

CENTERS FOR MEDICARE & MEDICAID SERVICES

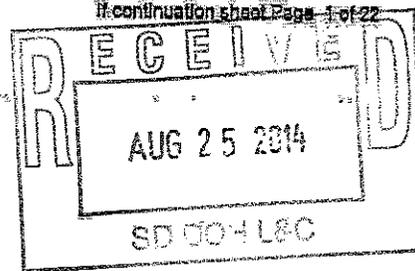
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>Amendments noted with asterisk per email telephone to facility administrator. RECDHME</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/29/14 through 7/31/14. Good Samaritan Society Canistota was found not in compliance with the following requirements: F156, F176, F221, F241, F270, F314, and F323.</p>	F 000	Initial Comments Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual.	
F 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p>	F 156		8/22/14 RECDHME

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 8/22/14

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 30 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.



## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 780 WEST MAIN ST CANISTOTA, SD 57012		
(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)	DATE COMPLETION DATE	
F 158	Continued From page 1  The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.  The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section.  A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.  A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 158	F 156 Notice of Rights, Rules, Services, Charges 1. For residents # 6, 13, and 14 the deficiency has been corrected. (date) and by whom the notification was done. The residents' family/POA has been notified of non-Medicare coverage. 2. For all other potential residents the facility will ensure the resident and family/POA receive timely Notice of Medicare Non-Coverage per GSS policy and procedure with appropriate form, at least two days prior to last covered day to allow resident / family member to appeal. 3. Education: MDS coordinator, DNS, Business Office, and Administrator have been in-serviced by Skilled Rehab Consultant on July 27, 2014 and in GSS Medicare workshop on August 5th and 6th, 2014 on notification of Medicare non-coverage-GSS Policy and procedure for Notification of Medicare Non-Coverage		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012	
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F-156	<p>Continued From page 2</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:                      Surveyor: 34030                      Preceptor: 32332                      Based on record review, interview, and policy review, the provider failed to notify residents or their families of changes in their medicare status in a timely manner for three of four sampled residents (6, 13, and 14). Findings include:</p> <p>1. Review of the provider's Notice of Medicare Non-Coverage records revealed:                      *Residents or families had been notified after the date the coverage had ended. Notification should have been given at least two days before the end of coverage to allow residents time to appeal. The following residents' records revealed:                      -Resident 6's end of services was 7/11/14, and notification was dated 7/13/14.                      -Resident 13's end of services was 7/14/14, and notification was dated 7/7/14.                      -Resident 14's end of services was 7/11/14, and notification was dated 7/12/14.</p> <p>Interview on 7/30/14 at 1:50 p.m. with the office</p>	F-156	<p>4. Audits: DNS or designee will audit weekly x one month and monthly x 3 months and quarterly x 1 quarter for all residents on Medicare part A or part B that Medicare non-coverage notifications are completed and timely communicated at least two days before end of coverage. Audit findings will be submitted to the QA committee. Results and trend of the audits will be reviewed by the QAPI committee monthly for further recommendations, identified root cause and to monitor compliance.</p> <p><i>* Will be brought to QAPI by the DNS or designee and PETSDDH/MF</i></p>	

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F 156	<p>Continued From page 3</p> <p>manager and the social worker revealed they "Had no further documentation regarding the above notifications.</p> <p>*Were not aware when notices were to have been given.</p> <p>Interview on 7/31/14 at 9:00 a.m. with the director of nursing revealed she agreed timely notice of Medicare non-coverage to the above residents or families had not been given.</p> <p>Review of the provider's January 2000 policy on Non-Coverage Notifications revealed "Notice of medicare non-coverage (GSS # 960) must be issued at least two days prior to the last covered day."</p>	F 156		
F 176 SS-D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 32392</p> <p>Based on observation, record review, interview, and policy review, the provider failed to ensure one of one sampled resident (10) who self-administered a medication had been assessed for capability to self-administer medication. Findings include:</p> <p>1. Observation on 7/30/14 at 9:45 a.m. of licensed practical nurse (LPN) A administering a nebulizer (a device used to administer medication</p>	F 176		

