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

ORIGINAL

PRINTED: 08/27/2015
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
	43A136		08/19/2015

NAME OF PROVIDER OR SUPPLIER
MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
2500 MINNEKAHTA AVENUE
HOT SPRINGS, SD 57747

(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	F 000		
	Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/18/15 through 8/19/15. Michael J Fitzmaurice South Dakota Veterans Home was found not in compliance with the following requirements: F241, F252, F280, and F281.			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation and interview, the provider failed to ensure dignity had been maintained for all residents using the toilet and handwashing facilities in all fifty-two residents' rooms. Findings include: 1. Random observations from 8/18/15 through 8/19/15 of all fifty-two resident room toilet and handwashing sink areas revealed those areas could only be separated by a privacy curtain from the remainder of the resident room. Interview on 8/19/15 at 10:00 a.m. with the physical plant manager confirmed resident rooms had been remodeled in 1996. The closet walls had been removed to make room for the addition of a sink and toilet in every resident room. Toilet	F 241	Dignity and respect of individuality- [1]The SD Veterans Home will provide corrective action for deficiency (re: Dignity and Respect of Individuality) all fifty-two resident room toilet and handwashing sink areas revealed those areas could only be separated by a privacy curtain from the remainder of the resident room. Staff will provide increased privacy and acknowledge dignity with the use of the toilet by the privacy curtain and close the door to the resident room. [2]To ensure the Veterans Home identifies other residents having the potential to be affected by the same deficiency practice all staff will be educated by 9/11/15 what constitutes dignity especially with personal care and toileting, and the planned use of privacy curtains and closed door. [3]The facility is undergoing a new structure building project that is planned for completion with a set move in date of 11/2015. This new facility will ensure this deficiency will not reoccur. The bathrooms will be enclosed within each resident room and have doors for privacy. [4]The DON or designee will monitor daily for compliance and re-educate staff in the event of non-compliance. Monitoring results will be shared with monthly QAPI to ensure sustainability. [5]Corrective action will be completed by 09/30/15	09/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Superintendent — (X6) DATE: 9/8/15

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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MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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F 241	Continued From page 1 and sink walls were not rebuilt due to federal resident room area square footage requirements.	F 241		
F 252 SS=B	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation and interview, the provider failed to maintain a homelike environment for all residents residing in the facility. Exposed plumbing, exhaust and return air piping, and cable runs were visible in the ceilings and along the walls in corridors, residents' rooms, and resident use areas. Findings include: 1. Random observations from 8/18/15 through 8/19/15 revealed corridors, residents' rooms, and resident use areas had plumbing, exhaust and return air piping, and cable runs visible in the ceilings and along the walls. Interview on 8/19/15 at 10:00 a.m. with the physical plant manager confirmed he was aware of the visible piping, venting, and cable runs. The building had been in that condition before he had started at the facility. At one time he had looked into putting in a false ceiling, but then the rooms would not have met the room height requirements.	F 252	Safe/clean/comfortable/homelike/environment- [1]To address this deficiency (re: F 252 Safe/Clean/ Comfortable/ Homelike/ Environment) the provider proposes to construct a replacement facility which has already begun and is slated for completion in 11/2015. [2]The Veterans Home identifies other residents that have the potential to be affected by the same deficiency by the architect has addressed the exposed piping and ductwork by concealing these items within the walls and above ceilings. [3]To ensure the deficient practice does not recur the replacement building will meet all construction requirements to participate as a Medicare/Medicaid certified nursing home. [4]Facility will be maintained under current SOP, with performance standards enforced and sustained by the DON and/or designee. Evaluation measures for corrective actions will be integrated into QAPI and reviewed monthly to ensure sustainability. [5]Corrective action will be completed when new facility is complete.	09/30/2015
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280	Participate Planning Care Revise- [1]Correcitve action has been accomplished for deficiency (re: F 280 The Right to Participate Planning Care- Revised CP) residents 11 and 12 care plans were not updated and revised to reflect current status. As of 09/01/15 those resident's care plans have been reviewed and revised to reflect their current status.	09/30/2015

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Continue from page 2

F 280 Continued From page 2
SS=D 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: 34030

Surveyor: 32573
Based on observation, interview, record review, and policy review, the provider failed to update and revise care plans for 2 of 12 sampled residents (11 and 12) to reflect their current status. Findings include:

Surveyor 34030
1. Review of resident 12's 6/9/15 physician's orders revealed an order for fluid restriction of "1500 milliliters (ml) per day."

