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
	435043	A. BUILDING _____ B. WING _____	C 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(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: 40788 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 12/28/21 through 12/30/21. Spearfish Canyon Healthcare was found not in compliance with the following requirements: F550, F689, F700 and F880. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 12/28/21 through 12/30/21. Areas surveyed included COVID-19 testing technique, availability of personal protective supplies, and resident care. Spearfish Canyon Healthcare was found in compliance.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550	Corrective Action Resident 23: nurse education provided by Director of Nursing on 1/3/2022 regarding privacy with wound care. Resident 2: Piano was moved to dining room for more accessibility prior to survey exit. Resident 3: Clinical nursing staff education provided by Director of Nursing on 1/3/2022 for privacy or offering insulin administration. Resident 12: resident to be involved in pain management decisions. Resident is now seen by pain management for better direction and management of pain.	1/27/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joshua Kelly | TITLE: Administrator | (X6) DATE: 1/24/2022

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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F 550	Continued From page 2 Findings include: 1. Observation and interview on 12/29/21 at 8:30 a.m. with LPN D performing wound care with resident 23 revealed: *He stood in front of his window with his pants and undergarment lowered to the floor while LPN D performed wound care to his right buttock. -The vertical blinds that covered that window remained open throughout the wound care treatment. -An apartment complex looked down on resident 23's room. *LPN D agreed she should have closed those blinds to ensure the resident's privacy had been maintained during that wound care treatment. Interview on 12/29/21 at 2:30 p.m. with resident 23 regarding the above wound care revealed he: *Had not noticed his blinds had not been shut during that treatment. -Would have preferred his blinds were closed during his wound care treatment. Surveyor: 45095 2. Interview on 12/28/21 at 3:37 p.m. with resident 2 in her room revealed: *She would like to play the piano more often. *Her piano was donated to the facility by her and her family. *She had been unable to play her piano many times due to the residents who were sleeping or watching TV where the piano was located. *She had visited with the facility staff regarding wanting to play her piano more often. *Staff had given her an option to go to the multi purpose room to play a different piano, but that	F 550		

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F 550	Continued From page 4 wheelchairs folded up in front of the piano. --Making the piano not accessible for playing. -There was a bird cage and six residents in wheelchairs in the small room either sleeping or watching TV. -The small room was crowded. *She agreed the location of the piano was not ideal and that the nursing staff may have told the resident it would not work for her to play due to other residents sleeping or watching TV in the bird lounge. Review of resident 2's medical record revealed: *She had been admitted on 6/22/18. *Her 9/14/21 brief interview for mental status (BIMS) score was a 15 meaning her cognition was intact. *Care plan initiated on 7/10/18 and revised on 11/4/19 revealed: -Activities listed for the resident included she played the piano. -Interventions listed were to invite, assist, and encourage the resident to participate in activities. 3. Observation on 12/29/21 at 5:20 p.m. revealed LPN I administered insulin to resident 3 in her abdomen in the 200 hallway at the nurse's medication cart. The resident had not been asked if she wanted to go to a private area for insulin administration. Interview on 12/30/21 at 10:57 a.m. with resident 3 revealed she: *Normally received insulin administered in her room. *Had not received insulin administration in the hallway before. *Was not upset with getting insulin administered	F 550		

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F 550	Continued From page 6 Review of resident 12's medical record revealed: *She had been admitted on 4/19/19. *Her 9/30/21 brief interview of mental status had been a 15, meaning she was cognitively intact. *She had multiple diagnoses that included chronic pain, osteoporosis, diseases of the nervous system and sense organs. *On 12/8/2021 at 4:00 p.m. there had been a nurses' note that read: *"Writer, admin [administrator] and regional nurse met with MD to discuss resident PRN use and the amount of Oxycodone that resident is taking a day." -"Resident is often noted to be resting in bed with her eyes closed and appears to be comfortable and will wake up and ask for pain medication and return to sleeping." -"MD gave orders to change the PRN dosing ...." *A 12/8/21 physician order to change her prn oxycodone 5 milligrams from 2 tablets by mouth as needed for pain twice per day to once per day. -There was no documentation of pain medication reduction having been discussed with resident 12 prior to the reduction of medication on 12/8/21. *A 12/9/21 facsimile from LPN I to resident 12's MD stating: resident 12 had been very upset that the MD had not explained why her pain medications were changed and requested that the MD visit with the resident. *A 12/10/21 physician progress note that read: -"Conference was held with [name of resident 12] today to discuss the teams decision to begin to wean her prn pain meds [medications]." -"The conversation did not last long as she immediately raised her voice yelling at me .....telling me "no" that I will not decrease her meds."	F 550		

