

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

ORIGINAL

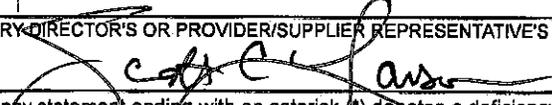
PRINTED: 09/21/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/08/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA OF BERESFORD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>606 W CEDAR BERESFORD, SD 57004</b>
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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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F 000	INITIAL COMMENTS  Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/6/16 through 9/8/16. Bethesda of Beresford was found not in compliance with the following requirements: F323, F441, and F518.	F 000		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation and interview, the provider failed to ensure the safety of the residents by: *The cement pads at three of four outside entrances (100, 200, and 300 wings), were elevated above the sidewalk level. *An uneven walking surface outside on the west side of the facility. Findings include:  1. Observation on 9/6/16 at 5:00 p.m. of the exit doors and sidewalk areas on the south and west side of the facility revealed: *The cement pads outside of wings 100, 200, and 300 exterior exit doors were at a higher level than the attached sidewalk and there were gaps	F 323	During the survey there were safety concerns with uneven walking surfaces outside the facility. Maintenance Manager has arranged for a contractor to raise the uneven cement slabs and fix the cracks that are creating the safety risk. This will be corrected by October 14, 2016.  A new environmental monitoring tour policy and procedure has been created in order to properly identify internal and external safety concerns on an ongoing basis. <b>Administrator will educate staff at the all staff meeting on October 5, 2016.</b> The safety director will organize the team and audits will be done at least quarterly for areas where residents are served and at least annually in areas where residents are not served. Findings will be brought to the Safety Director who will report to the Safety Committee and the Quality Assurance Committee on a quarterly basis for no less than 1 year (4 times).	10/14/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>10/25/16</b>
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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.

OCT 25 2016

SD DOH L&C

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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA OF BERESFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>806 W CEDAR BERESFORD, SD 57004</b>		
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F 323	Continued From page 1 between the exit door cement pads and the attached sidewalk. -The cement pad outside the 100 wing door was 7/8 of an inch taller and had a 1 and a 1/4 inch gap with the next piece of cement. -The cement pad outside the 200 wing door was 1 inch taller and had a 1 and 3/4 inch gap with the next piece of cement. -The cement pad outside the 300 wing door was 1 and 1/2 inch taller with a 1 and 1/4 inch gap with the next piece of cement. The next piece of cement connected to the sidewalk and was also uneven. That piece was 3/4 of an inch taller and had a 1 inch gap with the sidewalk. *The sidewalk on the south and west side of the facility had multiple gaps between cement slabs. -Between the 100 and 200 wing exit doors there was an iron grill over a drainage area that was 1/2 inch taller in height than the sidewalk. -Between 200 and 300 wing exit doors there was a former drainage area that was 1 inch taller than the sidewalk and had a 1 and 1/4 inch gap with the next section. -Between the sidewalk and the gazebo cement pad there was a gap which at the greatest point was 2 inches across.  Observation and interview on 9/8/16 at 2:20 p.m. with the maintenance director revealed he was aware of the uneven cement pads and sidewalk.  A policy regarding uneven walking surfaces was requested of the maintenance director on 9/8/16 at 2:20 p.m. On 9/8/16 at 3:00 p.m. the administrator stated there was none found.	F 323	This new policy and procedure will go into effect on September 23, 2016. Staff will be educated at an all staff meeting on October 5, 2016 about their responsibility to maintain a safe work environment as well as the new Monitoring Tour Policy.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 2</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441	<p>1. Facility Staff Development Coordinator/IP educated all of the housekeeping staff on 09/19/2016 to the requirement of allowing a 10 minute wet/sit time when using the 3M Non-Acid Disinfectant Bathroom Cleaner per the manufacturer's instructions when cleaning resident areas.</p> <p>2. Our facility Infection Preventionist will observe each housekeeper <b>each month X 3 then quarterly for minimum of 1 year</b> as they clean a room and perform competency checks on the procedure used to assure there is a 10 minute wet/sit time allowed before wiping it off when using the 3M Non-Acid Disinfectant Bathroom Cleaner.</p> <p>3. Our facility Infection Preventionist will also provide education to the housekeepers as needed during observation of their room cleaning technique.</p> <p>4. This will occur one time each month for 3 months and then quarterly thereafter. Results of these audits and competencies will be reported monthly <b>X 3 at Quality Assurance meeting by the facility infection Preventionist then quarterly for a minimum 1 year.</b></p>	10/5/16	

