

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

ORIGINAL

PRINTED: 10/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
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NAME OF PROVIDER OR SUPPLIER BENNETT COUNTY HOSPITAL AND NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551
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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: 30170 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/23/13 through 9/25/13. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: F279, F280, F281, F314, F323, F325, and F505.	F 000	Addendums noted with an asterisk per 10/23/13 telephone to facility COO. SC/SDDOH/MF	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 30170	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Miller</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/18/13</i>
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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 74 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 22 2013

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F 279	<p>Continued From page 1</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (6) who had been readmitted after a major injury from a fall had the appropriate care plan implemented to have reflected her current care needs. Findings include:</p> <p>1. Review of resident 6's complete medical record revealed: *She had been admitted on 11/5/12. *Her readmission date was 9/20/13. *Her current diagnoses were: -Right tibia (lower leg bone) fracture. -Right radial (bone in the lower arm) fracture. -Hypertension. -Diabetes mellitus type 2 (insulin dependent). -Vitamin D deficiency. *She had a full length leg brace on her right leg. *She had a cast to her right lower arm. *She was non-weight bearing to her affected leg. *She had been elevating her casted arm with a pillow.</p> <p>Review of her 11/15/13 care plan revealed: *The care plan had not been updated to address her current care needs. *There was no indication on the care plan that she had been readmitted with her current diagnoses from her fall in August 2013.</p> <p>Interview on 9/24/13 at 4:15 p.m. with the director of nursing regarding resident 6's current care plan revealed: *The care plan should have addressed the current care needs for the resident. *There should have been a temporary care plan implemented twenty-four hours after her admission.</p>	F 279	<p> *SC/SDDOH/MF</p> <p>Resident 6's care plan was updated to address her current diagnosis of right tibia fracture and right radial fracture, by the LPN on duty on 9/25/13 and reviewed by the DON. Current needs, interventions and treatments were identified.</p> <p>The DON or designee will review all new admits and readmissions within the last 30 days to ensure care plans are comprehensive and individualized, with measurable objectives and timetables to meet the residents medical, nursing and mental and psychosocial needs.</p> <p>The DON will provide an in-service for Nursing staff and the interdisciplinary team on 11/5/2013 to review this process.</p> <p>The DON or designee will review this process weekly for all new admits or readmissions to assure care plans are updated, individualized and comprehensive. Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA committee findings.</p>	*11/14/13 SC/SDDOH/MF	

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F 279	Continued From page 2	F 279		
F 280 SS=D	<p>Review of the provider's August 2002 Care Plan policy revealed:</p> <p>*Residents would receive and would have been provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment.</p> <p>*Each resident would have an individualized comprehensive plan of care that would include measurable objective and timetables, directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychological, and educational needs.</p> <p>*A staff person would have been designated to be the care plan coordinator and would have been responsible for coordinating and monitoring the implementation of the care plan.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed</p>	F 280		

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F 280	<p>Continued From page 3 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, record review, and policy review, the provider failed to ensure one of two sampled residents (1) with a current pressure ulcer had a comprehensive care plan that included the resident's current care needs. Findings include:</p> <p>1. Review of resident 1's complete medical record revealed: *She had been admitted on 9/11/08. *She had a history of a pressure ulcer to her heels. *Her diagnoses had included: -Insulin dependent diabetes mellitus. -Hypertension (high blood pressure).</p> <p>On 5/30/13 there had been a wound assessment worksheet completed that had included: -The measurement was 2.5 centimeters (cm) by 0.8 cm. -The writer had questioned whether there was deep tissue injury. -The treatment had included foam boots (did not specify anything else). *There was documentation on 5/31/13 that a pressure ulcer had been noted on her L (left) foot. *There was no further documentation regarding the pressure ulcer in the interdisciplinary notes *There was no further documentation in the medical record regarding the pressure ulcer.</p>	F 280	<p>[REDACTED]</p> <p>* SC/SDDOH/MF</p> <p>Resident 1's physicians order was updated to clarify that resident is to be repositioned or offloaded every 2 hours whether she is in her bed or wheelchair. Resident 1's care plan was updated to reflect this change.</p> <p>The DON will provide an in-service for Nursing staff and the interdisciplinary team on 11/5/2013 to review this process.</p> <p>The DON or designee will review this process at quarterly interdisciplinary team meetings, or when there is a significant change status to ensure appropriate interventions are in place and staff are practicing these interventions and documentating appropriately to reflect the care plan. Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA committee findings.</p>	* 11/14/13 SC/SDDOH/MF	

