

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

ORIGINAL

PRINTED: 03/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2014
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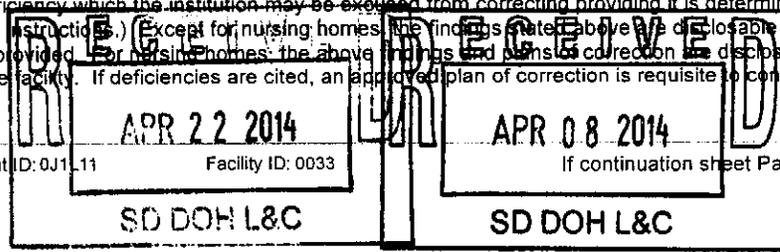
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401
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F 000	INITIAL COMMENTS Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/11/14 through 3/12/14. ManorCare Health Services was found not in compliance with the following requirements: F280, F309, F371, and F468.	F 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following Plan of Correction. The following Plan of Correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review and interview, the	F 280	1. Residents # 2,4,6,9,11 and 12 careplans were reviewed and revised to identify non-pharmacological interventions for pain. Resident #3 has discharged. 2. Reviewed/revised all like resident careplans to identify non-pharmacological interventions for pain.	4/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Francis Mastel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>04/07/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be exempt 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 for correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 280	<p>Continued From page 1</p> <p>provider failed to revise and review care plans related to identifying non-pharmacological (alternative methods used without medication) interventions and diversional activities for 7 of 14 sampled residents (2, 3, 4, 6, 9, 11, and 12) with pain. Findings include:</p> <p>1. Review of resident 2's 2/7/14 admission Minimum Data Set (MDS) (document containing health information pertinent to the resident) section J (pain information) revealed: *She had received pain medications within the past five days. *The provider had implemented non-pharmacological interventions.</p> <p>Review of resident 2's current care plan printed on 3/11/14 revealed: *She was at risk for pain. *She had a focus area of pain. *One of the interventions was to "Implement non-drug therapies to assist with pain and monitor for effectiveness." *No non-drug therapies had been listed.</p> <p>Review of resident 2's 1/31/14 pain assessment revealed: *She could have been repositioned to help relieve the pain. *No other non-pharmacological interventions had been listed.</p> <p>Review of resident 2's medical record revealed no documentation to support the use of any non-pharmacological interventions to assist with pain management.</p> <p>2. Review of resident 12's 2/6/14 admission MDS section J revealed:</p>	F 280	<p>3. ADNS and IDT reviewed and revised current procedure for careplan development review and revision. Licensed nurses were educated on development, review and revision of careplans related to identifying non-pharmacological interventions for pain.</p> <p>* 4. All new resident careplans will be audited by the DCD's/ADNS monthly for 3 months to ensure non-pharmacological interventions are identified. The ADNS will take results of review to QAA monthly until QAA advises to dis- for <i>continue further review</i> and recommendations.</p> <p>* <i>New Admissions, significant changes and quarterly assessment careplans.</i></p>	<p><i>2/16 4-21-14</i></p> <p><i>2/16 4-21-14</i></p>

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F 280	<p>Continued From page 2</p> <ul style="list-style-type: none"> *She had been on scheduled pain medications. *She had received as needed (PRN) pain medications plus the scheduled pain medications during the past five days. *The provider had implemented non-pharmacological interventions. <p>Review of resident 12's current care plan revealed:</p> <ul style="list-style-type: none"> *She was at risk for pain. *One of the interventions was to "Implement non-drug therapies to assist with pain and monitor for effectiveness." *No non-drug therapies had been listed. <p>A PAINAD scale (Pain Assessment in Advanced Dementia Scale) (scale indicating the severity of the resident's pain) had been the only pain assessment used by the provider for the residents. No non-pharmacological pain interventions had been provided on that form.</p> <p>Review of resident 12's medical record revealed no documentation to support the use of any non-pharmacological interventions.</p> <p>Surveyor: 32331</p> <p>3. Review of resident 4's 1/10/14 quarterly MDS section J revealed:</p> <ul style="list-style-type: none"> *He had received PRN pain medications plus the scheduled medications during the past five days. *The provider had implemented non-pharmacological interventions. <p>Review of resident 4's 1/7/14 care plan revealed:</p> <ul style="list-style-type: none"> *He was at risk for pain. *He had a focus area of pain. *One of the interventions was to "Implement non-drug therapies to assist with pain and 	F 280	