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F 441	<p>Continued From page 3 Surveyor: 35121</p> <p>Surveyor: 37545 A. Based on observation, interview, policy, review, and manufacturer's instruction review, the provider failed to follow the correct procedure for disinfection contact time for cleaning resident areas by two of two housekeeping staff (A and B). Findings include:</p> <p>1. Observation and interview on 9/07/16 at 9:36 a.m. of housekeeper A while cleaning a resident's bathroom revealed she: *Sprayed the chemical 3M Non-Acid Disinfectant Bathroom Cleaner on the top of the sink and on the toilet bowl seat. *Let the disinfectant set for five minutes, then wiped the surfaces with a cloth. *That was part of her normal cleaning routine as per her training by the housekeeping supervisor. *Was not aware of the ten minute contact time for proper disinfection.</p> <p>Observation and interview on 9/07/16 at 10:20 a.m. of housekeeper B while cleaning a resident's bathroom revealed she: *Sprayed the chemical 3M Non-Acid Disinfectant Bathroom Cleaner on the top of the sink and on the toilet bowl seat. *Immediately wiped both surfaces with a cloth. *That was part of her normal cleaning routine. *Was not aware of the ten minute contact time for proper disinfection. *Stated "This is how I was trained by the housekeeping supervisor".</p> <p>Interview on 9/8/16 at 1:30 p.m. with the housekeeping supervisor and the environmental services supervisor revealed it was their</p>	F 441	<p>5. The policy and procedure on cleaning rooms and allowing a 10-minute wet time when using the 3M Non-Acid Disinfectant Bathroom Cleaner will also be reviewed by our facility Infection Preventionist at our October 5<sup>th</sup> All Staff meeting.</p> <p>1. The facility's Whirlpool Tub Disinfection policy and procedure was updated and revised on 09/08/2016 by the DON to include the instructions to state "Disinfectant needs to remain wet for 10 minutes"</p> <p>2. A competency check will be completed for each bath aide to assure they demonstrate the proper requirements of allowing the 10-minute wet time while cleaning the whirlpool using the Penner Patient Care Whirlpool Disinfectant Cleaner.</p> <p>3. These competencies will be completed by 09/30/2016 and signed off by the facility Infection Preventionist or DON.</p> <p>4. Results of these competencies will be reported at the October QA committee meeting by the facility Infection Preventionist for any further review and/or recommendations.</p>		

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F 441	<p>Continued From page 4</p> <p>expectation the housekeeping staff would follow the manufacturer's instructions for the contact time on the 3M Non-Acid Disinfectant Bathroom Cleaner.</p> <p>Review of the provider's undated Resident Room Cleaning policy revealed no information regarding the contact time for disinfection when using the 3M Non-Acid Disinfectant Bathroom Cleaner.</p> <p>Review of the manufacturer's instructions for the 3M Non-Acid Disinfectant Spray Cleaner contact time revealed the product must sit for ten minutes to disinfect a surface.</p> <p>B. Based on observation, interview, manufacturer's instructions review, and policy and procedure review, the provider failed to follow manufacturer's instructions for disinfecting one of two whirlpool tubs located in the 100 hall during one of one observed whirlpool cleaning by certified nursing assistant (CNA) H. Findings include:</p> <p>1. Observation on 9/7/16 at 8:40 a.m. with CNA H during disinfecting of the whirlpool tub located in the 100 hall revealed: *She had: -Added approximately one gallon of pre-mixed disinfectant solution to the foot well of the whirlpool tub. -Added water in the foot well until it covered the water intake. -Turned the air jets on. -Sprayed the interior surfaces of the whirlpool tub with pre-mixed disinfectant solution. -Scrubbed the interior surfaces of the whirlpool tub with a brush for less than one minute. *The chair and some of the interior surfaces of</p>	F 441	<p>5. Education and competency checks will also be performed for each new bath aide employed prior to him/her giving their first whirlpool bath.</p> <p>6. The revised policy and procedure for cleaning the whirlpool will be reviewed at the nursing department meeting on 09/29/2016 and also at the facility All Staff Meeting on October 5, 2016 by the facility infection Preventionist.</p>	
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F 441	Continued From page 5 the whirlpool tub had dried at 8:45 a.m. five minutes after being sprayed. *She confirmed those areas were dry.  Interview on 9/07/16 at 8:50 a.m. with CNA H revealed she: *Agreed the disinfecting directions on the container of Penner Patient Care Whirlpool Disinfectant Cleaner revealed to "Wet all surfaces thoroughly. Allow to remain wet for 10 minutes." *Stated she would not have monitored the whirlpool or chair surfaces to ensure they had remained wet for a ten minute contact time. *She had been trained on whirlpool cleaning by another CNA.  Interview on 9/08/16 at 2:30 p.m. with the director of nursing confirmed: *Their Whirlpool Tub Disinfection policy and procedure did not follow the disinfectant manufacturer's instructions. *CNA H did not follow the correct procedure to disinfect the whirlpool tub according to the disinfectant manufacturer's instructions.  Review of the provider's updated 4/11/16 Whirlpool Tub Disinfection policy and procedure revealed to "Let disinfectant stay on surfaces for 10 minutes."  Review of Penner Patient Care Whirlpool Disinfectant Cleaner instructions revealed to "Wet all surfaces thoroughly. Allow to remain wet for 10 minutes."	F 441			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS  The facility must train all employees in emergency	F 518			

