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

ORIGINAL

PRINTED: 06/04/2015
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
	435126		05/28/2015

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	F 000		
	Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/26/15 through 5/28/15. Violet Tschetter Memorial Home was found not in compliance with the following requirements: F241 and F363.			
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.	F 241		
	This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure dignity had been provided for three of three observed residents (9, 11, and 13) who required assistance with eating in the main dining room during two of two observed meals. Findings include: 1a. Observation on 5/27/15 from 11:30 a.m. through 12:45 p.m. in the dining room revealed: *At 11:30 a.m. staff had been assisting residents into the dining room and placed the residents at tables. *Meal tray service had begun at 12:13 p.m. *At 12:20 p.m.: -Residents 11 and 13 were at the dining room table. Each resident had the food and beverages placed in front of them.		F241 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by	

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

Jessica Spencer — Executive Director — 6/12/15

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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F 241	Continued From page 1 -There were three female residents seated at resident 11 and 13's table. They had not received their food. *From 12:21 p.m. through 12:28 p.m.: -Resident 11 took her left hand second digit and wiped the plate, then placed her finger into her mouth. She continued doing this with no staff member assisting her during the above time frame. -Resident 13 picked up the blended fish from her plate and placed it on the table, then placed her finger in her mouth and licked it. Next she picked up the dessert in the plastic cup and placed it to her mouth and attempted to eat from the dish. Her silverware remained wrapped in a napkin beside her plate. No staff member assisted her during the above time frame. -During the above time an unidentified certified nursing assistant (CNA) had been seated at a table next to residents 11 and 13. The CNA had not assisted residents 11 or 13 with their meal. -During that time several staff members were passing trays to other residents. No one had stopped to assist residents 11 and 13. *At 12:44 p.m. the three other residents at resident 11 and 13's table received their meal. Observation on 5/27/15 from 5:10 p.m. through 6:03 p.m. in the dining room revealed: *At 5:55 p.m.: -Resident 13 received her meal. An unidentified CNA had assisted resident 13 with tray set-up and then left. -The three other female residents at the table received their meal trays. -Resident 11 had not received her meal tray. *During the above time frame CNA E sat down at resident 13's table and assisted other residents. *At 6:03 p.m.:	F 241	provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to 1. Residents #9, 11 and 13 are being served and assisted the same time as others at the dining table. Employee D was re-educated on 6/10/15 & E was re-educated on 6/12/15 regarding assisting residents at the time food is served to them. 2. Dining service and each resident was reviewed for meal service and assistance in addition to all served as others at the table. Dining service and notification to dietary has been reviewed/revised to assure residents are served timely and with others at the table. 3. Meal times were reviewed and may be adjusted to meet the increased needs of those needing assistance. Proposed start	

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F 241	Continued From page 2 -Resident 11 had her dietary card in her hand. -Registered nurse (RN) F came over to the table and remarked to CNA E resident 11 had not received her meal. -CNA E stated "I know." -RN F looked at resident 11's hand and found the dietary card. RN F took the dietary card and left the table. -At 6:05 p.m. resident 11 was served her meal. b. Review of resident 11's medical record revealed: *A diagnosis of Alzheimer's dementia (memory impairment). *The quarterly Minimum Data Set (MDS) assessment revealed: -She had short and term memory impairment. -The cognitive skills for daily decision making was coded severe impairment (never/rarely made decisions). -She had disorganized thinking and inattention. -She required set-up assistance with her meal and supervision. -The Brief Interview for Mental Status (BIMS) assessment had not been completed. *The nursing assistant care plan revealed she required set-up assistance at meal times. *The 3/11/15 care plan revealed: -An activities of daily living (ADL) deficit and required staff assistance for her ADLs. Goal: would continue to have her needs and wants met by staff. Set-up assistance with supervision: eating. -Potential for altered nutrition due to her Alzheimer's. Goal: would maintain her ability to eat independently after set-up assistance. Ate independently after set-up. c. Review of resident 13's medical record	F 241	times would include lunch service moving from 11:30am to 12:00pm and supper moving from 5:00pm to 5:30pm to ensure staff are present to assist with those residents needing individual help. Staff will be re-educated on 6/15/15 & 6/17/15 regarding dining service, serving all individuals at a table, assisting those in need at the time food is served, by defining and giving examples of dignity and including demonstration of dignity areas. 4. DNS/designee will audit four meals per week (varying meals) for one month then three meals per week for two months for meal service, all residents served at a table and those needing assistance are assisted at the time their food is served.	