CENTERS FOR MEDICARE & MEDICAID SERVICES

UMS NO. U936-0391

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F 176	<p>Continued From page 4</p> <p>to the lungs in the form of a mist) treatment revealed she:</p> <ul style="list-style-type: none"> <li>*Placed the liquid medication in the chamber of the nebulizer.</li> <li>*Checked resident 10's pulse and lungs.</li> <li>*Handed the resident the nebulizer chamber and turned the machine on.</li> <li>*Exited the room.</li> </ul> <p>Interview at that time with LPN A revealed:</p> <ul style="list-style-type: none"> <li>*Resident 10 had an order to self-administer the nebulizer medication.</li> <li>*Nursing staff placed the medication in the chamber for the resident to take.</li> <li>*Resident 10 often would not take the medication at the time it had been placed in the chamber.</li> <li>*The nursing staff would leave the medication in the chamber at resident 10's bedside until she was ready to take the treatment.</li> <li>*She had been unsure if resident 10 had been assessed for self-administering the medication.</li> <li>*She was unaware where the self-administration assessment was located.</li> </ul> <p>Review of resident 10's medical record revealed:</p> <ul style="list-style-type: none"> <li>*A fax communication from LPN A to the physician on 6/4/14 stated:</li> <li>- "Concern: May self-administer nebulizer after nurse sets up."</li> <li>*That order had been signed by the physician.</li> <li>*A self-administration assessment had not been located.</li> <li>*A 5/21/14 care plan indicated "Inability to self-medicate related to dementia."</li> </ul> <p>Interview on 7/30/14 at 4:20 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> <li>*The Minimum Data Set assessment nurse would have been responsible for assessing if the</li> </ul>	F 176	<p>F 176</p> <p>Resident Self-Administer Drugs if Deemed Safe</p> <ol style="list-style-type: none"> <li>1. For resident # 10 – The resident has had a decline in condition and no longer is deemed safe or appropriate to self-administer her inhaler. The physician order has been obtained to discontinue the self-administration of medication and the care plan updated.</li> <li>2. For all other potential residents, the licensed nurse under the direction of DNS will assess any resident who have verbalized a desire to self-administer medications. The GSS Resident Self-Administration of Medications assessment will be completed to deem resident safe to self-administer medications and care plan updated to reflect self-administration of medications if appropriate and physician orders are obtained per GSS policy and procedure Resident Self-Administration of medications. The resident will continue to be assessed for appropriate self-administration of medications quarterly and with significant changes.</li> </ol>		

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F 176	Continued From page 5 resident was capable of self-administering medication. *Resident 10 had not been assessed for her capability to self-administer medications.  Review of the provider's January 2011 Resident Self-Administration of Medication policy revealed: *The interdisciplinary team would make the determination if the resident could self-administer the medication safely. *The interdisciplinary team's determination the resident could safely self-administer medication would have been documented in the medical record. *The resident's care plan must indicate which medication the resident was self-administering. *The resident's ability to continue to safely self-administer must be reviewed periodically.	F 176	3. Education: Education for licensed nursing staff will be completed by 8/26/14 on GSS II.M.8c. Resident Self-Administration of medications and when appropriate for resident assessment prior to and ongoing for a resident self-administration of medications using the GSS Resident Self-administration of medications UDA.	8/26/14
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: 34030 Preceptor: 32332 Based on observation, interview, record review, and policy review, the provider failed to assess residents' use of side rails and a wheelchair half tray used for positioning for three of three sampled residents (2, 7, and 11). Findings include:	F 221	4. Audits: DNS or QAPI coordinator will complete a weekly audit x one month and monthly x 3 months and quarterly x 1 quarter to ensure physician orders have been obtained and the GSS Resident Self-administration of Medication UDA has been completed per GSS policy and procedure. DNS/Pharmacist and Interdisciplinary team will meet quarterly to review all residents that self-administer medications are still appropriate.  *(user defined assessment) PEPDOOH/MF	