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F 280	<p>Continued From page 4</p> <p>Review of resident 1's 3/13/13 comprehensive care plan revealed: *The resident had potential/actual impairment to the skin integrity of the heels. *On 5/21/13 she had red heels bilaterally (both). *There were no open areas. *Had a Mepilex dressing on bath days until healed. *The staff were to have monitored and document the location, size, and treatment of the skin injury. *The resident would need foam boots to her feet daily when up and when in bed to protect the skin and heels. Had history of pressure ulcers to her heels. *Treatment documentation was to have been done on the weekly skin assessment sheets (WSAS) and was to have included the measurement of each area of skin breakdown such a width, length, depth, type of tissue, and exudate (drainage), and any other notable changes or observations. *There were no other interventions in place regarding her history of a pressure ulcer on her heel.</p> <p>Review of resident 1's September 2013 physician's orders revealed: *There was an order to reposition every two hours while in bed. *The staff had been signing off every two hours throughout the twenty-four hour period that would have indicated the resident had always been in bed.</p> <p>2. Observation on 9/24/13 from 7:30 a.m. through 3:00 p.m. at random intervals of resident 1 revealed: *She had been lying in bed on her back with the foam boots on both feet.</p>	F 280			

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F 280	<p>Continued From page 5</p> <p>*The majority of the time she had been sitting in her wheelchair.</p> <p>Interview on 9/24/13 at 1:00 p.m. with the Minimum Data Set (MDS) coordinator regarding resident 1 revealed: *She should have been repositioned every two hours because of her history of pressure ulcers. *She had refused a pressure reducing mattress for her bed, but there had been no documentation of that in her medical record.</p> <p>Interview on 9/24/13 at 1:15 p.m. with resident 1 revealed: *Staff were not consistent with checking and changing her brief and with repositioning her. *She was incontinent of bowel and bladder and had worn a brief. *She had wore the foam boots daily.</p> <p>Interview on 9/24/13 at 1:25 p.m. with CNA B regarding the care of resident 1 revealed: *She had not been consistently repositioned every two hours. *There was room for improvement with repositioning consistently.</p> <p>Interview on 9/24/13 at 1:30 p.m. with certified nursing assistant (CNA) C regarding the care of resident 1 revealed: *She would reposition her every two hours. *She would place a rolled up sheepskin under her lower legs that would have kept her heels off the bed. *She would place the boots on daily and only removed them for a short time during the day to inspect her skin.</p> <p>Interview on 9/24/13 at 2:05 p.m. with the director</p>	F 280			

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F 280	<p>Continued From page 6</p> <p>of nursing regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *The care plan had not addressed her repositioning every two hours while in bed. *The staff should have been repositioning the resident every two hours whether she had been in bed or in the wheelchair. *The current care plan was not specific for the direct care staff for repositioning the resident. *The physician's order to reposition every two hours while in bed should have included also when the resident was in her wheelchair. <p>Review of the provider's August 2002 Care Plan policy revealed:</p> <ul style="list-style-type: none"> *Residents would have received and would have been provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. *Each resident would have an individualized comprehensive plan of care that would have included measurable objectives and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. *Through the use of departmental assessments, the Resident Assessment Instrument, and review of the physician's order any problems, needs, and concerns identified would have been addressed. <p>Review of the provider's August 2002 Comprehensive Care Plan policy revealed:</p> <ul style="list-style-type: none"> *Reviews, reassessments, and updates would have included the response to the care and reassessment of the resident's needs, problems, and concerns. *Care plans would have been reviewed at least quarterly and whenever there was any significant 	F 280		