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F 280	<p>Continued From page 3 monitor for effectiveness." *No non-drug therapies had been listed.</p> <p>Review of resident 4's 1/15/14 pain assessment using the PAINAD scale had been the only pain assessment used by the provider. That revealed no pain had been listed.</p> <p>Review of resident 4's medication administration record (MAR) from 3/1/14 to 3/8/14 revealed: *On 3/1/14 at 1:30 a.m. he was given Tylenol (pain medication) for pain and discomfort. *On 3/2/14 at 5:30 a.m. he was given Tylenol for his complaints of back pain. *On 3/8/14 at 9:30 p.m. he was given acetaminophen (pain medication) for his complaints of a headache. *No non-pharmacological interventions were listed on any of the above dates and times.</p> <p>Review of resident 4's medical record revealed from 3/1/14 through 3/11/14 pain medications had been given twenty-six times and nothing had been documented about trying non-drug therapies prior to using a pain medication.</p> <p>4. Review of resident 6's 2/18/14 quarterly MDS section J revealed: *He had been on scheduled pain medications. *He had received pain medications during the past five days. *The provider had implemented non-pharmacological interventions.</p> <p>Review of resident 6's 1/7/14 care plan revealed: *He was at risk for pain. *One of the interventions was to "implement non-drug therapies to assist with pain and monitor for effectiveness."</p>	F 280		
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F 280	<p>Continued From page 4</p> <p>*No non-drug therapies had been listed.</p> <p>Review of resident 4's 2/13/14 pain assessment using the PAINAD scale had been the only pain assessment used by the provider. That revealed no pain had been listed.</p> <p>Review of resident 6's medical record revealed from 3/1/14 through 3/11/14 pain medications had been given twenty-one times and nothing had been documented about trying non-drug therapies prior to using a pain medication.</p> <p>Surveyor: 32335</p> <p>5. Review of resident 3's 2/8/14 care plan revealed:</p> <p>*She was at risk for pain.</p> <p>*She had a focus area for pain.</p> <p>*One of the interventions was to "Implement non-drug therapies to assist with pain and monitor for effectiveness."</p> <p>*No specific non-drug therapies had been listed.</p> <p>Review of resident 3's 2/8/14 pain assessment revealed the following effective non-drug therapies:</p> <p>**"Music, art, drama therapy."</p> <p>**"Exercise or therapies."</p> <p>**"Warm/Cool compresses."</p> <p>**"Positioning."</p> <p>Those had not been transferred to the care plan.</p> <p>Review of resident 3's 2/25/14 pain assessment revealed the following effective non-drug therapies:</p> <p>**"Warm/Cool compresses."</p> <p>**"Positioning."</p>	F 280		

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F 280	<p>Continued From page 5</p> <p>Those had not been transferred to the care plan.</p> <p>Review of resident 3's medical record revealed: *From 3/1/14 through 3/11/14 she had been given PRN (as needed) hydrocodone (pain medication) two times for pain. *There had been no documentation for the following: -Attempts to use the non-drug therapies. -The effectiveness or non-effectiveness of the those non-drug therapies listed in both pain assessments.</p> <p>6. Review of resident 9's 1/24/14 care plan revealed: *He was at risk for pain. *He had a focus area for pain. *One of the interventions was to "Implement non-drug therapies to assist with pain and monitor for effectiveness." *No specific non-drug therapies had been listed.</p> <p>Review of resident 9's 3/7/14 pain assessment revealed the following effective non-drug therapies: **"Warm/Cool compresses." **"Positioning." Those had not been transferred to the care plan.</p> <p>Review of resident 9's medical record revealed: *From 3/1/14 through 3/9/14 he had been given PRN hydrocodone nine times for pain. *From 3/3/14 through 3/6/14 he had been given PRN Norco (pain medication) four times for pain. *There had been no documentation for the following: -Attempts to use the non-drug therapies. -The effectiveness or non-effectiveness of the those non-drug therapies listed in both pain</p>	F 280		