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F 550	Continued From page 8 *"Defining Goals and Appropriate Interventions: 1. The pain management interventions shall be consistent with the resident's goals for treatment."	F 550		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, record review, inservice record review, and policy review, the provider failed to ensure: *Two of two sampled residents (45 and 52) had been transferred with a mechanical lift by three of three observed certified nursing assistants (CNA) (M, O, and P) in a manner that had not created potential for a resident accident or injury. *One of two observed mechanical lifts had been maintained in a safe operating condition. Findings include: 1. Observation and interview on 12/28/21 at 9:53 a.m. of CNA M using the Volaro mechanical lift to transfer resident 52 from his wheelchair to the toilet revealed: *The built-in support strap on the shin rest had not been secured behind that resident's shins prior to using that lift. *She had thought it was unnecessary to use those straps with that resident.	F 689	Corrective Action Resident 15's sling was immediately replaced on 12/30/2021 and a new sling was provided. Resident 15's lift was immediately removed from service on 12/30/2021. The Director of Nursing/designee provided education relating to the proper use of shin straps when utilizing a mechanical lift. Facility staffwho provide or are responsible for the above cares and services will be educated/re-educated on procedures related to utilization of built-in-straps to include shin straps on or before 1/27/2022. Identification of others A full facility audit has been completed by the maintenance director/designee of all mechanical lifts, slings, and other DME to ensure equipment is in good working condition. This was conducted on or before 1/27/2022. Any equipment identified as not being in good working condition has been removed from the floor and replaced with equipment in working order.	1/27/2022

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F 689	Continued From page 10 the mechanical lift that was used to transfer him as it "was getting old". Observation and interview on 12/29/21 8:38 a.m. with a staff member [CNA] who asked not to be identified and resident 15 revealed: *There had been a mechanical lift sling hanging on the back of resident 15's room door. -The sling had a tear in the middle section that had been approximately 3 inches long. *The staff member stated: -Each resident had their own mechanical lift sling. -The mechanical lift sling that was used by resident 15 had been ripped for at least three years. --Resident 15 added, "A very long time". *The CNA had told several nurses that it had been ripped. -She had not notified the director of nursing or the administrator. -She thought the nurses would have done that. Continued observation and interview on 12/29/21 at 4:20 p.m. the CNA and resident 15 regarding the use of a mechanical lift revealed: *The clip buckle that attaches to the leg strap to secure the residents legs had one of two clips broken off. -This would have allowed the buckle to come apart. *While transferring the resident with the mechanical lift the CNA: -Stated she used her hand to push upwards on the hydraulic bar of the lift to stabilize the lift as it "wobbles". -Used the emergency controls on the lift to raise and lower the hydraulic bar when transferring the resident. *The control handles of the lift appeared to have	F 689	Monitoring Administrator/designee will conduct random reviews through observation and interviews on staff knowlege and function of strap related to the sling, 3 times per week for one month beginning 1/27/2022. Any issues identifed will be corrected immediately and re-education provided at that time. Monitoring results will be reported by administrator/designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the committee. The Central Supply Coordinator/designee will conduct monthly audits on slings/ harnessess to ensure they are in proper working condition beginning 1/14/2022. Monitoring results will be reported by administrator/designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the committee starting on or before 1/27/2022. The Maintenance Director/designee will conduct monthly audits on all mechanical lifts and document results. Monitoring results will be reported to QAPI committee until facility demonstrates sustatined compliance as determined by the committee.	