F 280 [2]To ensure the SD Veterans Home identifies other residents that have the potential to be affected by the same deficiency all residents have the right to participate in their own care plan to maintain accuracy and reflect their actual care status, and quarterly audits of resident care plans ensuring the provider updates and revises the care plan. [3]The systemic changes that have been made at the SD Veterans Home to ensure that the deficiencies will not reoccur are; review and update of the Team Care Conference and Team Care Creation policy includes resident and family participation in the team care conference by 09/30/15. Nursing and dietary staff will receive education regarding the importance of residents/family participating in care planning creation and maintaining the care plans as goals and interventions change on the active document, by 09/30/15. [4]The MDS Coordinator will perform monthly chart audits to ensure compliance with this deficiency and report to the DON. These audits will be monitored by the DON who will report monthly to QAPI, to ensure sustainability. [5]Corrective action will be completed by 09/30/15.

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F 280	Continued From page 3	F 280		
	Review of resident 12's medical records revealed: *Diagnoses of congestive heart failure and edema (too much fluid in the body that decreases the heart's ability to function.) Review of his 6/25/15 care plan revealed: *"3/31/15. Problem with dehydration and fluid volume deficit." -"Nurses...encourage fluid intake. Provide fluids consistently throughout the day. *"3/31/15. Related to: inadequate fluid intake." -"Nurse aide...offer fluids frequently..." Interview on 8/19/15 at 5:00 p.m. with registered nurse D regarding resident 12 revealed: *The resident was moved to their floor two months ago. *Nursing staff were aware of the orders for the fluid restriction from the transfer information given to them. *Record was kept of the resident's fluid intake at meals. He was not given any fluid in his room. *He rarely drank the total amount of fluid allowed. Resident 12's care plan had not been updated to reflect the change in orders on 6/9/15. Surveyor 32573 2. Review of resident 11's 8/3/15 physician's orders revealed an order for fluid restriction of "4 ounces milk and continue restriction of 1500 milliliters (mL) per day." Review of his 6/9/15 care plan revealed: *A problem manifested (shown) by "non compliant of 1800 mL fluid restriction." *The approach of complying with fluid restriction as ordered.			

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NAME OF PROVIDER OR SUPPLIER: MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 2500 MINNEKAHTA AVENUE, HOT SPRINGS, SD 57747

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F 280	Continued From page 4 "A goal of "respect fluid restrictions." Resident 11's care plan had not been updated to reflect the change in orders on 8/3/15. 3. Review of the 8/14/14 Comprehensive Care Planning policy revealed: *Updates to the electronic and paper care plan will be made by the IDT or nurse when a change in care or treatement occurs. *The unit supervisor was responsible for all changes in treatment plan and to ensure that information was relayed to the nurse assessment coordinator. Interview on 8/19/15 at 3:00 p.m. with the director of nursing revealed staff would have been expected to follow the physician's orders. The care plan should have been updated to reflect the most current orders.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure professional standards had been maintained for the following: *One of four observations of medication administration by 1 of 3 certified medication aides (CMA) A had pre-signed the medication administration record (MAR).	F 281	[1]The SD Veterans home will provide corrective action for the deficiency (re: F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS) 1 of 3 certified medication aides had pre-signed the medication administration record, prior to administering the medication to the resident. CMA A and other staff responsible for medication to the residents will review the Medication Administration policy dated 06/20/14, and sign off that they have read and understood the policy. The DON will retain all educational sign in roosters and training documentation related to this survey. [2]To ensure the SD Veterans Home identifies, and ensure all providers who may have the potential of be affected by the same deficiency, the Assistant Director of Nursing is requiring all Med Aids and Nursing staff will be re-educated by 09/30/15. [3]To ensure this deficiency does not reoccur the SD Veterans Home will implement a monthly monitoring medication administration checklist to be used by all nursing staff. [4]The DON or designee will monitor the data collected and staff will receive additional education as needed, and will report monthly to QAPI to ensure the corrective action is achieved and sustained. [5]Corrective action will be completed by 09/30/15.	09/30/2015

