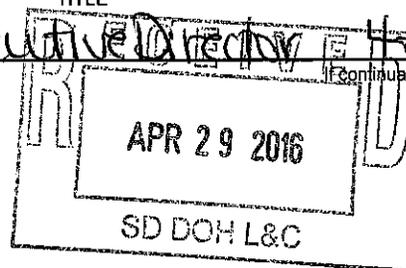
Kimberly George

TITLE

Executive Director

(X6) DATE

4-7-16



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40597	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016
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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
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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) COMPLETE DATE
S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on record review and interview, the provider failed to ensure: *Two of three recently hired sampled employees (B and D) had not received orientation training for 3 of 11 mandated topics (infection control and prevention, proper use of restraints, and care of residents with unique needs). *Two of five sampled employees (A and C) had completed annual training for 5 of 11 mandated topics (infection control and prevention, accident prevention and safety procedures, proper use of restraints, resident rights, and confidentiality of resident information). Findings include:</p> <p>1. Review of employees B and D's personnel files and orientation records revealed: *The employees had been hired on the following dates: -Certified nursing assistant (CNA) B on 1/12/16. -Registered nurse D on 12/9/15. *There had been no documentation of orientation training on infection control and prevention, proper use of restraints, and care of residents with unique needs.</p> <p>Interview on 4/5/16 at 4:00 p.m. with the administrator confirmed the above orientation topics had not been completed for employees B and D. Her expectation was for the training to have been done within one month of their hire date.</p> <p>2. Review of employees A and C's personnel files</p>	S 206		

South Dakota Department of Health

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S 206	<p>Continued From page 2</p> <p>and orientation records for all of 2015 and January 2016 through 4/5/16 revealed: *LPN A had no documentation she had completed annual training on: -Infection control and prevention. -Accident prevention and safety procedures. -Resident rights. -Confidentiality of resident information. *CNA/medication aide C had no documentation she had completed annual training on: -Infection control and prevention. -Accident prevention and safety procedures. -Proper use of restraints. -Resident rights. -Confidentiality of resident information.</p> <p>Interview on 4/5/16 at 4:00 p.m. with administrator regarding annual training revealed: *She was aware not all employees had completed the mandated training topics. *She confirmed the above annual training topics had not been completed for employees A and C in the last year and they should have been. *The provider had no policy on the mandated training topics for all employees. *She expected to have had the state regulation for the annual and orientation training program for all employees to have been followed.</p>	S 206		
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 35237 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 4/4/16 through 4/6/16. Diamond Care Center was found in compliance.</p>	S 000		