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F 689	Continued From page 12 -All staff had access to enter concerns for repairs into this system. *Staff would have also brought concerns regarding lifts to the DON. *Resident 15 had refused to use a different lift. *All slings would have been monitored by housekeeping when they washed the mechanical lift slings. *DON B had not been aware of a tear in resident 15's sling. Review of provider's May 2008 supervision, maintenance services policy revealed: *"1. The day-to-day maintenance operations is under the supervision of the Maintenance Director." *"2. The Maintenance Director is responsible for scheduling preventive maintenance service. 3. Duties and responsibilities of the Maintenance Director are outlined in his/her job description." Review of the provider's Maintenance Supervisor job description revealed: *"Maintenance Duties include" *"Maintain Care and use of supplies, equipment, etc. and maintain the appearance of work areas."	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of	F 700	Corrective Action Resident #14 no longer resides at the facility as of 12/31/2021 Director of Nursing/designee has completed all safety assessments and informed consents on residents 2, 7, 12, 15, 23, 30, 31, 40, 45, 46, 47, 47, 49, and 67 on 12/29/2021.	1/27/2022

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F 700	Continued From page 14 *Residents who had used side rails had them installed on their bed. -Those who did not need them did not have side rails. 2. Observation and interview on 12/28/21 at 9:40 a.m. with resident 12 revealed she had: *Been lying in her bed reading. -Her bed had bilateral side rails on the upper part of the bed that were in the upright position. *Wanted the side rails on her bed to help her turn in bed. *Not received education on the risks or benefits for use of the side rail. *Not signed an informed consent form. 3. Observation on 12/29/21 at 8:52 a.m. of resident 31's bed revealed: *She had not been in her bed. *Her bed had bilateral side rails on the upper part of her bed in the upright position. Interview on 12/30/21 at 9:18 a.m. with resident 31 revealed she had used the side rails to turn while in bed. 4. Observation and interview on 12/28/21 at 4:14 p.m. with resident 14 revealed he had: *Been lying in his bed watching television. -His bed had bilateral side rails on the upper part of the bed that were in the upright position. *Wanted the side rails on his bed to help him turn in bed. 5. Observation on 12/28/21 at 11:07 a.m. of resident 15's room revealed: *He had not been in his room. *His bed had bilateral side rails on the upper part of the bed that were in the upright position.	F 700	Monitoring Director of Nursing/designee will perform audits on all residents identified needing re-positioning bars/bedrails bi-weekly for 2 months, then monthly there after to ensure that risk vs benefit, safety assessment, and informed consent has been completed in a timely manner. Monitoring results will be reported by Director of Nursing/designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the committee starting 1/27/2022.	

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F 700	Continued From page 16 -Had a mat on the floor beside her bed. -Had quarter length bilateral side rails on her bed. *Was unable to state if she was able to functionally use those side rails. 12. Observation and interview on 12/28/21 at 4:05 p.m. of resident 47 in her room revealed she: *Had quarter length bilateral side rails on her bed. -She used them for bed mobility and transfers. 13. Observation and interview on 12/28/21 at 4:10 p.m. of resident 67 in his bed watching television revealed he: *Had a quarter length side rail on the exit side of his bed. -Stated he used it with bed mobility and transfers. 14. Observation and interview on 12/28 4:15 p.m. with resident 45 in her room revealed she: *Had a quarter length side rail on the exit side of her bed. -Stated she used it for bed mobility and transfers. Review of residents' 2, 7, 12, 14, 15, 23, 30, 31, 40, 45, 46, 47, 49, and 67s' records revealed no documentation: *The risks and benefits of side rails had been discussed with the residents or resident representatives. *Informed consent had been received prior to the use of the side rail(s). *What side rail alternatives had been attempted and failed prior to the installation and use of the identified rails. Interview on 12/29/21 at 10:25 a.m. with director of nursing B regarding side rail assessments revealed: *It was the responsibility of the floor nurse to	F 700		

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F 700	Continued From page 18 the resident's size and weight." -"5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol." -"7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. -8. The risks and benefits of side rails will be considered for each resident."	F 700		
F 880 SS=E	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:	F 880	Corrective Action For the identification of lack of: • Appropriate hand hygiene and glove use during personal cares and wound dressing change. • Appropriate procedural technique for rinsing and preparing for nebulizer treatment set-up. • Appropriate application of personal protective equipment (PPE) by staff when entering resident room where gown and gloves should be worn. • Appropriate handling of beverage containers by staff during meal delivery CNA M was educated on glove use including changing when moving from dirty to clean on 1/3/2022 by the Director of Nursing. UAP L was educated on glove use including changing when moving from dirty to clean on 1/3/2022 by the Director of Nursing. LPN D was educated on infection control practices to include hand hygiene and glove use when moving from dirty to clean on 1/3/2022 by the Director of Nursing.	1/27/2022