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F 281	Continued From page 5 *Notification of condition change for 1 of 12 sampled residents (2). Findings include: 1. Observation and record review on 8/18/15 at 11:40 a.m. revealed CMA A had signed the MAR prior to administering the medication to resident 16. Interview on 8/19/15 at 3:50 p.m. with registered nurse (RN) B confirmed that pre-signing of the MAR was not the facility's practice. Review of the provider's 11/03/05 Medication Administration policy revealed: *"Professional standards require that after the nurse (medication aide) administers the medication, the MAR is completed per policy to verify the medication was given as ordered." *"After administering a medication, the nurse records it immediately on the appropriate MAR. The nurse never charts a medication before administering it." 2. Review of resident 2's medical record revealed: *He had been admitted on 6/10/14. *He had diagnoses of: -Dementia (altered thought processes). -Parkinson's disease (movement disorder). -History of subdural hematoma (blood clot in brain). -History of seizures. -Adult failure to thrive. *He had fallen on 8/9/15 at 10:05 p.m. -His vital signs at that time had been within the normal ranges of 118/70. -The next morning his blood pressure had been 80/40 (that had not been his normal range).	F 281	Item #2 Review of the Providers notification and/or Family policy reveals: [1] While the SD Veterans Home cannot correct the documentation of resident 2. The SD Veterans Home will accomplish corrective action for those residents found to be affected by deficient practice(re: F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS) the provider (physician), resident and resident's legal representative/family member not being notified of any significant change as well as any further re-evaluation assessments being documented; the SD Veterans Home nursing staff will notify by electronic means or by phone the provider (physician), resident and resident's legal representative/family member of any significant change including, but not limited to abnormal vital signs. [2]To ensure the SD Veterans Home identifies other residents that have the potential to be affected by the same deficiency, documentation of condition, physician/family notification and new physician orders will be completed per policy. [3]To ensure corrective action is sustained and the issue does not occur again, the nursing staff will be re-educated on abnormal vital sign parameters and on the notification of physician procedures as well as following facility policy documentation standards by 09/30/15. [4]The DON or designee at the Veterans Home will monitor the data collected and report monthly to QAPI, to ensure sustainability of the corrective action. [5]Corrective action will be completed by 09/30/15.	09/30/2015

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F 281	Continued From page 6 -There had been no monitoring of his blood pressure until the next day. -There had been no reporting of the abnormal blood pressure to the physician. Review of the provider's 6/16/14 Notification of Provider and/or Family policy revealed: *"The provider [physician], resident, and resident's legal representative/family member will be notified for the following conditions/issues: -A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications)." *"Notification of the provider [physician] and resident's legal representative or interested party must e notified immediately of any significant event including, but not limited to: -Significant injury. -Deterioration of condition." Interview on 8/19/15 at 2:30 p.m. RNs B and C confirmed re-evaluation of the blood pressure should have been assessed. They stated the physician should have been notified of the abnormal blood pressure finding. At 3:40 p.m. that same day RNs B and C reviewed the medical record and confirmed there had been no further documentation of blood pressure assessments.	F 281		

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	43A136		08/19/2015

NAME OF PROVIDER OR SUPPLIER: MICHAEL J FITZMAURICE SOUTH DAKOTA VETERANS HOME

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K 000	INITIAL COMMENTS	K 000		
	Surveyor: 32334 A licensing survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/19/15. The Michael J. Fitzmaurice South Dakota Veterans Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/20/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.			
K 034 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4	K 034		
	This STANDARD is not met as evidenced by: Surveyor: 32334 Based on measurement, observation, and interview, the provider failed to maintain two of two conforming exit stairs (northwest and southwest) with the correct tread depths and riser heights. Findings include: 1. Observation and measurement at 9:45 a.m. on			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Fernandez
TITLE: Superintendent
(X6) DATE: 9/8/15

