SOUTH DAKOTA DEPARTMENT OF HEALTH

ORIGINAL

PRINTED: 04/28/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	10634		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE PO BOX 946 HURON, SD 57350

(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) COMPLETE DATE
S 000	Initial Comments Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/14/14 through 4/16/14. Violet Tschetter Memorial Home was found not in compliance with the following requirement: S239.	S 000	Addendums noted with an asterisk per 5/19/14 telephone to facility administrator. PE/SDDOH/MF	
S 239	Tuberculin Screening Requirements44:04:04:08. This Rule is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to monitor for signs and symptoms of tuberculosis (TB) for one of one sampled resident (10) with a history of a positive tuberculin screening test. Findings include: 1. Review of resident 10's medical record revealed: *He had been admitted on 9/22/09 with a history of being a positive TB reactor. *His vaccination record form indicated "+ TB reactor - see chest x-ray." *No chest x-ray report was found in the record. *No record of a TB risk assessment form was found. Interview on 4/16/14 at 1:30 p.m. with the director of nursing revealed: *She had not known the resident had been a positive TB reactor.	S 239		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Spencer

TITLE: Executive Director

(X6) DATE: 5-13-14

RECEIVED MAY 16 2014 SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10634	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2014
NAME OF PROVIDER OR SUPPLIER VIOLET TSCHETTER MEMORIAL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 50 SEVENTH ST SE PO BOX 946 HURON, SD 57350		

(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) COMPLETE DATE
S 239	Continued From Page 1 *The infection control nurse had not performed an annual TB risk assessment or completed that form. *A phone call to the resident's physician revealed he had not recalled resident 10 had been a postive TB reactor and had not assessed him for TB symptoms. *The provider had not followed their TB policy. Review of the provider's undated Tuberculosis Infection Control Plan policy and procedure revealed: *Residents with a history of a positive tuberculin skin test would have signs and symptoms reviewed annually using the "TB, Baseline Screening Tool for Residents, Providence Place." *The form would have been filed in the reisdent's chart (medical record).	S 239	S239 1. Resident #10 received a chest x-ray on 4/17/14. Resident's care plan was revised on 5/7/14. All residents were reviewed for TB reactor status on 5/5/14. 2. Facility implemented a TB log to be maintained by the Infection Control Nurse to indicate all positive reactors and ensure annual screenings are completed. Infection Control Nurse and nursing staff have been re-educated by the DNS on 5/7/14 on new system for monitoring TB positive reactors. 3. DNS/designee will audit TB log weekly for one month, and then every other week for 1 month. 4.. DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting quarterly for further recommendations regarding system and continued monitoring PE/SDDOH/MF	*05/17/14 PE/SDDOH/MF

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

ORIGINAL

PRINTED: 04/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/14/14 through 4/16/14. Violet Tschetter Memorial Home was found not in compliance with the following requirements: F221, F250, F280, F311, F314, and F441.	F 000	Addendums noted with an asterisk per 5/19/14 telephone to facility administrator. PE/SDDOH/MF	
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure side rails had been assessed for four of four observed residents (1, 9, 11, and 15) who had side rails on their beds. Findings include: 1. Random observations from entrance on 4/14/14 at 4:45 p.m. through 4/16/14 at 4:00 p.m. of resident 1's bed revealed a one-half side rail on her bed. During the entire observation period that side rail had always been raised. Review of resident 1's medical record revealed: *There had been no assessment indicating a need for a side rail. *There had been no physician's order for a side rail.	F 221		

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

Jessica Spencer — Executive Director — 5-13-14

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.