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F 280 F 281 SS=D	Continued From page 7 changes in the residents condition. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on record review, interview, and policy review, the provider failed to ensure an abnormal laboratory (lab) test value had been communicated to the physician for one of nine sampled residents (1) in a timely manner. Findings include: 1. Review of resident 1's complete medical record revealed: *She had been admitted on 9/11/08. *Her diagnoses had included: -Insulin dependent diabetes. -High blood pressure. -Cerebral vascular accident (stroke). Review of resident 1's physician's orders revealed there had been an order for a complete metabolic panel (CMP) every six months. Review of resident 1's lab test values revealed: *On 8/5/13 there had been a CMP completed. *The potassium level was 3.2 Meq/L (Millequivalents per Liter) (normal range was 3.6 Meq/L to 5.2 Meq/L). *The effects of potassium would have included transmission of nerve impulses, contraction of skeletal, smooth, and cardiac (heart) muscle.	F 280 F 281	 Resident 1's lab results were discussed with her provider on 9/25/13, order received to recheck labs on that date. Results were abnormal, provider notified and new orders received and carried out addressing the abnormal lab values. The DON or designee will review all current residents' recent lab values to assure the provider was notified and the abnormal lab values were addressed by the provider. The DON will provide an in-service for Nursing staff and the interdisciplinary team on 11/5/2013 to review this process. The DON or designee will review this process weekly to assure that abnormal lab values are brought to the providers attention and addressed appropriately. Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA committee findings.	*SC/SDDH/MF * 11/14/13 SC/SDDH/MF	

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F 281	Continued From page 8 *Potassium levels might have been decreased secondary to vomiting, diarrhea, diuretic (medication to remove fluid) use, and insulin administration. *There had been a notation on the bottom of the lab report the certified nurse practioner had been notified on 8/29/13. *That notification was twenty-four days after the lab value had been obtained. Interview on 9/25/13 at 11:15 a.m. with the director of nursing regarding abnormal lab values revealed: *She would have expected the nursing staff to have notified the physician of abnormal lab values as soon as possible. *The staff would either call or send a facsimile to the resident's physician when a lab value was abnormal.	F 281		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure one of two sampled residents (1) with a current pressure ulcer had the appropriate interventions in place and had consistent documentation. Findings include:</p> <p>1. Observation on 9/23/13 at 5:30 p.m. of resident 1 revealed: *She was sitting in her wheelchair (w/c) in her room. *There was a pressure reducing device in her w/c. *She had foam boots on both lower feet.</p> <p>Observation on 9/24/13 at 8:00 a.m. of resident 1 revealed: *She was lying in bed on her back. *She had foam boots on both feet. *Her heels were not positioned off the bed.</p> <p>Review of resident 1's interdisciplinary notes indicated a pressure ulcer had been identified to the left heel during a bath on 5/31/13.</p> <p>Review of the 5/29/13 care plan focus areas for resident 1 regarding her skin integrity revealed: *The resident had potential/actual impairment to her skin integrity on her heels. *She had a healing non-stageable deep tissue injury to the left heel. *She had received Mepilex dressing on the bath days. There had been a notation to " See EZ graphs (wound assessment worksheet.)" *"Keep skin clean and dry." *"Monitor/document location, size and treatment</p>	F 314	<p>[REDACTED]</p> <p>Resident 1's care plan was updated to note resident was to be repositioned every 2 hours regardless of whether she was in bed or in her wheelchair.</p> <p>A gel cushion was placed in her Resident 1's wheelchair, and a pressure relieving air mattress was placed on her bed on 9/25/13. She has been getting a dietary supplement of Benpro with each meal since 9/10/13. These were added to her care plan on 9/25/2013 by the DON.</p> <p>The RD will evaluate this resident monthly and make any recommendations to the DM. The DM will forward those recommendations to the DON who will forward to the provider for implementation.</p> <p>The DON or designee will review care plans for all residents with pressure ulcers or who are at risk for pressure ulcers based on their most recent Braden scale. Care plans for residents who are identified to be at risk or who currently have pressure ulcers will have an individualized comprehensive plan of care with measureable objectives and timetables directed toward achieving and maintaining the resident's optimal</p>	<p>* 8/1/14/13 8/1/14/13</p>