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F 518	<p>Continued From page 6</p> <p>procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, the provider failed to ensure three of three employees (C, D, and E) were aware of the code that would be announced to alert staff to a tornado warning. Findings include:</p> <p>1. Interview on 9/7/16 at 12:10 p.m. with certified nursing assistant (CNA) C revealed she had not known what would be announced overhead to alert staff to a tornado warning for the area.</p> <p>Interview on 9/7/16 at 12:15 p.m. with CNA D revealed she had not known what would be announced overhead to alert staff to a tornado warning for the area.</p> <p>Interview on 9/7/16 at 12:20 p.m. with CNA E revealed she had not known what would be announced overhead to alert staff to a tornado warning for the area.</p> <p>Interview on 9/7/16 at 3:05 p.m. with the maintenance director revealed: *Code Gray was announced overhead to identify a tornado warning for the area. *They just had a disaster training review where that had been covered. *He believed the CNAs identified above had attended one of the disaster training review sessions.</p>	F 518	<p>During survey 3 C.N.A.'s (C, D, and E) were not aware what should be announced overhead to alert staff of a tornado. Administrator reviewed Bethesda's disaster manual with all emergency procedures on 9/23/16, which include Emergency Call System, evacuation procedures, blizzards, thunderstorms, tornado, fire, and others. Administrator will review and educate all staff, including the 3 C.N.A.'s (C, D, and E) that were interviewed during survey, on the proper procedures &amp; responsibilities during an emergency at an all staff meeting on October 5, 2016. Administrator will also create cheat sheets to be placed by each phone on how to page over the intercom in case of an emergency. Human Resources will add the review of emergency procedures to the new employee orientation checklist and review with each new employee. Review of these procedures will also be done at least annually at an all staff meeting by Administrator/HR. HR/Maintenance Director will do an audit by interviewing 3 staff members on disaster codes/procedures for the first 3 months and then quarterly for a year. HR/Maintenance will bring audits to QA quarterly for a year.</p>	10/5/16

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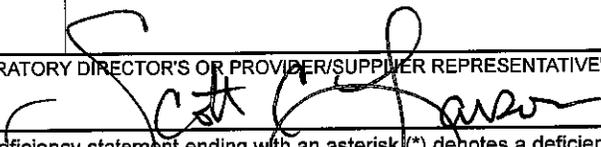
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F 518	Continued From page 7 A policy on training for tornado warnings was requested on 9/7/16 at 3:05 p.m. from the maintenance director but was not received before the end of the survey.	F 518		