RECEIVED MAY 15 2014 SD DOH L&C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1 *Her care plan initiated 3/20/14 had an intervention for an "assist bar to promote resident to self-reposition." *There had been an intervention revision on her care plan dated 3/20/14 that had stated "total assist of two for bed mobility." *Her 2/25/14 Minimum Data Set (MDS) assessment indicated "bed rails" had not been used. 2. Random observations from 4/14/14 at 4:45 p.m. through 4/16/14 at 4:00 p.m. of resident 9's bed revealed a one-fourth side rail on both sides of the upper half of his bed. During the entire observation period both of those side rails had been raised. Review of resident 9's medical record revealed: *There had been no assessment indicating a need for a side rail. *There had been no physician's order for a side rail. *There had been no mention of side rails on his care plan. *His 3/28/14 MDS assessment indicated "bed rails" had not been used. 3. Random observations from 4/14/14 at 4:45 p.m. through 4/16/14 at 4:00 p.m. of resident 15's bed revealed a raised one-half side rail on her bed. During the observation period the resident's side rail had always been raised. Review of resident 15's medical record revealed: *There had been no assessment indicating a need for a side rail. *There had been no physician's order for a side rail. *Her care plan initiated 1/26/14 had interventions	F 221	F221 1. Residents # 1, 9, 11 and 15's were assessed for assist rail use on 5/1/14. Resident #'s1 and 9 were assessed as not needed and removed on 5/1/14. For resident #'s11 and 15 physician order's for a therapy eval was obtained on 5/5/14. #11 obtained a physician's order on 5/9/14 for an assist rail. Resident #15 has been evaluated by therapy as able to maintain independence without assist rail but could benefit from having one. Resident #15 has her own bed and an assist rail that will accommodate her bed frame was ordered on 5/9/14. A physician's order will be obtained once assist rail arrives. Resident's #1, 9, 11 and 15's care plans were reviewed and revised as necessary on 5/6/ 14. Resident's 1, 9, 15 and 11's MDS's were modified on 5/13/14 to reflect accurracy. All residents with assist rails in place were assessed for assist rail use on 5/1/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2 that stated: -A grab bar as needed. -Independent with bed mobility. *Her 2/11/14 MDS assessment indicated "bed rails" had not been used. Surveyor: 26180 4. Observation on 4/16/14 at 9:30 a.m. revealed resident 11's bed had a one-quarter length side rail attached at the head of his bed. Review of resident 11's April 2014 physician's orders revealed there was not an order for a side rail. Review of resident 11's care plan with the last review date of 1/15/14 revealed it had not addressed a side rail. Review of resident 11's entire medical record revealed there were no side rail consents. 5. Interview on 4/16/14 at 10:00 a.m. with the MDS coordinator revealed she had not been completing assessments for the use of side rails. She stated she planned to begin completing assessments for the use of any side rail. Interview on 4/16/14 at 11:00 a.m. with the director of nurses confirmed assessments for the use of side rails had not been completed. She stated there was not a current policy for the use of side rails, but she had found one she planned to start using. Review of the provider's February 2007 Guidelines for Use of Assist Bar policy revealed: *The assist bar cannot be installed until a licensed nurse had completed an assessment.	F 221	2. MDSC and nursing staff have been re-educated by the DNS on 5/7/14 on assist rail use, assessments, physician order and care planning and new guideline. Facility has implemented new assessments for assist rail use upon admission, quarterly and with change of condition on 5/1/14.Guideline was implemented requiring a physician order and assessment for assist rail use on 5/1/14. 3. DNS/designee will audit 3 resident's for assist rails, assessments, physician orders and care plans per week for one month, and then 2 residents per week for 1 month, and then 1 resident per week for 1 month. 4. DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting quarterly for further recommendations regarding system and continued monitoring.	5-13-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 3 *Using the assist bar should be assessed every three months and with a significant change of condition. Review of the provider's 12/16/11 Restraint policy/guideline revealed: *"It is the policy of [name of facility] to only use physical restraints after: -1. Education on resident and/or family members. -2. Clinical assessment by the interdisciplinary team and appropriate care planning has been completed. -3. A physician order. -4. A consent signed by the family. -5. Re-evaluation will be done at last quarterly."	F 221		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and job description review, the provider failed to ensure one of five sampled residents (6) with medically related social service needs received appropriate services to maintain her psychosocial well-being. Findings include: 1. Review of resident 6's medical record revealed: *Diagnoses of depression disorder and anxiety.	