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F 280	<p>Continued From page 6 assessments.</p> <p>7. Review of resident 11's 2/11/14 care plan revealed: *She was at risk for pain. *She had a focus area for pain. *One of the interventions was to "Implement non-drug therapies to assist with pain and monitor for effectiveness." *No specific non-drug therapies had been listed.</p> <p>Review of resident 11's medical record revealed: *From 3/1/14 through 3/6/14 she had been given PRN Tylenol two times for pain. *There had been no documentation for the following: -Attempts to use the non-drug therapies. -The effectiveness or non-effectiveness of the those non-drug therapies.</p> <p>Interview on 3/12/14 at 11:30 a.m. with the DON revealed: *The non-drug therapies for pain should have been on the care plans. *They had not been monitoring the effectiveness or ineffectiveness of the non-drug therapies. *They had no policy and procedures just guidelines related to pain management and care plans.</p> <p>Surveyor: 32355 8. Interview on 3/12/14 at 1:40 p.m. with the MDS coordinator revealed: *She would have done the initial care plan only. *She had not been responsible for ensuring the entire care plan was completed and updated. *Each department (activities, nursing, social services, and dietary) had been responsible for their own focus areas on the care plan and any</p>	F 280		

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F 280	<p>Continued From page 7</p> <p>changes.</p> <p>*The only care plan updating she would have done came from the information she would have obtained every morning in the "Eagle Room" meeting.</p> <p>*She had been responsible for completing the assessment and inputting the information in section J of the MDS.</p> <p>*She would not have provided the non-pharmacological interventions for the care plans, as she was not a primary care giver.</p> <p>*She could not explain why no non-pharmacological interventions had been listed on the above care plans.</p> <p>*She would not have interviewed the staff on any non-pharmacological interventions they had been using for the residents.</p> <p>*She would not have interviewed the residents on non-pharmacological interventions for pain management.</p> <p>*She stated "All nurses had been trained in school on how to do care plans," and "The nurses could have done the updating, but they did not."</p> <p>*She had not felt the updating of the care plans was her responsibility.</p> <p>Interview on 3/12/14 at 2:10 p.m. with the director of nursing (DON) revealed:</p> <p>*The MDS coordinator was responsible for the initial and the updating of the care plan from the daily meetings.</p> <p>*The MDS coordinator had assistance with the MDSs and care plans up until a few months ago.</p> <p>*They were in the process of getting some more assistance for her.</p> <p>*The care plans had not been reviewed and revised like they should have been.</p> <p>*The nurses needed to have been more responsible in assisting the MDS coordinator with</p>	F 280		
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F 280	Continued From page 8 the updating of the care plans.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 32332 Based on observation, interview, record review, and policy review, the provider failed to report, assess, and intervene for one of four sampled residents (8) with weight loss. Findings include: 1. Review of resident 8's medical record revealed: *He had been admitted on 12/13/10. *He was weighed monthly. *His weight on 2/1/14 was 193 pounds (lb). *On 3/4/14 his weight had dropped to 178 lb. *No re-weight had been obtained on 3/4/14. *That would have been a 15 lb weight loss in one month. Random observations of resident 8 on 3/11/14 between 8:00 a.m. and 3:00 p.m. revealed: *He did not speak when spoken to by this surveyor. *He was often found asleep in his room in his wheelchair or bed before and after meals.	F 309	F309 1. Resident #8 was reweighed on 3/11/14 and doctor notified at that time with order received for dietary supplements tid. RD completed/review/assessment of #8 on 3/11/14. 2. Patients with current weight loss have been reviewed by the IDT. If needed, doctor was updated assessment by RD completed and interventions implemented. 3. The ADNS, Dietary Manager and RD reviewed policy and procedure for weighing and reweighing to ensure accurate weights are confirmed and concerns are forwarded for follow-up. Licensed nurses and CNA's were educated on procedure for weighing and reweighing to ensure accurate weights are confirmed and concerns are forwarded for follow-up.	4/21/14