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/7/16. Bethesda of Beresford was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>9/27/16</b>
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**SEP 29 2016**  
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South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement  Surveyor: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/6/16 through 9/8/16. Bethesda of Beresford was found not in compliance with the following requirements: S165, S210 and S236.	S 000		
S 165	44:73:02:18 Occupant Protection  Each facility shall be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the residents admitted to the facility.  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 34030 Surveyor #33265 Based on observation and interview, the provider failed to ensure the safety of the residents by: *The cement pads at three of four outside entrances (100, 200, and 300 wings), were elevated above the sidewalk level. *An uneven walking surface outside on the west side of the facility. Findings include:  1. Observation on 9/6/16 at 5:00 p.m. of the exit doors and sidewalk areas on the south and west side of the facility revealed: *The cement pads outside of wings 100, 200, and 300 exterior exit doors were at a higher level than the attached sidewalk and there were gaps between the exit door cement pads and the attached sidewalk.	S 165	During the survey there were safety concerns with uneven walking surfaces outside the facility. Maintenance Manager has arranged for a contractor to raise the uneven cement slabs and fix the cracks that are creating the safety risk. This will be corrected by October 14, 2016.  A new environmental monitoring tour policy and procedure has been created in order to properly identify internal and external safety concerns on an ongoing basis. <b>Administrator will educate staff at the all staff meeting on October 5, 2016.</b> The safety director will organize the team and audits will be done at least quarterly for areas where residents are served and at least annually in areas where residents are not served. Findings will be brought to the Safety Director who will report to the Safety Committee and the Quality Assurance Committee <b>on a quarterly basis for no less than 1 year (4 times).</b>	10/14/16

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

TITLE

*Administrator*

(X6) DATE

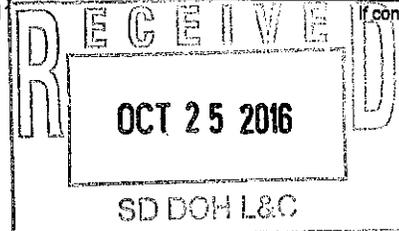
*10/24/16*

STATE FORM

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If continuation sheet 1 of 6



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10595</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/08/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA OF BERESFORD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>606 W CEDAR BERESFORD, SD 57004</b>
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S 165	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-The cement pad outside the 100 wing door was 7/8 of an inch taller and had a 1 and a 1/4 inch gap with the next piece of cement.</li> <li>-The cement pad outside the 200 wing door was 1 inch taller and had a 1 and 3/4 inch gap with the next piece of cement.</li> <li>-The cement pad outside the 300 wing door was 1 and 1/2 inch taller with a 1 and 1/4 inch gap with the next piece of cement. The next piece of cement connected to the sidewalk and was also uneven. That piece was 3/4 of an inch taller and had a 1 inch gap with the sidewalk.</li> <li>*The sidewalk on the south and west side of the facility had multiple gaps between cement slabs.</li> <li>-Between the 100 and 200 wing exit doors there was an iron grill over a drainage area that was 1/2 inch taller in height than the sidewalk.</li> <li>-Between 200 and 300 wing exit doors there was a former drainage area that was 1 inch taller than the sidewalk and had a 1 and 1/4 inch gap with the next section.</li> <li>-Between the sidewalk and the gazebo cement pad there was a gap which at the greatest point was 2 inches across.</li> </ul> <p>Observation and interview on 9/8/16 at 2:20 p.m. with the maintenance director revealed he was aware of the uneven cement pads and sidewalk.</p> <p>A policy regarding uneven walking surfaces was requested of the maintenance director on 9/8/16 at 2:20 p.m. On 9/8/16 at 3:00 p.m. the administrator stated there was none found.</p>	S 165	<p>This new policy and procedure will go into effect on September 23, 2016. Staff will be educated at an all staff meeting on October 5, 2016 about their responsibility to maintain a safe work environment as well as the new Monitoring Tour Policy.</p>	
S 210	<p>44:73:04:06 Employee Health Program</p> <p>The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health</p>	S 210		