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 4 *Citalopram (medication for depression and anxiety) had been ordered on 10/1/13. *Lorazepam (medication for anxiety) had been ordered as needed (PRN) on 10/1/13 and was increased to daily and PRN on 2/20/14. Review of resident 6's following Minimum Data Set (MDS) assessments revealed PHQ-9 scores (for screening and measuring the severity of depression): *On 9/3/13 a score of 4 indicating mild severity. *On 12/2/13 a score of 15 indicating moderately severe symptoms of depression. *On 2/25/14 a score of 13 indicating moderate depression with indicators of: -Little interaction with others. -Feeling down. -Feeling tired. -Decreased appetite. -Trouble concentrating. Review of a summary sheet from a resident 6's care conference held on 9/16/13 by the interdisciplinary team indicated: *There were no concerns. *No referrals or examinations (exams) had been needed at that time. Review of resident 6's social service notes related to the PHQ-9 scores indicated: *On 12/12/13 "Appears to fluctuate depending on how resident feels." *On 2/21/14 the social services designee had documented: -She was not receiving mental health professional-related services or programming. -The goals had not been assessed. Review of a summary sheet from a resident 6's	F 250	F250 1. Social Service Designee and Resident #6 discussed mental health professional-related services on 4/17/14. A physician order's for mental health evaluation was obtained on 4/22/14. Appointment has been scheduled for 5/20/14. All resident PHQ-9 scores were reviewed on 5/1/14. 2. Facilities system for identifying resident's in need of mental health evaluation and physician notification was revised to include reviewing PHQ-9 scores over 10.* 3. SSC/designee will audit all MDS's PHQ-9 scores per week for two months, and then all MDS's PHQ-9 scores per week for 1 month. 4. SSC/designee will present data collected to the Quality Improvement Quality Assurance meeting* for further recommendations regarding system and continued monitoring. *quarterly PETSDBOH/MF All nursing staff and IDT team were educated on using PHQ-9 scores on 05/07/14. PETSDBOH/MF	5-12-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 5 care conference held on 3/11/14 by the interdisciplinary team indicated: *There had been no documentation under the conference notes section. *The summary had indicated no referrals or exams had been needed at that time. Review of resident 6's updated 3/14/14 care plan indicated a problem of potential for altered mood symptoms. The goal had been no worsening of mood symptoms. Interventions listed for that problem included: *Monitoring for side effects of the antidepressant and antianxiety medications. *Monitor and report any new onset of mood symptoms or changes in mood symptoms to the charge nurse or social services. *It had not indicated the staff were to report worsening symptoms of depression or mood to the medical practitioner. Observation and interview on 4/15/14 at 4:20 p.m. with resident 6 revealed: *The resident forewarned the surveyor she would be crying much of the time. *The resident was teary-eyed for much of the interview. Interview on 4/16/14 at 10:30 a.m. with the social services designee revealed: *The resident's PHQ-9 scores fluctuated day-to-day depending on her mood. *The resident's primary physician had initially ordered the antidepressant. *She was not sure if the physician had been notified of the high PHQ-9 scores. *She was not sure if the physician had been approached about an increase in the dose of the antidepressant or to consider a different	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 6 antidepressant. *She shared the score information with the interdisciplinary team. *The staff would just monitor the moods day-to-day. *She was not sure if the moods would have been documented to monitor for worsening symptoms. *She was not sure if a psychiatric consultation had been offered. Interview on 4/16/14 at 1:30 pm. with the director of nursing regarding resident 6 revealed: *The resident should have been offered a psychiatric consult. *Her physician should have been notified of the elevated PHQ-9 scores. Review of the provider's updated 5/21/13 social services coordinator job description revealed the job summary was to "Identify and provide for each resident's social, emotional and psychological needs and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning of his/her discharge." The provider had been unable to provide a policy for medically related social services when requested.	F 250		