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F 314	<p>Continued From page 10 of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc (and so on) to MD (medical doctor)."</p> <p>***The resident needs foam boots to feet daily when up and in bed to protect the skin/heels. Has history of pressure ulcers to heels."</p> <p>***Weekly treatment documentation on the weekly skin assessment sheets to include measurement of each area of skin breakdown such as width, length, depth, type of tissue, and exudate, and any other notable changes or observations. Notify provider and follow recommendations."</p> <p>*There was no other interventions or documentation regarding repositioning every two hours while in bed.</p> <p>Interview on 9/24/13 at 1:15 p.m. with resident 1 revealed: *She would spend most of the day in her w/c, but would lie down at times during the day. *She had worn the foam boots consistently throughout the day. *She felt she had not been consistently repositioned every two hours. *She had been incontinent of bowel and bladder and wore a brief continually. She had required total assistance from staff with changing her incontinent brief. *Sometimes the staff placed a rolled up blanket under her lower legs to keep her heels off the bed.</p> <p>Interview on 9/24/13 at 1:25 p.m. with certified nursing assistant (CNA) B regarding repositioning of resident 1 indicated there was no regular consistency in repositioning. There could have been room for improvement for consistent repositioning.</p>	F 314	<p>medical, nursing, physical, functional, spiritual, emotional psychosocial and educational needs.</p> <p>The wound care nurse will be the only nurse to graph this wound on a weekly basis to limit variability and provide consistency in the graphs and charting. With the weekly wound graphs, documentation including measurement of each area of skin breakdown such as width, length, depth, type of tissue exudates and any other noticeable changes or observations, regarding what type of wound, age of wound, if the resident has been experiencing pain, the status of the wound regarding improvements, changes and deterioration of the wound will be documented.</p> <p>The MDS coordinator will meet with all C.N.A. staff individually to address charting on Activity of Daily Living flow sheets and will address proper charting for the turning and repositioning column. The MDS coordinator will meet with the Nursing Staff individually to educate on accuracy of the Braden Scale ie: comparison of the ADL assist level to their risk level. This education will be done prior to 11/14/13.</p>	

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F 314	Continued From page 11 Interview on 9/24/13 at 1:00 p.m. with the MDS coordinator regarding resident 1 revealed the care plan had no specific instructions for the staff to follow regarding her repositioning. Review of resident 1's Wound Assessment Worksheet from 5/31/13 through 9/19/13 for the left heel indicated there were varying findings: *On 5/31/13 the measurement was 2.5 centimeters (cm) in length and 0.8 cm in width. The writer had indicated a questionable deep tissue injury and had described the wound as denuded (skin pulled away.) *On 8/22/13 there was no measurement recorded; just a drawing. *On 8/26/13 the only measurement recorded was the depth at 0.1 cm. *On 9/3/13 the measurement was 0.5 cm length by 0.5 cm width, and it had been described as unstageable and eschar/slough (black/dead tissue). *On 9/11/13 the measurement was 0.3 cm length by 0.3 cm width, and it had been described as unstageable and had eschar/slough. *On 9/19/13 the measurement was 1.8 cm in length by 2.5 cm in width. The writer had indicated a continued deep tissue injury and eschar/slough. *There was no documentation regarding the following: -What type of wound. -Age of the wound. -If the resident had been experiencing pain. -The status of the wound regarding improvements, changes, and deterioration of the wound. -No treatment goals had been recorded. -There was no indication on the weekly skin	F 314	The DON or designee will review this process monthly to assure that care plans are up to date for all residents with current skin integrity issues as well as those at risk for. Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA committee findings. The DON or designee will review 1 resident per week to assure staff are following care practice compliance and documenting appropriately on residents with current pressure ulcers. Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA committee findings.		

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F 314	<p>Continued From page 12</p> <p>assessment foot illustration of the exact location of the wound.</p> <p>*There were multiple variations in the measurement of the left heel pressure ulcer from 5/31/13 through 9/19/13.</p> <p>*The documentation was not consistent, and there was no follow-up on the progression or deterioration of the left heel wound.</p> <p>Review of resident 1's Braden Risk Assessment scale (assessed skin conditions for risk of skin breakdown) revealed:</p> <p>*On 3/8/13 she had scored a twelve that indicated she was at high risk for developing a pressure ulcer.</p> <p>*On 5/22/13 she had scored fifteen that had placed her at low risk for developing a pressure ulcer.</p> <p>*On 6/27/13 she had scored a fourteen that had placed her at moderate risk for developing a pressure ulcer and indicated she had required minimal assistance.</p> <p>*On 8/26/13 she again had a score of fifteen.</p> <p>Review of resident 1's following Minimum Data Sets (MDS) coding revealed:</p> <p>*On 3/18/13 she needed extensive assistance (assist) for dressing, transfers, and bed mobility (changes in position while in bed). She was at risk for developing pressure ulcers. There was no pressure reducing devices, nutrition interventions, or turning and repositioning checked under skin and ulcer treatments.</p> <p>*On 5/20/13 she needed extensive assist for dressing, transfers, and bed mobility. There was no pressure reducing devices, nutrition interventions, or turning and repositioning checked under skin and ulcer treatments.</p> <p>*On 8/26/13 she was totally dependent on staff</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>assistance for transfers, dressing, and bed mobility. The only treatment checked had been pressure ulcer care.</p> <p>Review of resident 1's Activity of Daily Living flow sheet from April 2013 through September 23, 2013 revealed the turning and repositioning column had inconsistent documentation, and had not always been completed.</p> <p>Review of resident 1's September 2013 treatment record revealed: *On 7/12/11 there had been an order for repositioning every two hours while in bed. *There was consistent documentation every two hours throughout the twenty-four hour period. She had been repositioned every two hours while in bed.</p> <p>Interview on 9/24/13 at 1:30 p.m. with CNA C regarding the repositioning of resident 1 revealed: *She would attempt to reposition her every two hours. *The staff placed a rolled up sheepskin under her lower legs that would have kept her heels off of the bed. *She made sure the foam boots were on daily and would remove them for a short time to inspect her skin.</p> <p>Interview on 9/24/13 at 2:05 p.m. with the director of nursing (DON) regarding resident 1 revealed: *The residents current care plan had not mentioned the repositioning every two hours while in bed. *The staff should have been checking and changing the resident every two hours. The repositioning would have been included when changing her incontinent brief.</p>	F 314			