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F 221	<p>Continued From page 6.</p> <p>1. Random observation from 7/29/14 through 7/31/14 revealed: *Residents 2 and 7 had half side rails in the raised position at the top of their beds. *Resident 11 had a wheelchair with a half tray that she could move.</p> <p>Review of the above resident's complete medical records revealed: *Residents 2 and 7's side rails were used for positioning. No assessments on the appropriateness of use for those side rails had been found. *Resident 11's half tray had not been care planned or assessed for use.</p> <p>Interview on 7/30/14 at 1:25 p.m. with the director of nursing revealed she agreed initial and quarterly assessments for the above residents' devices should have been done.</p> <p>Review of the provider's November 2002 Policy and Procedure for Bed rails and Side rails revealed: *"Residents would be assessed for the appropriateness of side rails/specialty mattress/overlays." *"Assessments included, but were not limited to, the use of the Physical Restraint Assessment form, section G of the Minimum Data Set assessment, and input from the physical therapist and restorative nurse."</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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</p>	F 221	<p>Audit findings will be submitted to the QA committee. Results and trend of the audits will be reviewed by the QAPI committee monthly for further recommendations, identified root cause and to monitor compliance.</p> <p>F 221 * by the DNS or designee. PE/SDH/ME</p> <p>Right to be Free from Physical Restraints</p> <p>1. Resident # 2 –this resident does not have side rails on his specialty bed for bariatric. The other bed in the room is vacant and has no side rails. Resident # 7 – the licensed nurse completed the GSS physical device and restraint assessment and determined the half- rail with the bed remote built in it. This resident is independent with bed mobility and uses the side rail for positioning and positioning the actual bed. Resident # 11 – This resident uses the wheel chair tray for positioning of flacid left arm. This resident uses the tray for beverages and dinner ware to allow her more independence with her meal intake.</p>
F 241 88=E		F 241	

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F 241	<p>Continued From page 7</p> <p>full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 32335</p> <p>Based on observation, interview, and policy review, the provider failed to maintain resident appearance regarding chin hairs and dirty clothing for five of five observed residents (4, 5, 14, 15, and 16). Findings include:</p> <p>1. Observation and interview on 7/29/14 at 4:30 p.m. with resident 5 revealed she had several long gray chin hairs. She stated she wanted staff to shave the chin hairs, but they only did it when she asked them to help her.</p> <p>Random observations throughout the survey of residents 4, 14, and 16 revealed they also had long gray chin hairs.</p> <p>Interview on 7/31/14 at 11:00 a.m. with the director of nursing (DON) revealed she expected the staff to assist residents with their grooming needs including chin hairs on women.</p> <p>2. Random observations on 7/29/14 from 1:45 p.m. through 5:45 p.m. of resident 15 revealed she had large red spots from Jello on her shirt and pants. At 4:20 p.m. she had been out in the sitting area where several staff had walked by her. No staff member had assisted her with changing her dirty clothes.</p> <p>Review of resident 15's 5/27/14 Minimum Data Set assessment revealed she needed extensive assistance of one person to physically assist her with dressing.</p>	F 241	<p>This resident is able to move the tray at will. The licensed nurse completed the GSS physical device and restraint assessment. This device was determined to not be a physical restraint. The care plan has been updated to reflect the physical device is in place and will be reviewed with MDS process. The GSS physical device and restraint assessment has been completed and the devices have been determined to not be a restraint and the care plans have been updated to reflect the physical device usage and appropriateness.</p> <p>2. For all other residents. It is the policy of The Evangelical Lutheran Good Samaritan Society-Canistota to never utilize physical restraints for discipline or convenience. The licensed nurses will complete the GSS Physical Device and Restraint assessment to determine the device is considered a restraint. The GSS Physical Device and Restraint Review will be completed quarterly and with significant change in condition for any resident having a restraint.</p>	