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F 241	Continued From page 3 revealed: *A diagnosis of dementia. *Review of the annual 1/20/15 and quarterly 4/14/15 MDS assessments revealed: -1/20/15 MDS revealed she had short and long term memory impairment. She required set-up assistance with supervision for eating. -4/14/15 MDS revealed she had short and long term memory impairment. She required limited assistance and needed one person physical assistance with eating. *The nursing assistant care plan revealed she required the assistance of one for eating. *The 3/11/15 care plan revealed she required set-up assistance with supervision for eating. d. Interview on 5/27/15 at 6:05 p.m. with CNA E revealed resident's 11 and 13 required assistance with eating. Interview on 5/28/15 at 10:15 a.m. with the director of nursing regarding meal time revealed: *She recognized there was a problem with meal time. *They had looked into other options for meal time. *The CNAs did not come down to the dining room until they were done assisting residents on second and third floor. *Her expectations were: -For a CNA or nurse to be present in the dining room before meal service began. -For a CNA at other tables to monitor other tables where residents might have needed assistance. -She confirmed the facility used the How to Be a Nurse Assistant student handbook to educate CNAs on how to assist residents with eating. -They did not have a policy on feeding dependent residents.	F 241	5. The data collected will be presented to the Quarterly Quality Assurance committee by the DNS. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.	7-10-15

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F 241	Continued From page 4 Surveyor: 32331 2. Review of resident 9's medical record revealed: *Diagnoses that included Alzheimer's disease (memory impairment) and memory loss. *The quarterly 3/24/15 MDS assessment revealed: -She had short and long-term memory impairment. -The cognitive skills for daily decision making was coded severe impairment. -She required extensive assistance with eating with one person physical assistance. *The 3/25/15 care plan revealed she was: -Dependent on staff assistance of one with meals. -Her needs were to have been anticipated and met throughout the day. Observation on 5/27/15 from 6:01 p.m. through 6:08 p.m. of resident 9 in the dining room revealed: *At 6:01 p.m. she received her evening meal at her table in the main dining room *At 6:05 p.m. CNA D started to assist her with eating. *At 6:06 p.m. and at 6:08 p.m. CNA D wiped the resident's mouth with the bottom of her clothing protector. *Napkins had been available at her table. 3. Review of the provider's 2010 Dining and Food Service policy revealed the dining experience would have enhanced the individual's quality of life and would be supportive of the individual's needs during dining. Surveyor: 29354	F 241		

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F 241	Continued From page 5 Review of the provider's 4/7/12 Dignity policy revealed: *"Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. -Residents shall be treated with dignity and respect at all times. -Staff shall treat cognitively impaired residents with dignity and sensitivity." Review of How to Be a Nurse Assistant, student handbook, 5th Ed., page 326, revealed: *"Assisting Resident with Meals: -Encourage residents to feed themselves as much as possible. -Serve all residents at one table before moving to the next. -Check with residents frequently to offer assistance or substitutes for foods they are not eating." Review of the Long-Term Care Facilities Resident's Bill of Rights provided to new resident's in the admission packet, page 8, revealed: *"You are entitled to quality of life. A facility must provide care and an environment that contributes to your quality of life including: -Maintenance or enhancement of your ability to preserve individuality, exercise self-determination and control every day physical needs."	F 241		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National	F 363		

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F 363	Continued From page 6 Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, record review, interview, and policy review, the provider failed to follow the written menu's portion sizes correctly at: *Two of three observed meals for all residents on oral diets. *Three of three observed meals for residents on pureed diets. Findings include: 1. Observation and review of the written menu on 5/27/15 from 12:00 noon through 12:30 p.m. at the noon meal in the kitchen revealed cook A: *Served one-fourth cup of the pea salad for all residents that received the salad. -The written menu for that item was to have been one-half cup for the regular/NAS (no added salt), house mechanical soft (softer-type foods), limited concentrated sweets, and NIP (nutrition intervention program) diets, one-third cup for smaller servings, and three-eighth of a cup for the pureed diets. *Had not served any bread for that meal. -The written menu for that item was to have been one slice for the regular/ NAS, house mechanical soft, limited concentrated sweets, NIP diets, one-half slice for smaller servings, and a number twenty scoop size (approximately three tablespoons) for the pureed diet. *Both the pea salad and the bread portions were not followed and served per the written menu for SS [Spring/Summer] 2015. *At no time during the above observation time	F 363	F363 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusion set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to 1. Employee A was re-educated on 6/12/15 and Employees B & C were re-educated on 6/11/15	