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F 314	<p>Continued From page 14</p> <p>*The Braden Scale completed on 6/27/13 had not been accurate, because she had required more than minimal assistance for all activities of daily living.</p> <p>*The current order for repositioning her every two hours while in bed was not accurate, because she was in bed twenty-four hours a day.</p> <p>Interview on 9/24/13 at 2:30 p.m. with licensed practical nurse A regarding resident 1 revealed: *She would make sure the CNAs or herself would ensure the resident was repositioned every two hours. *The staff would either have placed a wedge or a roll to have kept her heels off the bed. *She agreed the treatment record indicating to reposition her every two hours while in bed was not accurate, because she was not always in bed.</p> <p>Interview on 9/25/13 at 8:15 a.m. with the DON regarding resident 1 revealed: *The care plan should have been more specific for repositioning. *There should have been other interventions implemented because of her history of pressure ulcers.</p> <p>Review of the provider's 7/25/12 Pressure Sore Skin Assessment and Prevention policy revealed: *The purpose of the policy was to: -Systematically assess residents with regard to risk of skin breakdown. -Accurately document assessments and reassessments of the residents. -To appropriately use prevention techniques and pressure-reducing devices on those residents at risk for pressure sores. *All residents would have been repositioned as noted in their plan of care.</p>	F 314		

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F 314	Continued From page 15 *Any resident at risk would have been placed on a pressure-reducing device. *Documentation would have been placed on the nursing assistants documentation record.	F 314	[REDACTED]	* SC/SDDCH/ME	
F 323 SS=D	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: 29164 Based on observation, interview, and policy review, the provider failed to ensure one of one sampled resident (11) had been assessed to ensure she was safe to smoke without assistance. Findings include: 1. Review of resident 11's care plan revealed: *She was a smoker. *Goals: She would not be injured from unsafe smoking practices and would not smoke without supervision. *Interventions: -She would be instructed about smoking risks and smoking cessation aids that were available. -She would be instructed on the facility policy on smoking regarding locations, times, and safety concerns. -She would have oral hygiene monitored.	F 323	A smoking assessment will be completed on Resident 11, as well as all resident's who smoke by the DON or designee, to ensure they are safe to smoke independently and safely. Smoking assessments will be done on all new admits who smoke, anyone who begins smoking after admit and then on a quarterly basis and with any significant change by the Charge Nurse. Findings will be discussed at team care meetings with interventions put in place as appropriate to the findings. The smoking policy will be updated to reflect this process. The DON will provide an in-service for Nursing staff and the interdisciplinary team on 11/5/13 to review this process. The DON or designee will review all new admits or new smokers to ensure a smoking assessment was completed and the appropriate restrictions, if any, are placed on the person's smoking privileges. Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA committee findings.	* 11/14/13 SC/SDDCH/ME	

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F 323	Continued From page 16 -Instruction to notify the charge nurse if it was suspected she had violated the facility smoking policy. -Instruction to observe clothing and skin for signs of cigarette burns. -Instruction to supervise her while smoking. -Her smoking supplies were to be stored at the nurses station. *The medical record had not included an assessment to determine she could smoke independently and safely. Interview on 9/25/13 at 11:30 a.m. with licensed practical nurse D revealed: *There were eight residents in the facility who smoked. *Residents were given four cigarette breaks per day. *A staff member would accompany the residents when they went outside to smoke. *She was unaware an assessment should have been completed to assess whether a resident was safe to smoke. *She agreed smoking assessments should have been completed on admission, quarterly, or with a significant change. Review of the provider's revised 4/19/04 Smoking Regulations for Employees, Patients, and Visitors Policy revealed "Upon admission, determination will be made by the nursing staff and/or medical provider if the resident/patient is deemed a responsible or non-responsible smoker, and what restrictions, if any, will need to be placed on the person's smoking privileges."	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325			