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F 241	Continued From page 3  Observation and interview on 7/29/14 at 5:45 p.m. with the DON regarding resident 15 revealed she verified the large red spots on her shirt and pants. Her expectation would have been for staff to have changed her dirty clothes prior to the evening meal.  3. Review of the provider's April 2005 Resident Dignity policy revealed: "The purpose was to promote, encourage, support, and enhance the residents' self esteem." "Grooming residents should have been done the way the resident wished it to be done."  F 279 SS-D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 241	A physician order must be obtained for any device considered a restraint. The MDS must be coded accurately to reflect restraint per the RAI manual Section P. The interdisciplinary team will determine with those reviews that the restraint is necessary and least restrictive. The care plan will be reviewed and updated to reflect what physical devices are in place, if they are determined to be a restraint and documentation completed by the interdisciplinary team that the physical device is still benefiting the resident or needed.  3. Education: Re-education was provided to all staff regarding restraint use on August 4, 2014. Nursing staff will be educated 1:1 with Staff Development Coordinator by 8/26/14 regarding the proper time to use the physical device and restraint assessment.	

8/26/14

CENTERS FOR MEDICARE & MEDICAID SERVICES

UMID INC. 0800-0001

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F-279	Continued From page 9  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to accurately develop and revise a comprehensive care plan for smoking safety and a pressure ulcer for 2 of 11 sampled residents (5 and 10). Findings include:  1. Random observation from 7/30/14 through 7/31/14 of resident 10 revealed she smoked outdoors.  Review of resident 10's 5/6/14 Tobacco Use Assessment revealed: *She smoked twice daily. *She had right-sided weakness. *Her history prior to coming to the nursing home indicated she had started her hair on fire, although her family denied the accusation. *Staff were to have monitored, observed, and assisted her during her smoking. *Her care plan would include interventions of: -Monitoring or assistance during time of smoking. -Assistance with lighting of the tobacco product. -Storing tobacco products. -Arranging a schedule of tobacco use monitoring, observation, and/or assistance by interdisciplinary staff, family, and/or volunteer.  Review of resident 10's 5/21/14 care plan revealed: *She had a potential for moods and behaviors, that included an intervention: "Follow smoking schedule as set up with res (resident) to prevent moods/behaviors." *There had been no mention of the Tobacco Use	F-279	4. Audits: The DNS or designee will complete audits weekly x one month and monthly x 3 months and quarterly x 1 quarter for all residents using side-rails and half tray tables to ensure that they are being used in the least restrictive way possible. Audit findings will be submitted to the QA committee. Results and trend of the audits will be reviewed by the QAPI committee monthly for further recommendations, identified root cause and to monitor compliance. F 241 * by DNS or designee. PEKDDHMP Dignity and Respect of Individuality I. For Resident # 4, 5, 14, 15, and 16 the deficiency has been corrected. The care plans have been updated to reflect the required assistance for grooming by staff and the daily routine 2. For all other potential residents. The facility will provide care for residents in a manner and environment that maintains resident dignity and self-esteem. This will include providing assistance to meet the grooming needs of each resident per the GSS Resident daily practices.	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F-279	<p>Continued From page 10 Assessment results. *No indication resident 10 required assistance or monitoring when she smoked.</p> <p>Interview on 7/30/14 at 4:28 p.m. with the director of nursing revealed resident 10's care plan had not included the results of the Tobacco Use Assessment to ensure resident safety.