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F 309	<p>Continued From page 9</p> <p>*He had eaten between 25-50% of his noon meal, but had drank his juice and milk.</p> <p>Interview and record review on 3/11/14 at 2:45 p.m. with the registered dietitian (RD) regarding resident 8 revealed:</p> <p>*She was unaware of the weight decrease for resident 8. She had not reviewed his information yet that month.</p> <p>*The certified nursing assistants (CNA) had from the first day to the seventh of each month to weigh each resident.</p> <p>*The current process had been:</p> <ul style="list-style-type: none"> -The CNAs weighed the residents as ordered. -The RD reviewed each resident's weight and called the physician with recommendations regarding the increase or decrease in weight. <p>Interview on 3/11/14 at 3:05 p.m. with the RD regarding resident 8 revealed:</p> <p>*She had the CNAs re-weigh him.</p> <p>*His weight had dropped from 178 lb on 3/4/14 to 172 lb on 3/11/14.</p> <p>*Since 2/1/14 (39 days prior to survey date) there had been a total decline of 10.8% of his body weight.</p> <p>*She had notified his physician on 3/11/14 and a dietary supplement was ordered three times daily.</p> <p>Interview and record review on 3/11/14 at 3:20 p.m. with the director of nursing regarding resident 8 revealed:</p> <p>*She was unaware of his weight decline.</p> <p>*She explained the process of weighing residents that included:</p> <ul style="list-style-type: none"> -The CNAs weighed each resident as ordered. -They entered that information into the provider's computer database. -The CNAs were not able to see the resident's 	F 309	<p><i>RD/designee will</i> 4-21-14</p> <p>4. Audit computer alerts for significant weight loss 3 times a week for 2 months <i>with appropriate update, report @ ADNS/designee</i></p> <p>The ADNS/designee will take results of audits to QAA monthly until QAA advises to discontinue. 4-21-14</p>	
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F 309	<p>Continued From page 10</p> <p>previous weights.</p> <ul style="list-style-type: none"> -The provider's computer database would send an alert (flag) to nursing staff that a resident's weight had changed. -Nursing staff should have alerted dietary to the resident's weight change. -The RD reviewed the information and made recommendations to the resident's physician if needed. <p>*When asked why the nursing staff had not reported resident 8's weight loss to the RD she replied: "I don't think they pay attention to the flags (computer alerts). They rely on dietary (the RD) to review that."</p> <p>*She agreed it had been a system failure, and it had needed correction.</p> <p>*She reported they had established a weight team after last year's survey. It consisted of:</p> <ul style="list-style-type: none"> - CNAs. -Physical therapy staff. -The RD. -The charge registered nurse (RN). <p>Interview and record review on 3/11/14 at 4:40 p.m. with RN I regarding resident 8's weight loss revealed:</p> <ul style="list-style-type: none"> *The weight team met monthly. *They met after 2/1/14 but had not met for the month of March yet. * They (the weight team) had no regularly scheduled day each month for the meeting. They (the team) would tell her each month when they had scheduled it. *She described the resident weight process as follows: <ul style="list-style-type: none"> -The CNA weighed the resident. -A flag popped up on the computer to alert the nurse of a change. -The nurse was to have notified the RD. 	F 309		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2014
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401
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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 309	<p>Continued From page 11</p> <p>*She agreed:</p> <ul style="list-style-type: none"> -The CNAs had no way of knowing the resident's previous weight. -The CNAs could not have alerted the nurses to the change since they had not known the resident's previous weight. -Resident 8's weight loss should have been reported to the RD. -Nursing staff should have immediately intervened. -The resident's physician should have been notified, so the provider could have implemented a plan to correct the weight loss. <p>*She stated the CNAs had observed a decrease in food intake.</p> <p>*Intake had been recorded by dietary staff daily.</p> <p>*The dietary staff had not notified the nurses nor had they told the RD of the decline in resident 8's food intake.</p> <p>*She said the resident's dementia might have progressed and caused him not to eat.</p> <p>*She had not reported that to the resident's physician.</p> <p>*She agreed that had been a system failure.</p> <p>*She agreed all staff needed to communicate to ensure weight changes were reported, assessed, and interventions were made on behalf of any resident with weight loss.</p> <p>Review of the provider's undated Important Information about Obtaining Routine Weights policy revealed:</p> <ul style="list-style-type: none"> *Nurses needed to have been notified of weight changes. *"Always re-weigh resident with a wt [weight] change of 5 lbs +/- [plus or minus] and report change to the nurse/RD." *Weight charts were made for each nurses station with monthly weights listed for reference. 	F 309		
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F 309	<p>Continued From page 12</p> <p>*Residents were to have been weighed the first through the seventh day of each month.</p> <p>Review of the provider's undated Steps for Obtaining Weights guidelines revealed weights were to have been compared to the previous weight. If there had been a change the nurse should have been notified, and the resident would have been re-weighed.</p>	F 309	<p>F371</p> <p>1. No residents were identified. Staff members A, B, C were educated on proper sanitizing of wiping cloths and proper hand hygiene for dietary staff.</p>	4/21/14
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to: *Maintain proper sanitizing of the wiping cloths for dietary staff at two of two meal observations and in two of two kitchens (central kitchen and the Aberdeen dining room's kitchen). *Maintain proper hand hygiene for dietary staff at two of two meal observations and in two of two kitchens (central kitchen and the Aberdeen dining room's kitchen). Findings include:</p>	F 371	<p>2. Residents of the facility have the potential to be affected. The RD/designee will complete kitchen observations with the staff.</p> <p>3. Dietary Manager and RD reviewed policy and procedure on appropriate hand hygiene for dietary staff and the use of wipe cloths for sanitizing. Education was provided to dietary staff related to hand hygiene and the use of wipe cloth by RD.</p> <p>4. The RD or designee will complete kitchen observations for proper hand hygiene and use of wipe cloth 5 times a week for 1 month times 2 months. RD/designee will take results to QAA monthly until QAA advises to discontinue <i>4-21-14</i> for review and further recommendations.</p>	