F 280 SS=D	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.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7 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: 29162 Based on record review, interview, and policy review, the provider failed to review and revise 4 of 12 sampled residents' (1, 5, 9, and 12) care plans to reflect their current status and conditions. Findings include: 1. Review of resident 1's care plan printed on 3/20/14 revealed she was to have: *A regular diet with ground meat. -Observation of the midday meal on 4/15/14 at 12:15 p.m. in the dining room rvealed she had been served a chicken leg. *"An assist bar to bed to promote/assist resident to self-reposition." *"Total assist of two for bed mobility." The above interventions contradicted each other. 2. Review of resident 9's medical record revealed he had suffered a stroke and was hospitalized from 3/18/14 through 3/21/14. His care plan prior	F 280	F280 1. Residents # 1, 5, 9 and 12's care plans were reviewed. Resident #1's diet was reviewed by physician on 5/6/14 and care plan updated on 5/7/14. Resident #1 was assessed for assist rail on 5/1/14; assist rail was not used and removed from bed on 5/1/14. Care plan corrected on 5/6/14. Resident #9's sleeping situation was assessed and care plan corrected on 5/6/14. Resident #5's care plan was corrected to include her activity preferences on 4/15/14. Resident #12's restorative therapy program was added to the care plan on 5/6/14. All care plans have been reviewed and revised as necessary. 2. MDSC, IDT and nursing staff have been re-educated by the DNS on 5/7/14 on revising care plans with change of conditions, including post hospitalization and change in therapy services, assistive devices such as side rails, diets and activity care plans. 3. DNS/designee will audit 3 care plans per week for one month, and then 2 care plans per week for 1 month, and then 1 care plan per week for 1 month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435126	A. BUILDING _____ B. WING _____	04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 to that hospitalization had stated he had slept in his recliner. When he had returned from the hospital he began sleeping in his bed. That had not been revised on his current care plan. 3. Interview on 4/16/14 at 11:00 a.m. with the director of nurses regarding residents 1 and 9 revealed: *Resident 1 should not have been served a whole chicken leg. *The intervention for the assist bar for self-repositioning and total assistance of two for bed mobility contradicted each other for resident 1. *Resident 9's care plan should have been revised when he had returned from the hospital to indicate he slept in his bed. Surveyor: 32333 4. Review of resident 5's complete medical record revealed: *She had a diagnosis of dementia. *She had not been able to plan her own activities. *Her current care plan updated on 3/25/14 made no mention of activities. *Review of her February 2014, March 2014, and April 2014 activity logs revealed multiple days where no activities had been documented as being offered or occurring. Interview on 4/15/14 at 4:55 p.m. with the activities director revealed resident 5's activity preferences should have been on her current care plan. All residents should have had activities careplanned. 5. Review of resident 12's complete medical record revealed: *She had been discharged from occupational	F 280 *quarterly PE/SDDH/MF	4.. DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.	5-9-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 therapy (OT) on 2/6/14. *An undated February 2014 note signed by the Minimum Data Set coordinator who was also the restorative nurse stated she had been started on a restorative program after working with skilled therapies in order to maintain the progress she had made. *Her 3/14/14 care plan stated "Therapies as ordered" as an intervention for potential alteration in comfort. *Her current care plan had not been updated to reflect her discharge from OT and the start of a restorative program. 6. Interview on 4/16/14 at 10:50 a.m. with the director of nursing revealed she would have expected care plans to have been updated and accurate to reflect the residents' current status. Review of the provider's August 2013 Care Plan Completion policy revealed: *All care plans should include individual and combined focus problems. *Any restraints or protective devices. *Any on sight care such as restorative nursing. *Type of assistance for bed mobility. *Safe patient handling including transfers and bed mobility devices. *Preference for activities.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 10 by: Surveyor: 32333 Based on record review and interview, the provider failed to ensure an effective restorative program had been maintained for four of nine sampled residents (4, 5, 10, and 12). Findings include: 1. Review of resident 5's October, November, and December 2013 restorative program documentation forms revealed: *To complete passive range of motion (PROM) to lower extremities and upper extremities ten to twenty repetitions on each joint to maintain range of motion and to help minimize risk of contractures to lower extremities and upper extremities. -October 2013 PROM had been documented as completed for fifteen minutes everyday except on 10/6/13, 10/9/13, 10/26/13, and 10/30/13. -November 2013 PROM had been documented as completed