

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

ORIGINAL

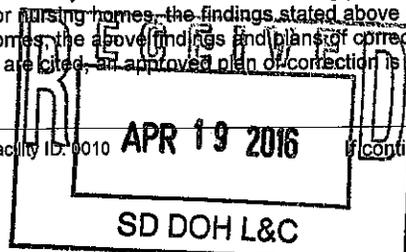
PRINTED: 04/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435126	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/30/2016
NAME OF PROVIDER OR SUPPLIER VIOLET TSCHETTER MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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: 35121 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/28/16 through 3/30/16. Violet Tschetter Memorial Home was found in compliance.	F 000			

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

Jessie Gorman Executive Director 4/15/16

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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435126	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2016
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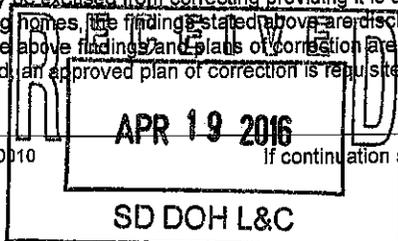
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/29/16. Violet Tschetter Memorial Home was found not in compliance with 42 CFR 483.70 (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 K046 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	K046 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 conclusions 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	
K 046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to provide proper illumination for the means of egress for the exit discharge at three of three marked exits from the facility. Findings include: 1. Observation at 11:30 a.m. on 3/29/16 revealed the exit discharge from the south wing was provided with a lighting fixture just above the exit door on the outside. Interview with the maintenance supervisor at the time of that observation indicated that light was not tied to the essential electrical service. He was unable to verify if the other two exits from the nursing home were provided with exit discharge lighting tied to the backup generator.	K 046	1. The emergency exit lighting will be tied into the generator and emergency exit lighting will be equipped with a double bulb system by May 13, 2016 2. Maintenance Supervisor will add 'check exit lighting' to monthly walk through checklist. 3. Maintenance Supervisor will audit each emergency exit light with generator check monthly for 4 months.	5/13/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Leanne Spenser</i>	TITLE Executive Director	(X6) DATE 4/15/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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NAME OF PROVIDER OR SUPPLIER VIOLET TSCHETTER MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 50 SEVENTH ST SE POST OFFICE BOX 946 HURON, SD 57350	
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K 046	Continued From page 1	K 046		
K 069 SS=D	<p>This deficiency has the potential to affect all residents and staff.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on document review, observation, and interview, the provider failed to ensure the kitchen hood fire suppression system was tied into the buildings fire alarm signaling system for one of one kitchen hood. Findings include:</p> <p>1. Document review at 10:30 a.m. on 3/29/16 revealed a commercial kitchen equipment inspection report dated 10/6/15. That report was prepared by Dakota Fire Equipment Inc. The report revealed no indication if the commercial kitchen hood fire suppression system was connected to the building fire alarm signaling system.</p> <p>Observation at 11:30 a.m. on 3/29/16 in the dietary kitchen revealed an Amerex wet chemical fire suppression system was installed for the commercial kitchen hood. That system was not provided with a supervisory sensor indicating that fire suppression system was not tied to the building's fire alarm signaling system.</p> <p>Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He believed the suppression system was tied to the building fire alarm system but indicated he would call to verify. Per phone correspondence at 1:00 p.m. on 3/29/16 revealed Dakota Fire Equipment was unable to verify if the</p>	K 069	<p>4. Maintenance Supervisor will present to the QA committee data collected which will be reviewed/discussed at the QA meeting at least quarterly, evaluation of the outcomes will determine if changes in the plan of action needs to occur and the frequency of monitoring.</p>	

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K 069	Continued From page 2 suppression system was tied to the building fire alarm system. This deficiency has the potential to affect two of six smoke compartments.	K 069	K069 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 conclusions 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 1. The kitchen hood system will be tied into the fire pane by May 13, 2016 2. Maintenance Supervisor will visually inspect kitchen hood system for 1 month. 3. Maintenance Supervisor will review next 2 inspection report from our Vendor for compliance. 4. Maintenance Supervisor will present to the QA committee data collected which will be reviewed/discussed at the QA meeting at least quarterly, evaluation of the outcomes will determine if changes in the plan of action needs to occur and the frequency of monitoring.	5/13/16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10634 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/30/2016
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S 000	Compliance/Noncompliance Statement Surveyor: 35121 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/28/16 through 3/30/16. Violet Tschetter Memorial Home was found not in compliance with the following requirement: S236.	S 000	*Addendums noted with an asterisk per 5/9/16 per telephone with facility administrator. S236 ML/SPDOH/EL 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 conclusions 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	
S 236	44:73:04:12(1) Tuberculin Screening Requirements 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 tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;	S 236	1. Employees A and B had completed TB testing before survey start date. 2. Staff Educator was re-educated that TB testing, including reading of the 2 nd step must be completed before the 14 th day. Facility implemented guideline that new	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessie Spamer TITLE: Executive Director (X6) DATE: 4/15/16

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Continuation sheet 1 of 3

South Dakota Department of Health

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HURON, SD 57350**

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S 236	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on employee file review, interview, and policy review, the provider failed to ensure two of five newly hired sampled employees (A and B) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include:</p> <p>1. Review of certified nursing assistant (CNA) A's employee file revealed: *A hire date of 3/15/16. *The two-step TB skin testing had not been completed. *The TB skin tests had not been completed fourteen days after having been hired.</p> <p>2. Review of CNA B's employee file revealed: *A hire date of 9/15/15. *The one-step and a two-step TB skin testing had not been completed within fourteen days. *The TB skin tests had not been completed fourteen days after having been hired.</p> <p>3. Interview on 3/30/16 at 9:10 a.m. with the director of nursing (DON) and at 12:30 p.m. with the staff development coordinator and the DON regarding the TB skin testing for employees A and B revealed: *The DON stated the provider's system needed to have been improved. *The DON agreed there was no completed documented TB skin testing within fourteen days of being hired. *The nursing staff were responsible for the employees' TB skin tests to have been given in a timely manner. *The DON and the staff development coordinator</p>	S 236	<p>hires receive the first step on first day of employment.</p> <p>3. DNS/designee will audit TB testing on each new hire [redacted] <i>MYSDDOH/EL</i> [redacted] <i>*for 6 months.</i></p> <p>4.. DNS/designee will present data collected to the Quality Improvement Quality Assurance meeting for further recommendations regarding system and continued monitoring <i>*for 6 months.</i> <i>MYSDDOH/EL</i></p>	<i>4/22/16</i>

South Dakota Department of Health

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S 236	Continued From page 2 both confirmed the above CNAs information. *The TB skin tests had not been given in a timely manner. *The TB skin tests had not followed the state guidelines for TB screenings for new employees. Review of the provider's 5/7/14 TB Screening Requirements policy revealed each new healthcare worker was to have received the two-step method of TB skin testing within fourteen days of employment.	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 35121 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/28/16 through 3/30/16. Violet Tschetter Memorial Home was found in compliance.	S 000		