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F 325	<p>Continued From page 17</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 12218 Based on record review, observation, and interview, the provider failed to ensure one of six sampled residents (4) with weight loss had been properly monitored, assessed, and nutritional interventions had been recommended and implemented. Findings include:</p> <p>1. Review of resident 4's 8/30/13 significant change Minimum Data Set (MDS) revealed the resident had a significant weight loss. Review of the MDS Care Assessment Area (CAA) 8/30/13 summary note by the MDS coordinator revealed the following statements regarding resident 4's weight problem: *"She was noted to weigh 118 pounds (lb) on 8/19(13) and 117 lb on 7/30(13)." *"She weighed 134 lb on 2/26(13) and on her last assessment she weighed 126 lb." *"This was about 14% weight loss in 180 days."</p> <p>Review of resident 4's Vital Signs Record revealed the following weights: *12/04/12: 146.2 lb.</p>	F 325	<p>[REDACTED]</p> <p>Resident 4 was placed on Ensure 2-3 times a day for her weight loss on 10/1/13. Her care plan was updated to reflect this by the DON on 10/1/2013.</p> <p>The DON or designee will review all resident weights for the last 6 months to assure that any 5% gain or loss in 30 days or 10% gain or loss in 180 days is care planned for with appropriate interventions as well as RD and provider notification.</p> <p>The DON will provide an in-service for Nursing staff and the interdisciplinary team on 11/5/13 to review this process.</p> <p>Findings will be reported to the QA committee by the DON monthly for the first quarter and then quarterly per QA committee findings.</p> <p>* Resident 4's weight will be monitored and assessed weekly by the DON until the weight has stabilized. SC/SDDOH/MF</p>	<p>* SC/SDDOH/MF</p> <p>* 11/14/13 SC/SDDOH/MF</p>

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F 325	<p>Continued From page 18</p> <p>*12/28/12: 133.2 lb. *01/29/13: 133.0 lb. *02/26/13: 134.4 lb *03/26/13: 127.8 lb. *04/26/13: 122.1 lb. *05/28/13: 125.1 lb. *06/25/13: 121.2 lb. *07/30/13: 117.0 lb. *08/29/13: 118.0 lb. *09/16/13: 114.0 lb.</p> <p>Resident 4's highest weight of 146.2 lb on 12/04/12 to her lowest weight on 9/16/13 represented a 32.2 lb weight loss or 24.7 percent body weight loss. In the last six and a half months resident 4 had gone from 133.4 lb on 2/26/13 to the latest recorded weight of 114 lb on 9/16/13. Resident 4 had a weight loss of 19.4 lb or a 14.5% body weight loss for that time period.</p> <p>Comparison review of the weight loss over the last 180 days or six month periods starting with the end of January 2013 revealed a continuous weight loss of over 10%. The weight comparisons were as follows: *01/29/13 to 07/30/13: weight was 133.0 lb to 117 lb and that = (equaled) a 16 lb or 12% weight loss. *02/26/13 to 08/28/13: weight was 134.4 lb to 118 lb and that = a 16.4 lb or 12.2% weight loss. *03/13/13 to 09/16/13: weight was 127.9 lb to 114 lb and that = a 13.9 lb or an 11% weight loss.</p> <p>Interview at 2:30 p.m. on 9/24/13 with the certified dietary manager (CDM) regarding resident 4 revealed: *She was not on a dietary supplement. *She had to be assisted at mealtimes. *She was not a good eater and talked a lot at</p>	F 325			