for fifteen minutes everyday except on 11/5/13, 11/20/13, 11/21/13, and 11/22/13. -December 2013 PROM had been documented as completed for fifteen minutes everyday except on 12/7/13. On 12/17/13 the program had been discontinued per the Minimum Data Set (MDS) coordinator who was also the restorative nurse. Review of resident 5's reason activity had not occurred form for the restorative program revealed the reason the activity had not occurred on the above dates was because the certified nursing assistant (CNA) had been "pulled to the floor." Review of an undated note from December 2013 signed by the MDS coordinator stated resident 5 had been on PROM to maintain her ability to	F 311	F311 1. Residents #4, 5, 10 and 12 were assessed for the restorative program on 5/6/14. #5 received physician order for therapy evaluation due to improved health status on 5/6/14, #10's restorative program was reviewed and added to the care plan on 5/6/14. Resident's 4 and 12 were reviewed for accuracy on 5/6/14. All resident's on the restorative program were reviewed and revised as needed on 5/9/14. 2. MDSC and nursing staff have been re-educated by the DNS on 5/7/14 on referral to and continuation of the restorative nursing program and care planning. Facility has implemented monthly restorative therapy evaluation forms to use when assessing residents on restorative program. 3. DNS/designee will audit 3 resident's on the restorative program for program individualization, care planning and evaluation of planned program per week for one month, and then 2 residents on restorative program per week for 1 month, and then 1 resident on the restorative program per week for 1 month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 11 participate in her own activities of daily living. She had further decline and had been unable to participate so she would not continue that program. Interview on 4/15/14 at 3:30 p.m. with the MDS coordinator regarding resident 5 revealed: *She was unsure why the resident had been discontinued from the restorative program. *There had been no further documentation regarding the discontinuation of the restorative program. *She confirmed there had been no documentation of the resident's refusal of her PROM. *She confirmed the October, November, and December 2013 PROM forms documented completion of the activity except when they had inadequate staff to complete the restorative program. Review of resident 12's complete medical record revealed: *She had been discontinued from OT on 2/6/14. *An undated note from February signed by the MDS coordinator stated she started a PROM and transfer program after working with skilled therapies to be able to maintain the progress she had made in skilled therapy. *Her current care plan had not been updated to reflect her discontinuation from OT and the start of her restorative program. Refer to F280, finding 5. 2. Review of resident 12's February, March, and April 2014 restorative program documentation forms revealed to complete PROM to left and right upper extremities. Those forms revealed restorative care had not been performed on the	F 311	4. DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting *quarterly PERIODICALLY for further recommendations regarding system and continued monitoring.	5-12-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 12 following dates: -February 2014: PROM had not been documented as completed on 2/15/14, 2/16/14, 2/18/14, and 2/19/14. -March 2014: PROM had not been documented as completed on 3/11/14, 3/12/14, 3/13/14, 3/14/14, 3/17/14, 3/23/14, and 3/24/14. -April 2014: 4/1/14 through 4/16/14 PROM had not been documented as completed on 4/14/14 or 4/15/14. Review of resident 12's reason activity had not occurred form for the restorative program revealed it had not occurred on the following dates 3/17/14, 3/23/14, and 3/24/14 because the CNA had been "pulled to the floor." Surveyor: 32332 3. Review of resident 10's medical record revealed restorative records for February and March 2014. The records indicated he had begun a PROM program and transfer exercises on 2/23/14. Taped to the back of each restorative record had been an undated computer-generated documentation by the restorative nurse indicating: *The resident had been receiving a PROM exercise and transfer exercise program. *He participated daily. *It would continue without changes. The above documentation had been duplicated (copied) then signed by the restorative nurse. Review of resident 10's 3/27/14 care plan revealed it had not included the restorative program. 4. Review of resident 4's medical record revealed	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 13 restorative records for October 2013 through March 2014. The records indicated she had been on a PROM program to prevent further contractures and to loosen the contractures she had in her legs. Taped to the back of each restorative record had been an undated computer-generated documentation by the restorative nurse indicating: *She was on a PROM program. *She participated daily. *It would continue without any changes. The above documentation had been duplicated each month, and then signed by the restorative nurse. 