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F 363	Continued From page 7 was the written menu observed to be reviewed by cook A. Interview on 5/27/15 at 12:20 p.m. with cook A revealed: *He had forgotten to serve the bread portions. *Bread had not been prepared to be served for that meal service. 2. Observation and review of the written menu on 5/27/15 from 5:20 p.m. through 6:00 p.m. with cook B at the evening meal in the kitchen revealed: *Six ounces (oz) of the three bean soup with ham was served for all residents that received the soup. -The written menu for that item was to have been eight oz for the regular/NAS, house mechanical soft, limited concentrated sweets, NIP, and pureed diets. Four oz was supposed to be served for smaller servings. *The soup portions were not followed and served per the written menu for the above meal. *At no time during the above observation time was the written menu observed to be reviewed by cook B. 3. Observation and review of the written menu on 5/28/15 from 7:58 a.m. through 8:45 a.m. with cook C at the breakfast meal in the in the kitchen revealed: *Two tablespoons of hash browns were served for residents on pureed diets. -The written menu for that item was to have been one-fourth cup for the pureed diets or a number twenty scoop (approximately three tablespoons) for a pureed with small servings. -A one-fourth cup measurement contained four tablespoons.	F 363	regarding following the menus for serving size, food on the menu and right consistency. 2. Meal service including portion size, menu items and consistency are being observed to assure residents receive the accurate meal. 3. Dietary staff will be educated on 6/15/15 & 6/17/15 regarding following the menu, serving size and consistency of food. Menus with extensions will be posted directly at the serving site for dietary staff to follow. 4. CDM/designee will monitor and audit five meals per week for two months and then three meals per week for 1 month. Monitoring and auditing will include: menus with extensions are used at each meal service, serving size is accurate, food served follows the	

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F 363	Continued From page 8 *The hash brown portions were not followed and served per the written menu for the above meal. *At no time during the above observation time was the written menu observed to be reviewed by cook C. 4. Interview on 5/28/15 at 10:10 a.m. with the certified dietary assistant regarding the food portions sizes and the written menu revealed: *She agreed the menu needed to have been followed as written. *She stated any deviation from the written menu for each resident needed to have been documented on the menu cards. *She stated the portions had not been consistently served to those residents that received them. *The serving staff needed to have referred to the posted written menu for the correct portion sizes to have been served. Interview on 5/28/15 at 11:40 a.m. with the director of nursing (DON) and the administrator revealed: *They agreed the written menu needed to have been followed for the correct food portion sizes to have been served. *The DON stated there had been residents with weight loss in the facility. Review of the provider's 5/26/15 Weight Summary Report revealed there had been sixteen out of forty-eight residents that had significant weight loss (a weight loss of five percent (%) or more in thirty days or a loss of ten % or more in six months) during the time frame of 12/30/14 through 5/26/15. Review of the provider's 2010 Accuracy of Diet	F 363	menu and consistency is accurate for each resident. 5. The data collected will be presented to the Quarterly Quality Assurance committee by the CDM/designee. It will be reviewed/discussed and at this time the QA committee will make the decision/recommendation regarding follow-up or changes.	6-30-15

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F 363	Continued From page 9 and Supplements Ordered policy revealed the facility staff were trained to carefully prepare and serve each individual's meals. Review of the provider's 2010 Menu Planning policy revealed the nutritional needs of individuals would be provided in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. Review of the provider's 2010 Accuracy and Quality of Tray Line Service policy revealed: *All trays were to have been checked by food service personnel for accuracy. *Trays were also to have been checked by the employees serving the trays before those trays were to have been given to the residents. *The menu extension sheet displayed food items and amounts for each kind of diet. -The tray was to have been checked against that above sheet to ensure that food was served as listed on the menu. *Each tray was to have been checked for proper portion sizes. *The food service manager or designee was responsible to ensure all foods needed were present at the time of tray assembly. Review of the provider's undated Portion Control policy revealed: *The menu listed the specific portion size for each food item. *Menus should have been posted at the trayline for staff to refer to for proper portioning of servings for each diet. *Serving too small of portions might result in residents not receiving the nutrients needed. *Dietary staff were to have been instructed by the	F 363		

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F 363	Continued From page 10 dietary professional on portion sizes. *Meal observations for quality control of portion sizes were to have been conducted by the dietary professional on a routine basis.	F 363		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/27/15. Violet Tschetter Memorial 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 upon correction of deficiency identified at K029, K050, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of one of four hazardous areas in one randomly observed area (kitchen pantry). Findings include:	K 029	K029 1. The kitchen pantry storage door was corrected by installing a self-closing device. 2. Facility walk through identified required doors had the self-closing feature. 3. Environmental Supervisor/designee will audit the facility required doors for full functioning self closure devices one time per month for three months. 4. Environmental Supervisor/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.	6-19-15

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Jessica Spencer — Executive Director — 6/12/15

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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 029	Continued From page 1 1. Observation at 8:45 a.m. on 5/27/15 revealed the kitchen pantry storage room was over 100 square feet in area. The door to the kitchen was not equipped with a self-closing device and had a 12 inch by 30 inch louver opening in the door. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Doors to hazardous areas are required to be self-closing. The deficiency affected requirements for providing separation of hazardous areas.	K 029		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure staff were familiar with fire drill procedures. Findings include: 1. Observation at 10:30 a.m. on 5/27/15 revealed the staff person responding to the fire had to be directed by the maintenance supervisor to perform the following functions during the fire drill:	K 050	K050 1. Employee was re-educated at the time of fire drill. 2. Employees will be re-educated on 6/15/15 & 6/17/15 to fire drills and their required response. 3. Environmental Supervisor/designee will audit each fire drill for compliance for 3 months. 4. Environmental Supervisor/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.	6-19-15