</p> <p>Surveyor: 32335 2. Review of resident 5's medical record revealed: *An admission date of 1/13/14. *On 2/7/14 a pressure ulcer had developed on her right heel. -That pressure ulcer had not been resolved at the time of the survey. *On 2/14/14 a pressure ulcer had developed on her bottom. -That pressure ulcer had been resolved on 4/1/14. *A referral to a wound clinic on 5/7/14.</p> <p>Review of resident 5's 1/29/14 care plan revealed *A concern for skin integrity related to a decrease in mobility. *The approaches or interventions were: -To monitor and report changes in skin. -Extensive assistance of two staff with toileting on the commode. -Extensive assistance with personal care. -Offer back rub every evening and as needed. -Encourage resident to shift weight. -Provide personal pads and change linens as needed. *On 2/21/14 after the two pressure ulcers had developed staff had added "8 ounces of milk at 3:00 p.m. and with bedtime medication pass."</p>	F 279	<p>3. Education: Re-education was provided to all staff on 8/4/14 regarding dignity related to appearance.</p> <p>4. Audits: The DNS or designee will audit for soiled clothing or facial hair weekly times one month and monthly x 3 months and quarterly x 1 quarter The DNS or designee will submit findings to the QAPI committee for evaluation. Audit findings will be submitted to the QA committee. Results and trend of the audits will be reviewed by the QAPI committee monthly for further recommendations, identified root cause and to monitor compliance.</p>	8/4/14
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**CENTERS FOR MEDICARE & MEDICAID SERVICES**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012	
(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 279	<p>Continued From page 11</p> <p>*On 2/27/14 after the two pressure ulcers had developed staff had added the following interventions:</p> <ul style="list-style-type: none"> <li>-An air mattress to the bed.</li> <li>-"Float right heel when in bed."</li> <li>-"Encourage to lay down one hour per day."</li> </ul> <p>Review of resident 5's wound documentation revealed:</p> <p>*On 2/18/14 a pressure relieving cushion was put into her wheelchair.</p> <p>*That intervention had not been included in the care plan.</p> <p>Review of resident 5's 4/18/14 and 7/17/14 care plans revealed the same approaches and interventions as mentioned above for nutritional and skin integrity. There were no additional interventions listed.</p> <p>On all the above mentioned care plans there had been no updates:</p> <ul style="list-style-type: none"> <li>*To reflect the development of the pressure ulcers or the treatment used.</li> <li>*Regarding the pressure relieving boots that were to be used every day.</li> <li>*Of a repositioning program.</li> <li>*Regarding her going to a wound clinic.</li> </ul> <p>Interview on 7/31/14 at 9:45 a.m. with the Minimum Data Set coordinator revealed the above interventions should have been included on resident 5's care plan.</p> <p>3. Review of the provider's revised April 2004 Care Plan policy revealed:</p> <p>*Care plans were to be reviewed, evaluated, and updated when there was a significant change in the resident's care.</p>	F 279	<p>F 279</p> <p>Develop Comprehensive Care plans</p> <p>1. Resident #10 care plan has been reviewed and revised to reflect current condition, approaches, interventions, and care needs. Care plan reflects the resident smokes and the staff will monitor and assist during the time of smoking. May need assistance to light the tobacco product by staff and the facility will store the tobacco products in the medication room for staff to retrieve and store. The care plan has been updated to reflect that mood and behaviors can be affected by her smoking needs.</p> <p>Resident #5 care plan has been reviewed and revised to reflect current conditions, approaches, interventions, and care needs. The care plan has been updated to reflect the alteration in skin integrity with risk for pressure ulcers and current stasis ulcer. The care plan includes focus, measurable goals and interventions in treatment of the current ulcer and interventions implemented to avoid future pressure ulcers from occurring.</p>	