5. Interview on 4/16/14 at 10:30 a.m. with the restorative nurse revealed: *The documentation had not been individualized to reflect: *The current status of each resident. *If goals had been attained. *The provider had identified last week that more information should have been included in her restorative assessments. Surveyor: 32333 Interview on 4/16/14 at 10:50 a.m. with the director of nursing (DON) revealed she would have expected appropriate restorative documentation to include dates and progress in the program. Interview on 4/16/14 at 2:45 p.m. with the DON confirmed there was no restorative nursing program policy or procedure.	F 311		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on interview, observation, record review, and guideline review, the provider failed to ensure one of two sampled resident (2) who developed a pressure sore had: *A repositioning schedule. *An effective pressure relieving device. *Education provided on the risks related to refusing cares and treatment which prevented pressure sores. Findings include: 1. Interview on 4/15/14 at 7:55 a.m. with certified nursing assistants (CNA) C and D regarding resident 2 revealed their daily routine/schedule with him included: *They got him up for the day. -They allowed him time using the commode (portable toilet) which they were doing at this time. -They would leave him on the commode for a while which was his request. -He let them know when he was ready to get off the commode. This usually took quite awhile. *He would then be sat in his recliner. That would	F 314	F314 1. Resident #2's current plan of care for skin has been evaluated. A repositioning schedule, a circulating air mattress and a pressure relieving cushion to recliner were implemented on 4/15/14. Care plan was revised on 4/15/14. Pressure Ulcer was resolved on 5/6/14. All residents with risk of skin issues were reviewed on 5/5/14. 2. DNS will oversee pressure ulcer prevention program and wound management. A new weekly skin inspection form was implemented on 5/8/14. Directed In-service training provided by DNS to MDSC and nursing staff on 5/7/14 on frequent repositioning, use of appropriate pressure relieving devises, pain management, with open skin areas; and skin care and dietary interventions to promote healing and care plan updates related to skin care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15 be about all they would do, because he sat there most of the day. -He did not usually go back to bed during the day. Observations and interview of resident 2 on 4/15/14 revealed: *At 9:00 a.m. he was sitting in his recliner with a vinyl covered foam pad under him. -There was not a gel cushion in his chair. *He continued to sit on the recliner with the pad under him at 11:00 a.m., but he had slid down in the chair. *He verbalized his bottom was sore from sitting on it in the same position. *He denied laying down during the day and complained that he just sat there. *He stated he was never repositioned during the day to take pressure off his bottom. *At 11:25 a.m. his friend/former caregiver entered the room and stated: -He thought they should have used a different pressure relieving cushion such as an eggcrate cushion or a donut hole for him to sit on. -That would take the pressure off his bottom. -He had not considered the cushion he was currently sitting on effective in taking the pressure off his bottom. -He had talked to staff about that concern before, but there had been no changes. -The reason he had slid down in the chair had been because he was uncomfortable. -The resident agreed with his friend. Interview on 4/15/14 at 11:30 a.m. with CNAs C and D regarding resident 2 revealed: *He had developed a reddened area on his bottom (buttock) about two weeks ago that they had been watching. -It was now a sore on his buttock that the nurses	F 314 *QUARTERLY PERIODICALLY	3. DNS/designee will audit 3 residents with skin issues per week for one month, and then 2 residents per week for 1 month, and then 1 resident per week for 1 month. 4.. DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring	5-12-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 16 were now putting something on. *They had not changed their routine with him after they realized his bottom was sore. *They confirmed he sat in his recliner most of the day. *He was not laid down in bed throughout the day. -They knew he had not wanted to be laid down. *They had not moved him from side-to-side to get him off of his bottom. *They had not documented when he was repositioned or that he had refused to be repositioned when he was offered. *He had the same pad in his chair since he had been admitted on 10/9/13. Review of resident 2's faxed to the physician communication revealed: *On 4/11/14- "Resident has multiple open areas to buttocks -- cleaned and Allevyn applied --will change after bath 2x/week (two times per week). Will begin repositioning program and scheduled toileting. Also new gel cushion on order. Any