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F 880	Continued From page 20 Surveyor: 40788 Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were maintained for: *Appropriate glove use by one of one certified nursing assistant (CNA) (M) during toileting assistance for one of one sampled resident (52). *Appropriate glove use by one of one unlicensed assistive personnel (UAP) (L) during nebulizer assistance for one of one sampled resident (34). *Hand hygiene and glove use during wound care by one of one wound care nurse/licensed practical (LPN) (D) and one of one LPN (I) for four of four sampled residents (3, 5, 23 and 30). *Personal protective equipment (PPE) use by one of one dietary aide (J) who had entered one of one sampled resident's (70) room who was on transmission based precautions (TBP). *Beverage handling by one of one observed dietary aide (S) during one of one meal service delivery. Findings include: 1. Observation on 12/28/21 at 9:53 a.m. of CNA M toileting resident 52 in his bathroom revealed: *He had a bowel movement. *CNA M removed his soiled undergarment and wiped the bowel movement off his skin. *Without changing her gloves, she applied a clean undergarment and pulled up his pants. Interview on 12/29/21 at 8:50 a.m. with CNA M regarding the above observation revealed she: *Was expected to change her gloves and perform hand hygiene after she cleaned a resident's skin following toilet use. -Stated she was "nervous" and had not done that.	F 880	Several visual audits were conducted by CDM/designee on proper beverage container handling during beverage delivery These audits were completed on or before 1/27/2022 Several audits have been conducted by the Infection Preventionist/designee on preparing nebulizer set-up and cleaning of nebulizer including rinsing. These audits were completed on or before 1/27/2022. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 2/27/2022 by Administrator/designee. Facility staff will be educated by the DON and/or IP and must return demonstrate proper infection control including handwashing, glove use, PPE donning and doffing through competency requirements. Clinical staff will be educated by the DON and/or IP regarding proper cleaning and care of nebulizer treatment and set-up. Return demonstration must occur through competency requirement.	

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F 880	Continued From page 22 *After performing wound care she washed her hands, turned the faucet off using her wet hands, and dried her hands with a paper towel. Observation and interview on 12/29/21 at 8:30 a.m. of wound care nurse/LPN D performing wound care with resident 23 revealed she: *Performed hand hygiene then gathered her wound care supplies. -Placed extra gloves in the front pocket of her scrub pants. *Removed the soiled gauze from resident 23's skin and without changing her gloves used a clean piece of gauze dampened with cleanser to wipe that same area. *Agreed extra gloves should have been left on a clean barrier inside of the resident's room and not her pant's pocket. *Agreed she should have performed hand hygiene and changed her gloves between handling soiled and clean dressing supplies. *Would "never" have turned the faucet off with her wet hands or used a resident's personal towel to dry her hands. -Thought she had done that because she was "nervous." *Stated she had been in her current position since 12/10/21. -Felt she needed additional training in that role. Review of the Quarter 3, 2018 Infection Control Guidelines for All Nursing Procedures revealed: *4. Hand hygiene is to be performed for the following situations: -"e. Before handling clean or soiled dressings, gauze pads, etc,;" Surveyor: 43844 4. Observation and interview on 12/29/21 at 9:22 a.m. with LPN D performing wound care of	F 880	• The team member that was identified does not typically rinse out nebulizer equipment as it is a task that is performed overnight. The team members routine was thrown off as she would wear gloves when preparing the nebulizer solution. • Facility identified a lack of education regarding donning and doffing PPE for residents on isolation precautions. • New dietary team member who had never passed drinks previously was not properly educated on infection control practices regarding passing of drinks. Administrator and DON had a telephone conversation with Lori Hintz at Great Plains QIN on 1/14/2022, Administrator sent Lori Hintz a copy of the 2567 to review F 880 and discuss the 5 Why's. Continued collaboration with Lori Hintz indicated that the Administrator is aware of the QIO, websites and resources. Facility is currently working with Dee Kaser, Great Plains QIN since 11/23/2021 performing specific auditing in hand hygiene, cleaning of lifts and high touch monitoring. Resources were provided by Lori Hintz with Great Plains QIN to include strategies to improve infection prevention processes, communication tools, GPQIN performance tracking tool as well as other useful resources. Monitoring Administrator, DON, and/or designee will conduct visual auditing weekly over all shifts to ensure identified and assigned tasks are being completed correctly. This will begin on or before 1/27/2022 and will continue for 2 months, and then will be conducted monthly until sustained compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435043	A. BUILDING _____ B. WING _____	C 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(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 24 completing a dressing change on resident 3's hand revealed she had: *Entered resident 3's room without performing hand hygiene or putting on gloves. *Removed resident 3's bloody dressing from her hand. -Blood had dripped from her hand and dressing onto the floor and had formed a quarter sized pool of blood. *Put on a pair of gloves over her now soiled hands. *Picked up a green and white colored pen from the bedside table and had used it to poke a hole in a bottle of sterile saline solution. *Poured the sterile saline solution on a 4x4 gauze dressing, spilling some of the saline solution on the bedside table, and washed blood from resident 3's hand with it. *Used the same 4x4 gauze to wipe the blood off the floor, then disposed of it in the trashcan. *Taken off the soiled gloves and had put on a pair of new gloves without performing hand hygiene. *Taken a sterile dressing and placed it on resident 3's hand. *Thrown the remaining dressings in the trashcan. *Wiped the wet bedside table with facial tissue. *Removed her gloves. *Not performed hand hygiene. *Touched resident 3's hand. *Then washed her hands and left the room. Interview on 12/29/21 at 10:39 a.m. with LPN I revealed she agreed she had not performed proper hand hygiene while completing resident 3's dressing change. 6. Observation on 12/28/21 at 10:09 a.m. of resident 70's room revealed the door had been closed and there was a sign on the door that	F 880		