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	435126	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/27/2015

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K 050	Continued From page 2 *Close the corridor doors in the smoke compartment. *Announce the fire location over the paging system. *Pull the manual alarm box to initiate the fire alarm. Interview with the maintenance supervisor at 11:15 a.m. on 5/27/15 confirmed that finding. He stated the staff person responding to the fire drill location had been with the facility for several years, and he expected a better drill response. The deficiency affected requirements for staff familiarity with fire drill procedures.	K 050		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to conduct the required annual inspection of the kitchen range exhaust ductwork. Findings include: 1. Document review of the kitchen hood system inspections revealed there was no documentation indicating the entire exhaust ductwork had been inspected for cleanliness/grease build-up within the last year. Interview with the maintenance supervisor at 10:45 a.m. on 5/27/15 revealed he performed cleaning of the hood grease filters and reachable ductwork from the main floor. He stated the	K 069	K069 1. Maintenance Supervisor was re-educated to the regulation during the survey. 2. The kitchen hood system annual inspection has been scheduled for June 17, 2015. 3. Environmental Supervisor/designee will audit the kitchen hood inspection and facility cleaning one time per month. 4. Environmental Supervisor/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring.	6-19-15

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K 069	Continued From page 3 kitchen hood exhaust extended up three floors and through the roof. The exhaust system had recently had a new exhaust fan installed. He added he did not clean the ductwork from the rooftop ventilator down. He was not able to inspect the entire three floors of ductwork. The deficiency affected the requirements for the kitchen range hood and exhaust system.	K 069		

ORIGINAL

PRINTED: 06/05/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10634 S	A. BUILDING: _____ B. WING _____	05/28/2015

NAME OF PROVIDER OR SUPPLIER: **VIOLET TSCHETTER MEMORIAL HOME**

STREET ADDRESS, CITY, STATE, ZIP CODE: **50 7TH ST SE POST OFFICE BOX 946 HURON, SD 57350**

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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/26/15 to 5/28/15. Violet Tschetter Memorial Home was found not in compliance with the following requirement: S301.	S 000	Addendums noted with an asterisk per 7/6/15 telephone to facility administrator. SW/SDDOH/JJ	
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 met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure three of nine required annual in-service training sessions (food safety, food-borne illness, and leftover food handling policies) were offered for all food-handling staff yearly. Findings include: 1. Record review of the required in-service training sessions from April 2014 through 5/27/15 for all food handling staff revealed: *Those staff had not all received annual training on the following:	S 301	S301 1. Facility identified which staff to include as food handlers during the survey process. 2. Staff identified as food handlers will receive the required training on 6/15/15 & 6/17/15. All staff identified as food handlers will be required to receive the annual education topics listed in S301. 3. CDM/designee will audit employees for training one time per month for 3 months. 4. CDM/designee will present data collected to the Quality Improvement Quality Assurance meeting* for further recommendations regarding system and continued monitoring. → quarterly for three months SW/SDDOH/JJ	6-19-15

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

TITLE: Executive Director

(X6) DATE: 6/12/15

STATE FORM 6899 593211 If continuation sheet 1 of 3

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South Dakota Department of Health

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S 301	Continued From page 1 -Food safety. -Food-borne illness. -Leftover food handling policies. Interview on 5/27/15 at 11:25 a.m. with the certified dietary manager regarding required annual in-service training sessions for all food handlers revealed: *Food handling staff were identified as dietary, nursing, and activities. *There had been an in-service on food safety, food-borne illness, and leftover food handling policies for all dietary staff. -There had not been those same in-services as the above for nursing and activities staff. *She had not known all food handling staff were to have received that annual in-service training. Interview on 5/28/15 at 11:40 a.m. with the director of nursing and the administrator regarding required annual in-service training sessions for all food handlers revealed: *Food handling staff were identified as dietary, nursing, and activities. *There had been an in-service on food safety, food-borne illness, and leftover food handling policies for all dietary staff. -There had not been those same in-services as the above for nursing and activities staff. *They had not known all food handling staff were to have received that annual in-service training. Review of the provider's 2010 Inservice Training policy revealed: *In-service training was to have been offered on a regular basis to update employees' knowledge of providing quality service. *A yearly in-service schedule would have been developed so employees received training on a regular basis.	S 301		

South Dakota Department of Health

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S 301	Continued From page 2 *In-services would have covered a range of topics, including: -Documentation in the food service department. -Meal service. -Sanitation and infection control. -Food safety.	S 301		