STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/3/20 through 2/5/20. Platte Care Center was found not in compliance with the following requirement: F880.	F 000	Initial comments: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by law. For the purpose of any allegation the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilities allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 880 SS=D	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 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(e) 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	F 880	The facility acknowledges that proper infection control practices were not properly followed in accordance to facility policy. Staff education on infection control policy and practices will be held February 25th, 26th, and 27th 2020. Additional electronic learning is being assigned to all staff responisble for wound dressing care. The Director of Nursing will monitor each month, for twelve months, direct observation of each staff who provides wound care. The Director of Nursing will also complete direct observation of Certified Nursing Assistant staff monthly, for twelve months, to assure continued infection control practices. The Director of Nursing will add to quality dashboard and report results to monthly Quality Assurance Performance Improvement, QAPI, and quarterly to QA meetings.	3/16/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 02/20/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369

(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 880	Continued From page 1 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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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: 26632	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 2 Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of three observed certified nursing assistants (CNA) A sanitized all surfaces after personal care for one of three observed residents (12). *One of one observed licensed practical nurse (LPN) (B) followed infection control measures during the dressing change for one of one sampled resident (28). Findings include: 1. Observation on 2/4/20 at 8:57 a.m. of CNA A after she had completed personal care for resident 12 revealed: *She had assisted the resident onto a bedside commode. -Removed her soiled brief and placed it in a small garbage bag. -She then placed that bag on the bathroom counter by the sink. *After she had completed the resident's personal care she used Super-Sani cloths and: -Sanitized the EZ lift, the frame of the commode, and emptied the contents of the commode into the toilet. -Rinsed the commode with water from the sink and emptied the contents in the toilet. *She did not sanitize the toilet seat, faucet, or the counter. *She used the paper towel she had dried her hands with to wipeup the water that had splashed around the sink. 2. Observation on 2/5/20 at 10:50 a.m. of LPN B during dressing changes to resident 28's right elbow wound and bilateral lower legs revealed: *She entered the room, put on a barrier gown, then stepped outside of the room, and got a pair	F 880		

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F 880	Continued From page 3 of gloves. She had not completed any hand hygiene. *She had already removed the bilateral leg dressings prior to this observation and had placed a clean barrier on the resident's bed with the following laying on that barrier: packages of ABD dressings, a roll of kling wrap, a roll of silk tape, a small plastic medication cup that contained ointment, and a can of saline wound cleanser. *She: -Removed the resident's right arm protective skin sleeve and pushed up her shirt sleeve. -Placed a barrier under her right elbow. -Removed the soiled dressing and put it in a small garbage bag that was on the residents bed. *Without changing her gloves: -She cleaned the wound with the saline wound cleanser. -Placed the can of saline wound cleanser back on the clean barrier next to the clean dressing items. -She took the medication cup that had ointment in it and put the ointment on the opened wound area with her finger. -Applied the 4X4 gauze dressing, wrapped Kling around that dressing, and secured it with silk tape. -She placed that roll of tape back on the clean barrier. *Removed her gloves and with no hand hygiene she: -Retrieved gloves from the hall dispenser and two rolls of Kling from the resident's dressing tote on top of the treatment cart. -She placed those rolls of Kling wrap on the clean barrier. -Opened the packages of ABDs and put them on the resident's: –Right heel, right shin, top of her left foot, and left shin using the silk tape.	F 880		

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F 880	Continued From page 4 --Wrapped both legs with Kling and then ACE wraps on both of her legs. She secured both the Kling wrap and ACE wraps with silk tape. *Removed her gloves and with no hand hygiene she placed the can of saline wound cleanser, two packages of ABDs, and the roll of silk tape back in the resident's dressing tote on top of the treatment cart. -That tub contained a pair of scissors and other packages of clean dressings. *Removed her barrier gown and placed it in the regular garbage. *Removed her gloves and washed her hands. *After she dried her hands she used the same paper towel to dry off the counter top around the sink. *She then placed the soiled dressing garbage bag into the treatment cart garbage bin. *She documented the dressing change on the electronic medical record. Review of resident 28's medical record revealed: *On 1/27/20 her primary physician had assessed her right elbow due to increased edema, reddened skin, and pain. *An antibiotic was ordered. *On 2/3/20 her physician lanced the abscess area to her right elbow and took a swab sample for a culture and sensitivity. *On 02/05/20 at 1:36 p.m. it was noted the wound had a positive culture for methicillin resistant staphylococcus aureus (MRSA) to her right elbow. 3. Interview on 2/5/20 at 4:00 p.m. with director of nursing C revealed: *She had done education on infection control within the last month. *LPN B had attended that education.	F 880		

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F 880	Continued From page 5 *Agreed LPN B had missed opportunities for glove changes and hand hygiene. *Agreed CNA A should have sanitized the toilet seat and the countertop. Review of the provider's July 2019 Long Term Care Standard Precautions policy revealed: "Employees shall wash their hands/perform hand hygiene immediately or as soon as feasible after removal of gloves and other personal protective equipment."	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING _____ B. WING _____	02/05/2020