other new orders?" -The fax was returned to the facility on 4/14/14 with a physician order that read "Ok as above." *On 4/11/14 the physician was notified the resident's Foley catheter (for bladder elimination) had been pulled out. The physician discontinued it at that time. Review of resident 2's April weekly skin assessments revealed: *On 4/3/14 he: -Was alert and oriented. -Had a Foley catheter. -Had a pressure relieving mattress (did not specify where or what type). -Was not on a turn and repositioning program. *On 4/10/14 there were no changes except the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 17 question regarding a repositioning program had changed to "Is the resident turned and repositioned frequently" and the answer was no. Review of resident 2's Minimum Data Set (MDS) observation tool used from 2/4/14 through 2/10/14 prior to the MDS assessment being completed revealed: *During the day, evening, and night shifts he was assisted by staff with bed mobility zero to one time. *On 2/6/14 he was assisted by staff twice during the night shift. *During the three shifts he was assisted with transfers zero to one time. *On 2/6/14 he was assisted three times on the evening shift. *Some areas were left unanswered. Review of resident 2's 2/13/14 pressure ulcer assessment revealed: *He was at risk for pressure ulcer development. *He had no existing pressure ulcers. *Risk factors included: -Immobility (lack of independent movement). -Altered mental status (occasional confusion). -Being on an antidepressant medication. -Diagnosis of diabetes, cancer, and dementia. -Was a new admission. -Had a Foley catheter. *The nurse identified the following considerations for the care plan decision included "[resident's name] is at risk or pressure ulcers. He requires an extensive assist of one for his bed mobility. He is also incontinent of his bowels and has a catheter for his urine. He has no skin breakdown at this time." Review of resident 2's 2/13/14 care plan	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 18 revealed: *On 11/9/13 a problem included "Toileting deficit and at risk for impaired skin integrity related to resident has a Foley catheter in place for urination and has a peg tube (tube inserted in stomach for feeding) with a dressing." *An intervention added on 2/26/14 revealed "has gel cushion in recliner and wheelchair at all times to prevent skin breakdown." *There were no repositioning interventions identified. Review of resident 2's 2/9/14 MDS assessment revealed he had been assessed for having been not at risk for pressure ulcers. Review of resident 2's mood and behavior flow sheets for February and March 2014 revealed he had not refused care necessary to achieve resident goals for health and well being. Interview on 4/15/14 at 4:15 p.m. with licensed practical nurse (LPN) H regarding resident 2 revealed: *One of her responsibilities was doing the weekly skin assessments. *He had not always allowed staff to lay him down during the day. -They did not have records of daily repositioning or if a resident refused to do that. *She was sure she had educated him on the risks of not being repositioned, and there was no documentation of those discussions. *She agreed the assessments of refusals which had been completed prior to the MDS would not have been accurate. *Occupational therapist (OT) H was the person who completed all the positioning assessments.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 19 Interview on 4/15/14 at 5:50 p.m. with OT H regarding resident 2 revealed she: *Had not worked with him since December when he had returned from a hospitalization. -In December she worked with him on transfers, standing endurance, and dressing. -He had not been sitting as much during that time. *Had not received any recent referrals to evaluate him for positioning with these changes. *Would never have recommended the cushion he currently had in his chair, because it was not effective when someone was sitting up as much as he was. -That type of cushion became flat, because the foam broke down after a period of time and would then offer no pressure relief. -She had no idea where the cushion came from. Interview on 4/16/14 at 9:40 a.m. with the director of nursing regarding resident 2 revealed: *A repositioning schedule should have been put in place when the skin breakdown was first identified. *They should have documented when he refused care and the discussions they had with him regarding risks of refusing to be repositioned. *She was unaware they even had the type of pressure relieving cushion he had in his chair. *She thought those old cushions must have been in storage, and staff must have found them. *She was unsure of what type of cushion he currently had in his chair. Review of the provider's undated Pressure Ulcer Prevention Program guidelines revealed the components of the program included: "1. Comprehension evaluation of the resident's clinical condition and pressure ulcer risk factors	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 20 at admission and as required throughout the resident's stay. 2. Recognition of any risk factors identified on the comprehensive assessment. 