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401	
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F 371	<p>Continued From page 13</p> <p>1. Observation on 3/11/14 at 8:15 a.m. in the central kitchen revealed a wet cloth on the counter laying next to the plates located next to the food steam table area.</p> <p>Observation on 3/11/14 at 11:08 a.m. in the central kitchen revealed a wet cloth on the food production table laying next to a steam table pan and three serving spoons.</p> <p>Observation on 3/11/14 at 11:30 a.m. in the central kitchen revealed a wet cloth on the food counter laying next to the opened Styrofoam cups and packaged crackers. This surveyor observed cook A pick up the wet cloth, and she wiped down the following: *The food steam table counter. *The coffee pot area. *The area around the microwave. *The can opener. *She then placed the same wet cloth on the food counter next to the Styrofoam cups and crackers.</p> <p>Observation on 3/11/14 at 11:35 a.m. in the central kitchen with food service supervisor C revealed she had: *Wiped down a steam table cart with a wet cloth. *Placed the same wet cloth on the cart's handle and pushed the cart out of the central kitchen area down two resident hallways toward the Aberdeen dining room's kitchen. *The wet cloths needed to have been in sanitizing solution when not in use.</p> <p>2. Observation on 3/11/14 from 11:37 a.m. through 11:45 a.m. with food service supervisor C in the Aberdeen dining room kitchen revealed she had: *Removed the same wet cloth from the steam</p>	F 371	

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401	
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F 371	<p>Continued From page 14</p> <p>table cart's handle that she had been holding. *Placed that wet cloth on top of the steam table counter next to the prepared residents' food. *Put her apron on. *Removed the food lids from the steam table with the same wet cloth. *Placed that wet cloth on the counter laying next to residents' food plates and two covered bowls of pureed bread located next to a handsink. *Started preparing to obtain food temperatures of the foods in the steam table with a thermometer. *Picked up the above wet cloth laying next to the residents' food plates and pureed bread. *Wiped her hands with the wet cloth. *Placed the wet cloth back on the counter laying next to the plates and the pureed bread. *Obtained all the hot food temperatures from the steam table with a food thermometer. *Used a hand sanitizer on her hands and rubbed her hands together with the sanitizing gel for five seconds. *Started dishing up residents' food on plates for the noon meal service. *At no time were hands washed, or the wet cloths placed into a sanitizing solution.</p> <p>Observation on 3/11/14 at 12:08 p.m. of food service supervisor C at the above location revealed she: *Had completed serving the residents' meals. *Covered up the steam table foods with lids. *Picked up the serving utensils and placed them on a tray on top of the steam table lids and covered them with a white towel. *Picked up that same wet cloth on the counter laying next to the remaining plates. *Placed the wet cloth on the handle of the steam table cart and pushed the cart back down two resident hallways toward the central kitchen.</p>	F 371	

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
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F 371	<p>Continued From page 15</p> <p>Observation on 3/11/14 from 12:15 p.m. through 12:30 p.m. of food service supervisor C in the central kitchen revealed she:</p> <ul style="list-style-type: none"> *Pushed the steam table cart in a corner and then removed the same wet cloth as the above from the handle of the steam table cart. *Used the same wet cloth to remove the lids from another steam table that contained prepared foods. *Wiped off the steam table counter with the wet cloth. *Placed the same wet cloth on the steam table counter. *Washed her hands in the handsink. *Obtained all the hot food temperatures from the steam table with a food thermometer. *Used a hand sanitizer on her hands and had rubbed her hands together with the sanitizing gel for five seconds. *Removed the wet cloth from the steam table counter and discarded it. *Started serving the residents food from the steam table. <p>3. Observation on 3/12/14 at 7:30 a.m. in the Aberdeen dining room's kitchen revealed there was a wet cloth lying next to the cereal bowls next to the handsink. The residents there were being served breakfast. The wet cloths needed to have been in sanitizing solution when not in use.</p> <p>4. Observation on 3/12/14 at 8:15 a.m. in the central kitchen revealed cook B after a fire drill:</p> <ul style="list-style-type: none"> *Returned to the kitchen from the resident hallway. *Placed his apron on. *Removed the steam table covers from the food located in the steam table. 	F 371		

