

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Spearfish Canyon Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10th Street Spearfish, SD 57783	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>43844</p> <p>Based on review of provider's 4/24/24 South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview, and policy review, the provider failed to ensure a thorough investigation was completed for one of one resident (1) who had a burn from hot coffee.</p> <p>1. Review of provider's SD DOH FRI revealed the following:</p> <p>*On 4/24/24 resident 1 had a coffee burn from spilling her hot coffee on her lap at breakfast.</p> <p>*A certified nursing assistant (CNA) [D] alerted licensed practical nurse (LPN) C of the spill.</p> <p>*LPN C assessed the skin and noted redness and two small blisters to the right upper, inner thigh. CNA [D] stated that resident</p> <p>was in dining room for breakfast and resident spilled coffee in own lap.</p> <p>Review of resident 1's electronic medical record revealed the following:</p> <p>*Her Brief Interview of Mental Status score was a five, which meant her cognition was impaired.</p> <p>*A 3/28/24 hot liquid safety evaluation revealed she was not at risk for spilling hot liquids.</p> <p>*A 4/24/24 hot liquid safety evaluation revealed she had cognitive impairment, tremors or abnormal muscle movements of her hands, and altered range of motion or contractures of her fingers.</p> <p>-This evaluation included an intervention that she was to be provided a cup with a lid and to drink hot liquids at a table only.</p> <p>Observation at on 5/1/24 at 12:02 p.m. of resident 1 in the dining room revealed she had a two-handed cup with a lid for her coffee.</p> <p>Interview on 5/1/24 at 3:10 p.m. with director of nursing B regarding resident 1's burn revealed:</p> <p>*Resident 1 was cognitively impaired and was not able to say what happened.</p> <p>(continued on next page)</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Spearfish Canyon Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10th Street Spearfish, SD 57783	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*An unknown CNA [D] observed resident 1 spill her coffee at approximately 8:30 a.m. on 4/24/24.</p> <p>*That CNA [D] took resident 1 to her room and called for a nurse [LPN C], to assist, over the walkie-talkie.</p> <p>*There were no statements from individuals who may have had knowledge of the event.</p> <p>Interview on 5/1/24 at 3:43 p.m. with LPN C regarding resident 1's coffee burn revealed:</p> <p>*She thought CNA D was the CNA who notified her of the event but was not sure.</p> <p>*She went to resident 1's room to assess the resident for the coffee burn.</p> <p>-Resident 1's right abdomen was red and her right inner thigh was red and had a blister on it.</p> <p>-She contacted the resident's physician and received an order for Silvadene for partial thickness burn.</p> <p>Interview on 5/2/24 at 9:22 a.m. with CNA D regarding resident 1's coffee burn revealed:</p> <p>*An unknown therapist had notified her resident 1 had spilled her coffee on herself in the dining room.</p> <p>-She was not able to recall who that therapist was.</p> <p>*After she was notified, she took resident 1 to her room and called for a nurse [LPN C] over the walkie-talkie to assess resident 1.</p> <p>-LPN C had responded to that call.</p> <p>Review of the provider's 3/2018 Abuse and Neglect-Clinical Protocol policy revealed:</p> <p>*The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes.</p> <p>*The physician will provide adequate documentation regarding significant negative outcomes that have resulted from a resident's underlying medical illnesses or conditions, despite appropriate care.</p> <p>Review of the provider's 7/2017 Accidents and Incidents - Investigating and Reporting policy revealed:</p> <p>*All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator.</p> <p>*The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.</p> <p>*The following data, as applicable, shall be included on the Report of Incident/Accident form.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435043	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Spearfish Canyon Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N 10th Street Spearfish, SD 57783	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The circumstances surrounding the accident or incident.</p> <p>-The name(s) of witnesses and their accounts of the accident or incident;</p> <p>-The signature and title of the person completing the report.</p>