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S 210	<p>Continued From page 2</p> <p>professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview, and record review, the provider failed to ensure two of three newly hired employees (F and G) had a health screening completed by a licensed professional before beginning employment. Findings include:</p> <p>1. Review of the dietary cook's (G) employee file revealed: *She had been hired on 5/21/16. *There had been no health care assessment signed by a licensed professional when hired.</p> <p>2. Review of the registered nurse's (F) employee file revealed: *She had been hired on 6/27/16. *There had been no health care assessment signed by a licensed professional when hired.</p> <p>3. Interview and record review on 9/8/16 at 2:55</p>	S 210	<p>Our facility will ensure that all newly hired employees have a health screening completed by a facility licensed professional before beginning employment.</p> <p>1.The facility EMPLOYEE HEALTH ASSESSMENT form has been revised and now includes a statement that a facility licensed professional will sign after she has performed a health screening of the newly hired employee. This signature is stating that the licensed professional feels the employee is free of communicable disease based on the assessment and medical history review that was done.</p> <p>2.The EMPLOYEE HEALTH ASSESSMENT will be arranged and coordinated to be done with the employee by the facility HR/Payroll director and the licensed professional nurse The Employee Health Assessment is to be done prior to or on the first day of employment.</p> <p>3.The licensed professional nurse will complete the form and turn it in to the HR/payroll director when the assessment is complete.</p> <p>4.The facility HR/payroll director will conduct monthly employee file audits to assure this assessment has been completed.</p> <p>5.Results of these audits will be reported at the facility QA meeting <b>monthly X 3 then quarterly by HR director for minimum of 1 year.</b></p>	10/25/16
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S 210	Continued From page 3  p.m. with the director of nursing (DON) regarding the above revealed: *A health assessment form was part of the new employee orientation packet. -There was no space for a signature or statement by the licensed professional who completed the form. *She had not been aware there needed to be a signed health care assessment by a licensed professional.  A policy on health care assessment at the time of hire was requested of the DON on 9/8/16 at 2:55 p.m. None was received before the end of the survey.	S 210	<b>Employees G &amp; F health care assessment was signed and placed in employee file. All other employee records will be audited for proper health care assessment documentation by October 25th, 2016 by the HR/Payroll director</b>	
S 236	44:73:04:12(1) Tuberculin Screening Requirements  Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are	S 236	Employee G was administered 2-step test on 9/29 and read on 10/2/16 and second one was administered on 10/7/16 and completed on 10/10/16. 1. The facility will ensure all newly hired health care worker or residents will receive the two-step method of tuberculin skin or blood assay test to establish baseline within 14 days of employment or admission to a facility. New employees will be audited each month for the first 3 months by the HR director and then quarterly after that for the first year. 2. All current employee files will be audited by our facility HR/payroll director by October 25,2016, to assure all employees do have the required two-step tuberculin skin or blood assay test completed in their file.	10/25/16

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S 236	<p>Continued From page 4</p> <p>not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview, employee files review, and screening requirements review, the provider failed to ensure one of three newly hired employees (G) had completed a two-step tuberculin (TB) skin test during the first two weeks of employment. Findings include:</p> <p>1. Review of dietary cook G's employee record revealed: *She had been hired on 5/21/16. *There were no records of previous TB skin testing in her file. *There had been a TB skin test administered on 5/19/16, but there was no record of the results of the skin test.</p> <p>Interview and review of employee G's file on 9/8/16 at 11:00 a.m. with the human resource/payroll director revealed: *They had requested a copy of her TB skin tests from her previous employer. *They never received a copy, and she had requested them again.</p> <p>Interview with the director of nursing (DON) on 9/8/16 at 11:05 a.m. regarding the TB skin test for employee G revealed she would have to find out if the nurse who administered the TB skin test on</p>	S 236	<p>3. All new employees will receive their first step TB on or before their first day of work in the facility. The facility HR/payroll director will notify the facility infection Preventionist when the newly hired employee will start. The Infection Preventionist will set up a time to meet with the new employee and ensure they receive the first step TB skin test and will then continue to track the completion of the series until done-within 14 days of hire.</p> <p>4. The infection Preventionist will turn in the TB form to the HR/payroll director when the TB series is completed and the form is complete.</p> <p>5. The facility HR/payroll director will continue audits of newly hired employees each month to assure the TB skin testing process was completed and placed in the employee file.</p> <p>6. Results of these audits will be reported by the facility <b>HR/Payroll director</b> at our facility monthly QA meeting for the <b>first quarter then quarterly after that for 1 year.</b></p>	
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S 236	<p>Continued From page 5</p> <p>5/19/16 had documented the results somewhere else.</p> <p>Further interview on 9/8/16 at 1:30 p.m. with the human resource/payroll director revealed the TB skin tests could not be located by the previous employer.</p> <p>Further interview on 9/8/16 at 1:40 p.m. with the DON revealed the TB skin test had not been read.</p> <p>Review of the provider's Tuberculin Screening Requirements dated 1/30/06 revealed each new healthcare worker was to have received the two-step method of TB skin testing within fourteen days of employment.</p>	S 236		
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 33265</p> <p>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 9/6/16 through 9/8/16. Bethesda of Beresford was found in compliance.</p>	S 000		