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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K 034	Continued From page 1 8/19/15 revealed the tread height and depth for the northwest and southwest stair enclosures were nine inches for the risers and nine and one half inches for the treads. Those steps were not consistent in tread width and riser height. Interview at the time of the observation with the physical plant manager revealed that condition had existed since the stair enclosures had been constructed. Review of the last survey conducted on 5/20/14 confirmed that condition existed. The building meets the FSES. Please mark an "F" in the completion date column.	K 034	Life Safety Code Standard- FSES – Building scheduled for demolition Dec 2015.	F
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, interview, and record review, the provider failed to maintain sprinklers for the main entrance. Sprinkler coverage did not extend out to the combustible canopy. Findings include: 1. Observation at 8:45 a.m. on 8/19/15 revealed the automatic sprinkler protection did not extend into the attached canopy at the front (main) entrance. The canopy was approximately 15 feet by 150 feet. It was constructed of 1 foot by 8 foot planks and heavy timber supports/beams, and had a metal roof. Interview at the time of the	K 062	Life Safety Code Standard- Building will be vacated Nov 10 and demolition scheduled for Dec 2015.	F

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K 062	Continued From page 2 observation with the physical plant manager revealed that condition had existed since the porch with attached canopy had been constructed. Review of the last survey conducted on 5/20/14 confirmed that condition existed. The facility meets the FSES. Please mark an "F" in the completion date column to indicate the facility's intent to correct the deficiencies identified in K000.	K 062		

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NAME OF PROVIDER OR SUPPLIER: MICHAEL J FITZMAURICE SOUTH DAKOTA VE

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S 000	Initial Comments Surveyor: 32572 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/18/15 through 8/19/15. Michael J. Fitzmaurice South Dakota Veterans Home was found not in compliance with the following requirements: S210, S236, and S301.	S 000		
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 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. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 34030 Based on employee file review, interview, and policy review, the provider failed to ensure one of five newly hired sampled employees (E) was evaluated by a health professional to determine	S 210	[1]Corrective action has been accomplished for the deficiency (re: S210 Employee Health Program) provider failed to ensure one of five newly hired sampled employees was evaluated by a health professional to determine employee was free from reportable communicable diseases, as of 09/01/15 employee E and all current employee records were brought into compliance. [2]The SD Veterans Home will identify other employees having the potential to be affected by the same deficiency by ensuring all new employees receive and complete the health screening and TB testing documentation forms from the nursing department and the human resource department on their first day of employment. [3]The systemic changes that will be made to ensure the deficiency does not occur and will require all new employee documentation be submitted to the DON for review within 14 days of hire. Health issues identified will be forwarded to the medical director for further review. The Employee Health Program policy will be updated by 09/30/15. [4]To ensure that the corrective action is achieved and sustained the DON will monitor the data collected and report monthly to QAPI. [5]Corrective action will be completed by 09/30/15.	09/30/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Richardson | TITLE: Superintendent | (X6) DATE: 9/8/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10523		08/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHAEL J FITZMAURICE SOUTH DAKOTA VE	2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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S 210	Continued From page 1 she was free from a reportable communicable disease. Findings include: 1. Review of employee E's employee file revealed: *She had been employed since 6/24/15. *She had not been evaluated by a health professional to determine she was free from a reportable communicable disease. Interview on 8/19/15 at 5:00 p.m. with the assistant director of nursing revealed: *The director of nursing was presently out of the building, and they were unable to access the necessary information before the end of this survey. *She agreed the health evaluation should have been done on every employee. Review on 8/24/15 of information later provided by the facility revealed no health evaluation on employee E had been done. Review of the provider's 9/1/10 Employee Health Program policy revealed: *"To determine that all new employees are free from any communicable diseases, each employee will receive a health screening following the offer and acceptance of employment at the [name of facility]." *"This screening will be completed before assignment or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests." *"The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease."	S 210		