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F 371	<p>Continued From page 16</p> <p>*Used a hand sanitizer on his hands and rubbed his hands together with the sanitizing gel for ten seconds.</p> <p>*Proceeded to serve food to the residents from the steam table for the breakfast meal.</p> <p>*At no time were his hands washed.</p> <p>5. Interview on 3/12/14 at 1:30 p.m. with the registered dietitian and the administrator confirmed proper handwashing and sanitizing of the wet cloths needed to have been followed in the kitchen.</p> <p>Review of the provider's 4/7/06 Cleaning Procedure-Sanitizing Food Contact and Non-Food Contact Surfaces policy revealed: *There needed to have been a bucket labeled as "cleaning cloths with sanitizer" or a designated pail. *The cleaning cloths needed to have been in a solution whenever they were not in use.</p> <p>Review of the provider's 4/7/06 Handwashing policy revealed: *Proper handwashing promoted safe food handling practices and infection control. *The following list included, but was not limited to, when hands were to have been washed: -When entering the kitchen. -After handling soiled utensils or dishes. -During food preparation as often as necessary to remove soil and to prevent cross-contamination when changing tasks. -After engaging in any activities that contaminated the hands. *Hands were to have been washed in the designated handwashing sinks in the kitchens. *Soap and water handwashing was the preferred method for cleaning hands.</p>	F 371		
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F 468 SS=D	<p>483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS</p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation and interview, the provider failed to have handrails securely attached to the wall in two of five hallways down from nurse station one and nurse station two. Findings include:</p> <p>1. Observation on 3/11/14 at 6:00 p.m. revealed: *The handrails were loose outside resident rooms 118, 140, 142, 144, 147, 148, 151, 153, and 155. *The handrail outside resident rooms 142 and 144 had pulled away from the wall a quarter inch. *The handrail outside resident room 147 had pulled away from the wall a half inch. *The handrail on the left side of resident room 148 had pulled away from the wall a quarter inch.</p> <p>Observation and interview on 3/12/14 at 2:20 p.m. with the maintenance supervisor revealed: *He agreed the above handrails were loose and not securely attached to the walls. *He had not recently checked the handrails. *There was not a preventative maintenance program for checking the handrails. *They did not have a policy and procedure for checking the handrails.</p>	F 468	<p>It is the practice of the facility to equip the corridors with firmly secured handrails on each side.</p> <p>1. Identified handrails were secured firmly on 3/12/14.</p> <p>2. Implemented preventative maintenance schedule for the Maintenance Director to check weekly that handrails are firmly secured.</p> <p>Audits of handrails weekly for 2 months with results taken by Administrator to QAA or until QAA advises to discontinue for further review/recommendations.</p>	4/21/14 JAA by maintenance director 4-21-14 JAA
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C. FINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2014
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/11/14. ManorCare Health Services (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K044 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated. The latching hardware was 3/17/14 installed on 3/17/14. The Administrator will take results to the QAA committee.	
K 044	NFPA 101 LIFE SAFETY CODE STANDARD SS=D Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the two hour fire-resistive rating of horizontal exits in one of one location (cross-corridor doors). Findings include: 1. Observation at 11:15 a.m. on 3/11/14 revealed a 2 hour fire resistive rated horizontal exit with 1-1/2 hour fire resistive rated cross-corridor doors separating building 1 (original building) from building 2 (addition). Further observation revealed the west leaf of those doors was not provided with the proper rated hardware. The bottom portion of the surface mounted vertical rod latching hardware that latched the door into the	K 044		

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

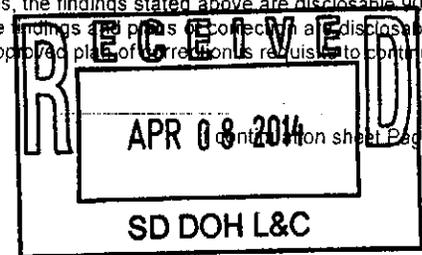
Frances Mastel

TITLE

Administrator 04/07/14

(X6) DATE

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 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 required to continued program participation.