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F 325	<p>Continued From page 19</p> <p>meals.</p> <p>*She was not on any special dietary snacks.</p> <p>*They had not tried any dietary supplement recently to see if she would take it.</p> <p>Review of the consultant registered dietitian's (RD) nutritional assessments for resident 4 revealed:</p> <p>*On 05/03/13 stated: "Intake 58%, sleeps a lot at mealtime at assisted table. Assessment: Weight fluctuations could be from fluid loss/gain. Resident's intake has not changed significantly. Recommendations: Encourage resident to stay awake during meals, assist at meals as necessary, offer resident whatever she desires at meals and snacks."</p> <p>*On 07/11/13: "Intake 50 -75%. noon with the best meal intake. Assessment: Resident with continued weight loss. Recommendations: continue with diet order, offer resident whatever she desires at meals and snacks."</p> <p>*On 09/10/13: "Intake 47%. Assessment: Resident with continued weight loss ... resident talks during meals and does not eat much. Recommendation: Continue with current diet but discourage resident from talking too much during meals. Encourage to eat. Offer resident whatever she desires at meals and snacks."</p> <p>Interview at 6:00 p.m. on 9/24/13 with the RD regarding resident 4 revealed:</p> <p>*He was aware of the weight loss, as he had listed at least the last six months weights on his assessment.</p> <p>*He had not recommended a dietary supplement.</p> <p>*His recommendation was for the staff to encourage the resident to eat, to find out what she liked, and to try to get her to eat more.</p> <p>*He was not opposed to the resident being given</p>	F 325			

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F 505	<p>Continued From page 21</p> <p>-8/5/13 there was a CMP completed.</p> <p>-The potassium level was 3.2 millequivalents per Liter (Meq/L) (normal range was 3.6 Meq/L to 5.2 Meq/L).</p> <p>*The effects of potassium would have included:</p> <ul style="list-style-type: none"> - Transmission of nerve impulses. -Contraction of skeletal, smooth, and cardiac (heart) muscles. <p>*Potassium levels might have been decreased secondary to:</p> <ul style="list-style-type: none"> -Vomiting, diarrhea, diuretic use, and insulin administration. <p>*There had been a notation on the bottom of the lab report the certified nurse practitioner had been notified on 8/29/13 that was twenty-four days after the results had been obtained.</p> <p>Interview on 9/25/13 at 11:15 a.m. with the director of nursing regarding abnormal lab values revealed:</p> <ul style="list-style-type: none"> *She would have expected the nursing staff to have verified the physician of abnormal lab values as soon as possible. *The staff would either call or send a facsimile to the resident's physician when lab values were abnormal. <p>Review of the provider's undated Lab Results Reporting policy revealed the objective was to uniformly and reliably present the results to the providers.</p>	F 505			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A075	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
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NAME OF PROVIDER OR SUPPLIER BENNETT COUNTY HOSPITAL AND NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551
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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 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/25/13. Bennett County Hospital and Nursing Home 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 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 9/26/13 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K062 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 10/24/13 telephone to facility COO. CH/SDDOH/MF	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and document review, the	K 033	*CH/SDDOH/MF *CH/SDDOH/MF	* F CH/SDDOH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John Miller</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/18/13</i>
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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.

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

PRINTED: 09/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A075	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
NAME OF PROVIDER OR SUPPLIER BENNETT COUNTY HOSPITAL AND NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551	
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K 033	Continued From page 1 provider failed to maintain a protected path of egress from the basement to the exterior of the building. The single basement stairway discharged onto the main level and was not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include: 1. Observation at 1:00 p.m. revealed a basement stair enclosure discharged onto the main level corridor system. A continuous one hour enclosure was not provided to the exterior of the building. Review of the previous life safety code survey conducted on 7/10/12 confirmed that finding.	K 033		
K 062 SS=D	The building meets the FSES. Please mark an "F" in the completion date column. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system maintenance was performed as required. Record review of the August 2013 fire sprinkler system annual inspection report revealed documentation was not available for the following and was cited on the report: dry system piping pitch inspection, wet system internal inspection, wet and dry gauge replacements, testing/replacement of dry system heads over 10	K 062	 Maintenance Supervisor will arrange for dry system piping pitch inspection, wet system internal inspection, wet and dry gauge inspection, and testing/replacement of dry system heads over 10 yrs old and frequent air compressor run times through qualified contractors. Maintenance Supervisor will provide documentation of findings/recommendations to Chief Operations Officer and arrangements for all necessary repairs/parts replacements will be made. Maintenance Supervisor will check for compliance with this Life Safety Code Standard monthly for the first quarter and then quarterly per QA committee findings.	<i>11/14/13</i> <i>04/30/2014/ME</i>

