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
	435125	A. BUILDING _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN ROSLYN, SD 57261

(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 6/27/21 through 6/29/21. Strand-Kjorsvig Community Rest Home was found in compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rachel Holler TITLE Administrator (X6) DATE 7/13/2021

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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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 6/27/21 through 6/29/21. Strand-Kjorsvig Community Rest Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rachel Holler TITLE Administrator (X6) DATE 7/13/2021

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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	435125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	**801 S MAIN ROSLYN, SD 57261**

(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: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/28/21. Strand-Kjorsvig Community Rest Home (Building 01) 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 and the Fire Safety Evaluation System (FSES) dated 6/29/21. Please mark an F in the completion date column for K233 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K223 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The preperation of the following plan of correction for this deficiency does not constitute and should not be interpereted as an admission nor an agreement by the facilty of the truth of the facts alleged on conclusions set forth in the statment of deficiencies. The Plan of correction prepared for this deficiency was executed solely because it is requirred by provisions of state and federal law. Without waiving the forgoing statment, the facility state that with respect to.	
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect	K 223	On 6/29/2021 the maintanance director fixed the doors to fully close. The maintenance durectir ir desugnee will audit corridor doors to ensure the doors fully close once per month for 3 months. The maintanance director or designee will present audit findings at monthly QUAPI meetings for review.	6/29/2021

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

Rachel Holler | Administrator | 7/23/2021

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
	435125	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	**801 S MAIN** **ROSLYN, SD 57261**

(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 223	Continued From page 1 smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to ensure doors equipped with a self-closing device in smoke barriers were smoke tight in two randomly observed locations (smoke doors on each side of the dining area). Findings include: 1. Observation on 6/28/21 at 11:00 a.m. during the building tour revealed the north set of cross-corridor doors into the dining area would not fully close. Both doors were held open with magnetic hold open devices. Further observation revealed the doors were too swelled to close together. That gap created by the misalignment would not create a smoke tight seal required for a smoke barrier door. 2. Observation on 6/28/21 at 11:10 a.m. during the building tour revealed the south set of cross-corridor doors into the dining area would not fully close. Both doors were held open with magnetic hold open devices. Further observation revealed the doors were too swelled to close together. That gap created by the misalignment would not create a smoke tight seal required for a smoke barrier door. Interview with the maintenance director and the nursing home administrator at the time of observation confirmed that condition. Both indicated they were unaware that door was not	K 223		

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STRAND-KJORSVIG COMMUNITY REST HOME	**801 S MAIN** **ROSLYN, SD 57261**

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K 223	Continued From page 2 functioning properly. The maintenance director commented that the annual check was done in April, 2021. During the exit interview on 6/28/21 at 3:20 p.m. the administrator noted that fire and smoke doors were not a part of their fire drill checks. These deficiencies have the potential to affect all three smoke compartments.	K 223		
K 233 SS=C	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches in the cross-corridor smoke barriers in two of two locations (east and west corridors). Findings include: 1. Observation on 6/28/21 at 10:25 a.m. revealed the cross-corridor doors in the east and west wing corridors were only 32 inches wide and did not provide a clear opening width of 32 inches. Review of the previous survey report revealed those doors were the original doors. This deficiency may affect all residents and staff	K 233		F

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K 233	Continued From page 3 present during a fire emergency. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 233		

South Dakota Department of Health

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	10673	A. BUILDING: _____ B. WING _____	06/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	801 S MAIN POST OFFICE BOX 195 ROSLYN, SD 57261

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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 6/27/21 through 6/29/21. Strand-Kjorsvig Community Rest Home was found not in compliance with the following requirement: S206.	S 000	The preperation 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 statment of defifiencies. The plan of correction prepared for this deficiency was exectured solely because it is required by provisions of state and federal law. Without waiving the forgoing statment, the facility states that with respect to	
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	A new formal education policy will be written up by the administrator and adopted at Strand-Kjorsvig. CNA A and B will have documented education on all required topics completed by 7/23/2021 this will be the responsibility of the administrator. All other staff file will be reviewed to ensure the staff have complete the required orientation All new staff will have training completed and documented prior to starting thier position. Audits will be conducted by the administrator on new employees, 2x/week for 2 week 1x/ week for 3 weeks 1x/ month for 2 months Administrator will present audit findings at the monthly QUAPI meetings for review.	7/23/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachel Holler — TITLE: Administrator — (X6) DATE: 7/13/2021

South Dakota Department of Health

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to ensure required new employee orientation training had been completed for two of two sampled employees (A and B). Findings include: 1. Review of certified nursing assistant (CNA) A and B's personnel records revealed: *CNA A had been hired on 9/14/20. *CNA B had been hired on 10/3/20. *Neither CNA A or CNA B had completed any of the required orientation topics. *Those subjects include: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Proper use of restraints. -Resident rights. -Confidentiality of resident information. -Incidents and diseases reporting. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation, and mistreatment. -Facility identified needs. Interview on 6/29/21 at 2:30 p.m. with emergency permit holder C and business office manager D revealed: *CNA's A and B had not completed any of the required orientation subjects listed above. *They were aware new employees were required	S 206		

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S 206	Continued From page 2 to complete the orientation training within thirty days of employment. *Did not have a organized orientation program.	S 206		