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E 000	Initial Comments Surveyor: 26632 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 2/3/20 through 2/5/20. Platte Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO (X6) DATE: 02/20/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A072	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/04/2020

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PLATTE CARE CENTER	609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/4/20. Platte 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 K712, K916, and K923 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000	Initial comments: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by law. For the purpose of any allegation the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilities allegation of compliance in accordance with section 7305 of the State Operations Manual.	
K 712 SS=D	Fire Drills 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: 18087 Based on observation, interview, and document review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (sounding the alarm and announcing the fire location). Findings include:	K 712	K712 The Director of Plant Operations acknowledges and accepts that Platte Care Center failed the fire drill that was run on 2/4/2020 during the DOH inspection. To improve our process of training and education of fire safety we will be running a monthly drill specific to the LTC area. Drills will be run so that each shift is covered in each quarter. Shift definitions are, 700-1600 day, 1600-2300 evening and 2300-700 night. The Internal Fire and Disaster plan (policy #2) will be assigned to all staff using the Avera education web site. Staff will need to read and acknowledge that they have	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 2/25/2020

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	43A072	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD 57369

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K 712	Continued From page 1 1. Observation at 2:45 p.m. on 2/4/20 revealed the staff member responding to the simulated fire in the therapy room removed the wheelchair occupied person to the corridor, closed the door, and announced the fire condition once over the radio. She then proceeded to close other corridor doors while the wheelchair occupied person remained in the corridor and had not been taken to a place of safety. After going to the nurses station and announcing the condition in person another staff member pulled the manual pull station there and sounded the fire alarm. During the fire drill response, a different staff member arrived and entered the room without a fire extinguisher and without checking the metal door or handle prior to entering the room. Their fire drill procedure was RACE (Rescue, Alarm, Contain, and Extinguish). Interview with the plant operations director at the time of the observation confirmed those findings. Document review revealed the provider was performing the minimum number of required fire drills, one per shift per quarter. Further interview with the plant operations director revealed those fire drills were held simultaneously with the attached hospital and attached clinic. The deficiency had the potential to affect 100% of the occupants of the building.	K 712	completed the assignment by 3/31/2020 This will be a yearly manditory learning assiignment for all staff. Plant Operations Director will be responsible for implementing the drill and ensuring that they are run during the correct shifts and at a random times each month. The Director of Plant Operations will report monthly drills to Saftey Committee (meets monthly) and to QAPI(meets monthly) along with adding this to his Quality Assurance Dashboard(meets quarterly).	3/16/2020
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923	K923 The Director of Plant Operations acknowledges that Platte Care Center failed to store oxygen tanks correctly as found on 2/4/2020 durning DOH survey.	

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K 923	Continued From page 2 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to protect medical gas storage as required in one of one oxygen cylinder storage rooms. Findings include:	K 923	Our remedy for the storage of oxygen tanks in an area with out proper distances of 5 feet to combustible material is that tanks will be stored in the main oxygen room of the basement. This will be the responsibilty of Plant Operations to remove tanks from the closet and to add checking closet for tanks to our weekly logs. this will be reported to Quality Assuance and to QAPI. The Director of Plant Operations will be responsible for the competion of these logs.	3/16/2020

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K 923	Continued From page 3 1. Observation at 1:25 p.m. on 2/4/20 revealed combustible materials were found stored within five feet of oxygen cylinders in the oxygen cylinder storage room. The minimum five feet of separation between combustibles and oxygen storage was not maintained. Wood shelves above the cylinders held combustible items, as well as to the side adjacent to the cylinders. The room also contained two oxygen concentrators which cannot be stored with oxygen cylinders. Interview with the plant operations director and the administrator at the time of the observation confirmed those findings. Ref: 2012 NFPA 99 Section 11.3.2.3 The deficiency affected one of three smoke compartments.	K 923		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	43A072	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**2/4/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLATTE CARE CENTER	**609 EAST 7TH POST OFFICE BOX 200 PLATTE, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 916	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation, interview, and record review, the provider failed to maintain the remote annunciator at one of one location (hospital nurses station). Findings include: 1. Observation at 12:50 p.m. on 2/4/20 revealed the annunciator for the generator was mounted at the hospital nurses station. Interview with the plant operations director at the time of the observation revealed the diesel generator provided emergency power to both the hospital and the nursing home. Record review revealed there was no documentation showing the functions on the annunciator had been tested. Further interview with the plant operations director revealed there was a statement of services provided by the servicing contractor who should have performed that task. Testing of the lamp switch on the annunciator showed the indicator lamps had power to them. This deficiency has the potential to affect 100% of the occupants of the building.

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The above isolated deficiencies pose no actual harm to the residents

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10664	A. BUILDING: _____ B. WING _____	02/05/2020

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PLATTE CARE CENTER	601 E 7TH POST OFFICE BOX 200 PLATTE, SD 57369

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S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/3/20 through 2/5/20. Platte Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/3/20 through 2/5/20. Platte Care Center was found in compliance.	S 000		

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

TITLE: CEO

(X6) DATE: 02/20/2020

STATE FORM 6899 18JO11 If continuation sheet 1 of 1