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NAME OF PROVIDER OR SUPPLIER: MICHAEL J FITZMAURICE SOUTH DAKOTA VE

STREET ADDRESS, CITY, STATE, ZIP CODE: 2500 MINNEKAHTA AVENUE, HOT SPRINGS, SD 57747

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S 236	Continued From page 2	S 236	[1]Corrective action has been accomplished for the deficiency (re: S210 Employee Health Program) provider failed to ensure one of five newly hired sampled employees was evaluated by a health professional to determine employee was free from reportable communicable diseases, as of 09/01/15 all current employee records were brought into compliance. [2]The SD Veterans Home will identify other employees having the potential to be affected by the same deficiency by ensuring all new employees receive and complete the health screening and TB testing documentation forms from the nursing department and the human resource department on their first day of employment. [3]The systemic changes that will be made to ensure the deficiency does not occur and will require all new employee documentation be submitted to the DON for review within 14 days of hire. Health issues identified will be forwarded to the medical director for further review. The Employee Health Program policy will be updated by 09/30/15. [4]To ensure that the corrective action is achieved and sustained the DON will monitor the data collected and report monthly to QAPI. [5]Corrective action will be completed by 09/30/15.	09/30/2015
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS	S 236		

Tuberculin screening requirements for healthcare workers or residents are as follows:

(1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed 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;

This Administrative Rules of South Dakota is not met as evidenced by:
Surveyor: 34030
Based on employee file review, interview, and policy review, the provider failed to ensure one of five newly hired sampled employees (E) received the second half of the two-step Tuberculin (TB) screening within two weeks of employment. Findings include:

1. Review of employee E's employee files revealed:
*She had been employed since 6/24/15.
*At the time of this survey no record existed regarding her TB test.

South Dakota Department of Health

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S 236	Continued From page 3 Review of information later provided by the facility revealed: *She received the first TB test on 6/18/15. *The second test had not been done. *There had been no documention of a TB test completed within the last year. Interview on 8/19/15 at 5:00 p.m. with the assistant director of nursing revealed: *The director of nursing was presently out of the building, and they were unable to access the necessary information before the end of this survey. *She agreed the two-step TB screening should have been done on every employee. Review of the provider's 9/1/10 Employee Health Program policy revealed "Each new employee shall receive the two-step method of Mantoux [TB] skin test to establish a baseline within 14 days of employment."	S 236		
S 301	44:04:07:16 Required dietary insevice training The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing inservice 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 Administrative Rules of South Dakota is not	S 301	[1]To ensure the Veterans Home will provide corrective action for those employees found to have been affected by (re: S301 Required Dietary In-service Training) the Food Service Director has reviewed all current employee in-services to identify the missing in-services, and has scheduled in-service training to all employees for 09/30/15. [3] Systemic changes made to ensure the deficient practice does not reoccur; Food Service Director is requiring all employees to read and sign off on policy and procedure manuals, which include the nine required dietary in-services on an annual basis. [4]To ensure the corrective action is achieved and sustained; the Food Service Director will monitor and observe staff's sign off sheets to ensure each staff member is up to date with in-services. The Food Service Director will monitor the data collected and report quarterly to QAPI. [5]Corrective action will be completed by 09/30/15.	09/30/2015

South Dakota Department of Health

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STREET ADDRESS, CITY, STATE, ZIP CODE: 2500 MINNEKAHTA AVENUE HOT SPRINGS, SD 57747

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S 301	Continued From page 4 met as evidenced by: Surveyor: 34030 Based on record review and interview, the provider failed to ensure four of nine required annual in-service training sessions (food handling and preparation techniques; serving and distribution procedures; leftover food handling policy; and time and temperature controls for food preperation [prep] and service) had been completed for all food handling staff. Findings include: 1. Record review and interview with the assistant dietary manager of the dietary in-services from the past year revealed: *Five of the required in-services had been done. *She was unaware of the requirements of all nine inservices needing to be completed annally. *She agreed not all of the required in-services had been covered. A policy about required in-service education for dietary and food handling staff was requested from the assistant dietary manager, but was not received by the end of the survey.	S 301		