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K 044	Continued From page 1 floor was not provided. Interview with the maintenance director at the time of the observation confirmed that condition.	K 044			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2014
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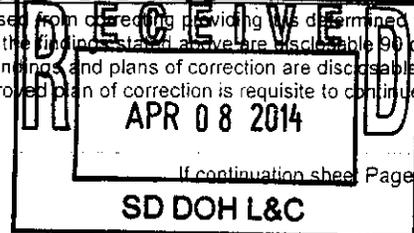
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING 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: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/11/14. ManorCare Health Services (building 02) 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 upon correction of the deficiency identified at K044 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.	
K 044 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain the two hour fire-resistive rating of horizontal exits in one of one location (cross-corridor doors). Findings include: 1. Observation at 11:15 a.m. on 3/11/14 revealed a 2 hour fire resistive rated horizontal exit with 1-1/2 hour fire resistive rated cross-corridor doors separating building 1 (original building) from building 2 (addition). Further observation revealed the west leaf of those doors was not provided with the proper rated hardware. The bottom portion of the surface mounted vertical rod latching hardware that latched the door into the	K 044	The latching hardware was installed on 3/17/14. The Administrator will take results to the QAA committee.	3/17/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Frances Mastel</i>	TITLE <i>Administrator</i>	(X6) DATE <i>04/07/14</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.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2014
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVENUE NW ABERDEEN, SD 57401		
(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 044	Continued From page 1 floor was not provided. Interview with the maintenance director at the time of the observation confirmed that condition.	K 044		

ORIGINAL

PRINTED: 03/24/2014
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2014
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401
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S 000	Initial Comments Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/11/14 through 3/12/14. ManorCare Health Services was found not in compliance with the following requirements: S206, S210, S236, and S301.	S 000	The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	* 1. The facility will provide a formal orientation program for all personnel. General orientation program and 2014 inservice calendar will include the 10 required subjects. 4/21/14 2. HR/designee will monitor completion of all required annual inservices. monthly 4-21-14 3. HR/designee will report monthly to QAA for further review/recommendations. 4-21-14 * Employees D, E, G & H were educated by 4-21-14. Employee F was terminated. 4-21-14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Frances Thastel* TITLE: _____ (X6) DATE: _____

STATE FORM 021199

RECEIVED

APR 23 2014

SD DOH L&C

RECEIVED

APR 08 2014

SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10588	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/12/2014
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S 206

Continued From Page 1

This Rule is not met as evidenced by:
Surveyor: 32355
Based on record review and interview, the provider failed to ensure all required in-service training sessions each year and upon being hired were offered to all staff and five of five newly hired employees (D, E, F, G, and H). Findings include:

- Review of the annual required in-service agendas for 2013 and to date in 2014 revealed the newly hired employees D, E, F, G, H, and all the staff had no training in dining assistance, nutritional risks, and hydration needs of residents.

Interview on 3/12/14 at 8:40 a.m. with the human resource director and the administrator confirmed they had failed to include dining assistance, nutritional risks, and hydration among their orientation and annual training topics.

The provider was not able to provide this surveyor with a policy and procedure regarding required training topics for newly hired staff and all staff prior to the survey exit.

S 206

S210

- The facility will evaluate all personnel by a licensed health professional for freedom of communicable disease within 14 days of employment.
- Audits will be completed by HR/designee weekly for 2 months to ensure Employee Medical History form is completed within 14 days. The Administrator will take results of audits to QAA monthly ~~until QAA~~ for further review/recommendations.