3. Evaluation of the individual risk factors and determination, based on clinical judgment, selection of interventions to stabilize, reduce or remove the underlying risk factors identified on the assessment(s). 4. Monitor the effects of the interventions and modify the interventions when indicated. 5. Re-assessment of the individual's pressure ulcer risk factors as required. 6. Education program includes pressure ulcer prevention, the assessment and treatment of pressure ulcers."	F 314		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, policy review, and manufacturer's operating manual review, the provider failed to disinfect two of two whirlpool bathtubs according to the manufacturer's recommendations. Findings include: 1. Observation on 4/15/14 at 9:55 a.m. of certified nursing assistant (CNA) F cleaning the third floor whirlpool bathtub revealed she followed the directions posted on the tub room wall for the Apollo whirlpool bath cleaning process. She: *Placed the bath chair in the tub, closed the door, and sealed the tub drain. *Turned the tub selector knob to "tub cleaner," which contained a solution of Turbo-Clean (a pre-disinfectant). *Turned the whirlpool on to allow the cleaning solution into the tub well.	F 441	F441 1. New cleaning and disinfecting guidelines were posted on 5/8/14 ensuring cleaning and disinfecting of the whirlpool tub for all residents use. 2. The cleaning schedule and disinfecting guidelines were reviewed/revised ensuring manufacturer guidelines are being followed on 5/5/14. Nursing staff have been re-educated by the DNS on 5/7/14 on whirlpool cleaning and disinfecting guidelines. 3. DNS/designee will audit 5 aides for cleaning and disinfecting whirlpool tub procedures per week for one month, and then 3 aides for cleaning and disinfecting whirlpool tub procedures per week for one month. 4. DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.	5-9-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 *Turned the control knob to "off," lifted the seat bottom off the chair, and scrubbed the tub, chair, and underneath the seat bottom. *Opened the tub drain. *Turned the selector knob to "rinse." *Turned the whirlpool on until clear water came out of the jets. *Shut off the jets and used the shower wand to rinse the tub and shower chair. Interview at that time with CNA F revealed: *She used the whirlpool tub cleaner to clean the tub between each resident. *She disinfected the whirlpool tub using Cid-A-L II once daily, only after the last bath. *She did not disinfect the whirlpool tub between each resident. 2. Observation on 4/15/14 at 10:05 a.m. of CNA G cleaning the second floor whirlpool bathtub revealed she followed the directions posted on the tub room wall for the Apollo whirlpool bath cleaning process. She: *Placed the bath chair in the tub, closed the door, and sealed the tub drain. *Turned the tub selector knob to "tub cleaner," which contained a solution of Turbo-Clean. *Turned the whirlpool on to allow the cleaning solution into the tub well. *Turned the control knob to "off," lifted the seat bottom off the chair, and scrubbed the tub, chair, and underneath the seat bottom. *Opened the tub drain. *Turned the selector knob to "rinse." *Turned the whirlpool on until clear water came out of the jets. *Shut off the jets and used the shower wand to rinse the tub and shower chair.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435126		04/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 Interview at that time with CNA G revealed: *She used the whirlpool tub cleaner to clean the tub between residents. *She disinfected the whirlpool tub using Cid-A-L II once daily, only after the last bath. *She did not disinfect the whirlpool tub between each resident. 3. Review of the December 2010 Apollo Advantage Bathing System operating manual revealed the whirlpool tub was to have been cleaned and disinfected before bathing each resident. Review of the provider's April 2012 Policy for General Cleaning and Maintenance of Equipment revealed equipment would be cleaned and decontaminated according to the manufacturer's recommendation. Interview on 4/16/14 at 1:30 p.m. with the director on nursing revealed her expectation was the whirlpool tub was to have been disinfected according to the manufacturer's recommendations.	F 441		

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

ORIGINAL

PRINTED: 04/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	435126		**04/15/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIOLET TSCHETTER MEMORIAL HOME	**50 SEVENTH ST SE POST OFFICE BOX 946** **HURON, SD 57350**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/15/14. The Violet Tschetter Memorial Home was found in compliance with 42 CFR Part 483.70(a), requirements for Long Term Care Facilities.	K 000		

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

Jessica Spencer Executive Director 5-13-14

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.

MAY 15 2014
SD DOH L&C