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F 880	Continued From page 26 *Delivered the drinks to resident 14. *Did not perform hand hygiene. *Pushed the cart down the hallway and into the dining room. Interview on 12/30/21 at approximately 12:15 p.m. with dietary aide S revealed she: *Agreed she had held drinking glasses against her clothing. *Had not been known this would contaminate the drinking glasses. Interview on 12/30/21 at 1:40 p.m. with director of nursing B and infection control nurse/licensed practical nurse G regarding the above infection control observations revealed they: *Agreed hand hygiene, glove use, and PPE practices had not been performed as they would have expected in order to prevent or mitigate the spread of infection. *Educated staff regarding infection prevention and control and performed hand hygiene, glove use, and PPE audits. -That was an ongoing need. Review of the provider's 2018 handwashing/hand hygiene policy revealed: *Policy - "This facility considers hand hygiene the primary means to preen the spread of infections." *"Policy Interpretation and Implementation." -"2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." -"6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious	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 28 together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water...." -"Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves." -"3. When removing gloves..... 5. Perform hand hygiene."	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
	435043	A. BUILDING _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments Surveyor: 18087 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 on 12/30/21. Spearfish Canyon Healthcare was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1/21/2022

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
	435043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	**1020 N 10TH STREET** **SPEARFISH, SD 57783**

(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
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the life safety code (LSC) (2012 existing health care occupancy) was conducted from 12/30/21. Spearfish Canyon Healthcare 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 K222, K281, K522, K712, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 712 SS=C	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 A. Based on observation and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (closing corridor doors and checking the door for the fire location). Findings include:	K 712	Corrective Action Maintenance Director met with facility staff on 1/17/22 to provide education/re-education on proper procedures during a fire/fire-drill including closing corridor doors, checking the door for the fire location, and locations of fire pull stations and extinguishers, and how to identify and announce fire location. Maintenance Director reformatted the fire drill after action report on or before 1/24/2022 to include calling back to the monitoring company with the time they received the notification, and the time of the fire drill in consistent date format. Identification of Others This deficiency had the potential to affect 100% of the occupants.	1/24/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Joshua Kelly | Administrator | 1/24/2022

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	435043	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/30/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	**1020 N 10TH STREET** **SPEARFISH, SD 57783**