4/21/14

S 210

44:04:04:06 EMPLOYEE HEALTH PROGRAM

The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health 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

S 210

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401		
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S 210	<p>Continued From Page 2</p> <p>communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. 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 the physician's designee to no longer have the disease in a communicable stage.</p> <p>This Rule is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to ensure four of five newly hired employees (D, E, F, and H) had been evaluated by a licensed health professional within fourteen days of being hired for freedom of communicable diseases. Findings include:</p> <p>1. Review of employee D's personnel file revealed: *A 2/17/14 hire date. *She had completed and signed the employee medical history on 2/17/14. *The employee medical history had been evaluated by a licensed health professional, but no date of when that had occurred was documented.</p> <p>Review of employee E's personnel file revealed: *A 1/2/14 hire date. *She had completed and signed the employee medical history on 1/2/14. *The employee medical history had been evaluated by a licensed health care professional on 1/21/14.</p> <p>Review of employee F's personnel file revealed: *A 10/30/13 hire date. *She had completed and signed the employee</p>	S 210		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 400 8TH AVE NW ABERDEEN, SD 57401	
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S 210	<p>Continued From Page 3</p> <p>medical history on 10/30/13. *The employee medical history had been evaluated by a licensed health care professional on 11/21/13.</p> <p>Review of employee H's personnel file revealed: *A 9/26/13 hire date. *She had completed and signed the employee medical history on 9/26/13. *The employee medical history had been evaluated by a licensed health care professional on 11/21/13.</p> <p>Interview on 3/12/14 at 8:45 a.m. with the human resource director and the administrator confirmed the above employees had not been evaluated by a licensed health professional within the required fourteen days of having been hired.</p> <p>Review of the provider's 6/1/02 Employee Health policy revealed "It is the policy of HCR Manor Care to comply with state and federal regulations regarding the health of employees and to ensure that employees are free of communicable diseases." There had not been any fourteen day deadline mentioned in the policy.</p>	S 210	<p>S236 * HR/designee 4-21-14 JAL</p> <p>1. The facility will ensure 4/21/14 all new healthcare workers receive the 2 step method of mantoux skin test within 14 days of employment.</p> <p>2. Audits will be completed by HR/designee weekly for 2 months to ensure completion of 2 step mantoux skin test within 14 days. The Administrator will take results of audits to QAA monthly for until QAA advises to discontinue. review and further recommendations. JAL 4-21-14</p>
S 236	<p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed</p>	S 236	<p>* HR/designee was educated on mantoux skin testing. 4-21-14 JAL</p>

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S 236	<p>Continued From Page 4</p> <p>within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Rule is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to ensure two of five sampled new employees (F and G) completed their two-step tuberculin (TB) screening requirement within fourteen days of being hired. Findings include:</p> <p>1. Review of employee F's personnel file revealed: *A 10/30/13 hire date. *The first TB screening skin test had been given on 10/28/13 with the results read on 10/30/13. *The second TB screening skin test had not been given until 12/10/13 with the results read on 12/13/13.</p> <p>Review of employee G's personnel file revealed: *A 10/14/13 hire date. *The first TB screening skin test had been given on 10/11/13 with the results read on 10/14/13. *The second TB screening skin test had not been given until 11/1/13 with the results read on 11/3/13.</p> <p>Interview on 3/12/14 at 3:00 p.m. with the human resource director revealed she had not been aware the TB screening skin test had to be</p>	S 236		

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S 236	Continued From Page 5 completed within fourteen days of being hired. She had followed the provider's policy of one to three weeks following the first TB screening skin test.	S 236		
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S 301	44:04:07:16 Required dietary in-service training The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Rule is not met as evidenced by: Surveyor: 32331 Based on record review and interview, the provider failed to ensure four of the nine required annual in-service training sessions (food safety,	S 301	S301 1. The facility will provide in-service training for dietary and food-handling employees on the following: food safety, food-borne illnesses, leftover food handling policy and time and temperature controls for food preparation and services. 2. HR/designee will monitor completion of all required annual in-services. 3. HR/designee will report in-service completion to QAA monthly for review/ recommendations. <i>29M 4-21-14</i>	4/21/14
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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 301	<p>Continued From Page 6</p> <p>food-borne illnesses, leftover food handling policies, and time and temperature controls for food preparation and service) each year were offered for all dietary and food-handling staff. Findings include:</p> <p>1. Record review on 3/12/14 of the required in-service training sessions for 2013 and 2014 for all dietary and food-handling staff revealed those staff had received no training in food safety, food-borne illnesses, leftover food handling policies, and time and temperature controls for food preparation and service.</p> <p>Interview on 3/12/14 at 1:20 p.m. with the registered dietitian confirmed they had failed to include food safety, food-borne illnesses, leftover food handling policies, and time and temperature controls for food preparation and service among all dietary and food-handling staff training topics.</p> <p>The provider was not able to provide this surveyor with a policy and procedure regarding required training topics for all dietary and food-handling staff prior to the survey exit.</p>	S 301		