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NAME OF PROVIDER OR SUPPLIER BENNETT COUNTY HOSPITAL AND NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN POST OFFICE BOX 70 MARTIN, SD 57551	
(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 062	Continued From page 2 years old, and frequent air compressor run times. Findings include: 1. Record review of the provider's automatic sprinkler system August 2013 annual inspection report indicated the following: a. The dry fire sprinkler system had been installed in 1990 and had not been checked for piping pitch since that time. b. The wet fire sprinkler system had been installed in 1989 and had not had an internal obstruction inspection done since that time. c. The wet water gauge had been dated 1982, and the dry water gauge and air gauge had been dated 2005 and were due for replacement. d. Testing and/or replacement of dry sprinklers older than 10 years was required and had not been done. e. The dry system air compressor had run frequently; for example five times within 30 minutes frequently indicating potential leakage in the piping. f. Interview at 3:00 p.m. on 9/25/13 with the supervisor of housekeeping and laundry confirmed those conditions.	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069		

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K 069	<p>Continued From page 3 Surveyor: 18087 Based on observation, record review, and staff interview, it was determined the provider failed to maintain the baffle type grease filters in the stove exhaust hood in accordance with NFPA 96. One of the filters was damaged. Findings include:</p> <p>1. Observation at 1:30 p.m. on 9/25/13 revealed the kitchen stove exhaust hood had one damaged baffle type grease filter in the overhead exhaust duct. The resulting one-inch gap between filters would allow grease to pass through into the exhaust duct. Review of the hood inspection report dated January 31, 2013 revealed the damaged filter had been noted on the report. Interview with the dietary manager at 1:45 p.m. confirmed that finding.</p>	K 069	<p><i>KCH/SDOH/ME</i> [REDACTED]</p> <p>Maintenance Supervisor removed, had repaired, and then replaced the damaged baffle type grease filter in the stove exhaust hood in accordance with NFPA 96 on 10/10/2013.</p> <p>Maintenance Supervisor will check all filters in the stove exhaust monthly to ensure that they remain in good working order and will report findings monthly to the QA Committee for the first quarter then quarterly per the QA Committee.</p>	<p><i>*/11/14/13 CH/SDOH/ME</i></p>

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
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NAME OF PROVIDER OR SUPPLIER BENNETT COUNTY HOSPITAL AND NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN, PO BOX 70 MARTIN, SD 57551
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S 000

Initial Comments

S 000

* Addendums noted with an asterisk per 10/23/13 telephone to facility COO. SC/SDDH/MF

Surveyor: 30170
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/23/13 through 9/25/13. Bennett County Hospital and Nursing Home was found not in compliance with the following requirement: S296

S 296

44:04:07.07 Director of dietetic services

S 296

A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved the Dietary Managers Association, must enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Dietary Managers Association, or successfully completed equivalent training as determined by the Health Department. The dietetic manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each...resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian must approve all menus, assess the nutritional status of...residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the...residents must be on duty daily over a

*SC/SDDH/MF

11/4/2013
Facility has registered Cook E and one other Cook to take the ServSafe Course November 21st at a location in Rapid City. (This was the first available date for the course in our area).

DM will check this indicator monthly to ensure that there is at least one additional cook on staff that is ServSafe Certified. DM will notify the Chief Operations Officer whenever a ServSafe Certified cook leaves employment so that another qualified employee may be identified and trained for certification. DM will report findings/status to the QA committee monthly for the first quarter and then quarterly per the QA committee's recommendations.

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

John Miller

TITLE

Administrator

RECEIVED 10/18/13

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10646	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/25/2013
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S 296	Continued From Page 1 period of 12 or more hours in nursing facilities... This Rule is not met as evidenced by: Surveyor: 12218 Based on record review and interview, the provider failed to ensure at least one of the four cooks (D) had completed the ServSafe class, had passed the national examination, and had received an official ServSafe certificate. Findings include: 1. Review of the ServSafe certificates displayed on the wall in the dietary manager's office revealed there was only one certificate and not at least two certificates as required. Interview at 4:00 p.m. on 9/23/13 with the certified dietary manager (CDM) revealed: *She had a ServSafe certificate. *She was the only one who had a ServSafe certificate. *Previously they had as many as five dietary employees' certificates displayed on the wall. *The others were no longer employed at the nursing home. *She stated the administrator would not send a new cook through the ServSafe class until they had been employed for six months. Interview at 12:45 p.m. on 9/25/13 with the administrator revealed she was aware they only had one dietary employee with the ServSafe certificate. She stated cook E had been employed almost six months. She would send him through the class.	S 296		