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K 918	Continued From page 2 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 under load conditions include a complete simulated 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: 18087 A. Based on record review and interview, the provider failed to perform monthly generator load tests for at least 30 minutes plus cooldown time each month for 7 of 12 months in 2021 (May, June, July, September, October, November, and	K 918	Battery conductivity test was performed on 1/3/2022 and findings were within range. Identification of Others This deficiency affected 100% of the building occupants. Systemic Changes Maintenance Director/designee will ensure that the generator monthly load test lasts for at least 30 minutes plus cooldown by reviewing times indicated on hours meter monthly. Maintenance Director/designee will conduct a monthly battery conductivity test and record findings on monthly generator logs. Monitoring Administrator/designee will review monthly generator load and battery conductivity log, monthly to ensure compliance. Monitoring results will be reported by Maintenance Director/designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee beginning on or before 1/27/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 4 conductivity documentation requirement. The deficiency affected 100% of the building occupants.	K 918		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435043	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 222	Continued From Page 1 initiate a process and release but took 23 seconds to release. Interview at the time of the observation with the administrator and the maintenance supervisor confirmed those conditions. They were unaware the two magnetically locked doors were non-compliant. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected one set of seven exit doors. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)
K 281	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure adequate illumination of means of egress was provided at one of seven exit discharge locations (main entrance). Findings include: 1. Observation on 12/30/21 at 9:30 a.m. revealed the main entrance was also a marked exit. The exit discharge was provided with a single lamp light fixture. Lighting has to be provided so that minimum lighting would still be provided in the event a single lighting source was lost. That lighting also has to be capable of providing one and one-half hours of emergency lighting upon loss of normal power. Interview with the administrator and maintenance supervisor at the time of the above observation confirmed that condition. They were not aware if the exit discharge was in compliance with the minimum lighting requirements. They stated they were part of new management for the provider and did not know if the exit discharge lighting was on backup emergency power. This deficiency has the ability to affect one of seven smoke compartments.
K 522	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials

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
	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

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Administrator 1/21/2022

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	435043	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 918	Continued From page 4 conductivity documentation requirement. The deficiency affected 100% of the building occupants.	K 918		

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:
	435043	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 222	Continued From Page 1 initiate a process and release but took 23 seconds to release. Interview at the time of the observation with the administrator and the maintenance supervisor confirmed those conditions. They were unaware the two magnetically locked doors were non-compliant. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected one set of seven exit doors. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)
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South Dakota Department of Health

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	10686	A. BUILDING: _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPEARFISH CANYON HEALTHCARE	1020 N 10TH STREET SPEARFISH, SD 57783

(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: 40788 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/28/21 through 12/30/21. Spearfish Canyon Healthcare was found not in compliance with the following requirement: S115.	S 000		
S 115	44:73:01:07 Reports Each facility shall fax, email, or mail to the department the pertinent data necessary to comply with the requirements of all applicable administrative rules and statutes. Any incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person shall be reported within 24 hours of becoming informed of the alleged incident or event. The facility shall report each incident or event orally or in writing to the state's attorney of the county in which the facility is located, to the Department of Social Services, or to a law enforcement officer. The facility shall report each incident or event to the department within 24 hours, and conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall report to the department within 24 hours of the event any death resulting from other than natural causes originating on facility property such as accidents. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event.	S 115	Corrective Action Administrator obtained a copy of the updated algorithm on when to report. This was obtained on 12/30/2021. Resident 47's fall was reported to SDDOH on 1/24/2022. Identification of others Administrator conducted a 30-day look back of risk management to verify all residents were reported per updated algorithm. Systemic Changes Administrator/designee provided education to Interdisciplinary team on the need to report all falls that include any of the following; serious bodily injury, extream physical pain, possibility of loss or impairment of a bodily member, mental faculty, or organ, a risk of death, or injury that may require surgery, hospitalization, or rehabilitation, and where medical treatment beyond first aide is required.	1/27/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Joshua Kelly — Administrator — 1/24/2020

JAN 24 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10686	A. BUILDING: _____ B. WING _____	12/30/2021

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S 115	Continued From page 2 onto the platform of a wheelchair van lift as she moved her wheelchair onto that lift. -"I hit my head on the seat of my wheelchair." *A nurse assessment after the fall of that resident revealed no physical injuries. -The resident received as needed pain medication for post-fall headaches. *On 10/29/21 at 7:37 a.m. and 11:17 a.m. she rated her headache pain a 10 out of 10. -Her physician was notified of that information and ordered a computed tomography (CT) of her head related to the head trauma she had received from her fall. Interview on 12/30/21 at 4:00 p.m. with administrator A regarding resident 47's fall revealed he: *Confirmed it had not been reported to the SD-DOH. *Had thought only falls resulting in major injuries such as broken bones or cuts requiring sutures were reported to SD-DOH. -Used a fall reporting algorithm from the SD-DOH website for fall reporting guidance. *Had not known that algorithm had been updated with modified fall reporting guidance. Review of the undated Abuse Investigation and Reporting policy revealed: *Policy: -"All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management."	S 115		