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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F 279  
F 314  
SS-G

Continued From page 12  
\*The plan of care would reflect the current care required for the resident.

**483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**

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: 32335  
Based on observation, record review, interview, and policy review, the provider failed to appropriately assess and identify the resident was at risk for developing pressure ulcers (a sore caused by unrelieved pressure that resulted in damage to tissue) and had not provided interventions upon admission for one of three sampled residents (5) resulting in two facility acquired pressure ulcers. Findings include:

1. Observation on 7/29/14 at 4:20 p.m. of resident 5 revealed she was hunched over sitting in a wheelchair.

Review of resident 5's medical record revealed:  
\*An admission date of 1/13/14.  
\*There were no pressure ulcers upon admission.  
\*There was no vascular (circulatory) diagnosis upon admission.

F 279  
F 314

2. For all other potential residents the facility will ensure the resident's individual care plan reflects focus, measurable goals and interventions. The care plan will be updated and reflect current status of the resident. The care plan must be developed to meet the resident's medical, nursing, mental and psychosocial well-being and identified in the comprehensive assessment.

3. Education: In-service training will be completed in regards to care planning per GSS policy and procedure for Care plan assessments by 8/26/14.

4. Audits: DNS or designee will audit residents' that use tobacco or have pressure ulcers weekly times 4, monthly times 3 and quarterly x 1 quarter. Audit findings will be submitted to the QA committee. Results and trend of the audits will be reviewed by the QAPI committee monthly for further recommendations, identified root cause and to monitor compliance.  
\*x by DNS or designee. VE/SDDH/MP

8/26/14

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

CIVIL NO. 0300-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 314	<p>Continued From page 13</p> <p>*A 1/13/14 initial care plan had no documentation of skin issues or interventions.</p> <p>*On 2/7/14 a pressure ulcer had developed on her right heel.</p> <p>*On 2/14/14 a pressure ulcer had developed on her bottom.</p> <p>Review of resident 5's Braden Scale for Predicting Pressure Sore Risk assessments completed on 1/13/14, 1/20/14, 1/27/14, and 2/3/14 revealed:</p> <p>*None of those assessments had been completed by the Minimum Data Set (MDS) coordinator.</p> <p>*The assessments all had the same answers and scores of 19 out of 23:</p> <ul style="list-style-type: none"> <li>-Scores of 10-12 indicated high risk.</li> <li>-Scores of 13-14 indicated moderate risk.</li> <li>-Scores of 15-18 indicated mild risk.</li> </ul> <p>*Under sensory perception staff had rated her a 4 out of 4 meaning she had "No impairment; responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort."</p> <p>*Under moisture staff had rated her a 4 out of 4 meaning "Rarely moist; skin is usually dry; linen requires changing only at routine intervals."</p> <p>*Under activity staff had rated her a 3 out of 4 meaning "Walks occasionally; walks occasionally during day but for very short distance, with or without assistance. Spends majority of each shift in bed or chair."</p> <p>*Under mobility staff had rated her a 3 out of 4 meaning "Slightly limited; makes frequent though slight changes in body or extremity position independently."</p> <p>*Under nutrition staff had rated her a 3 out of 4 meaning "Adequate; eats over half of most meals. Eats a total of 4 servings of protein (meat,</p>	F 314	<p>F 314 Treatment/Services to Prevent Pressure Sores</p> <ol style="list-style-type: none"> <li>1. For Resident # 5 the deficiency is corrected. Resident #5's pressure ulcer on the buttock remains resolved. R) Heel wound has been diagnosed recently (8/13/14) DM ulcer per physician. The wound continues to be monitored daily with treatment and measured weekly per the wound data collection tool and weekly RN assessment. The care plan has been updated to reflect focus, measurable goals and interventions have been implemented with treatment of the current wound.</li> <li>2. For all other potential residents the licensed nurse will complete the Braden Assessment weekly x 4 upon admission and as triggered by the MDS process. The licensed nurse will update the care plan to reflect focus, measurable goals and implement</li> </ol>	
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**CENTERS FOR MEDICARE & MEDICAID SERVICES**

UMB NU. 0838-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435067	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
(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
F314	<p>Continued From page 14</p> <p>dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered."</p> <p>*Under friction and shear staff had rated her a 2 out of 3 meaning "Potential problem: moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down."</p> <p>Review of resident 5's Braden assessment completed on 4/11/14 revealed she had a score of 18. The Braden assessment completed on 7/8/14 revealed she had a score of 16. Those two assessments had been completed by the MDS coordinator. There had been no Braden assessment completed from 2/3/14 to 4/11/14 after she had developed two pressure ulcers.</p> <p>Review of resident 5's 1/19/14 MDS assessment revealed she needed extensive assistance with two people physically helping her to move in bed, transfer, and walk in her room. She also needed total assistance from one person to move around the building in her wheelchair. Walking in the hallway had not occurred. She was occasionally incontinent of bladder.</p> <p>Review of resident 5's 1/19/14 care plan revealed no mention of skin concerns or being at risk for pressure ulcers. There were no interventions to prevent pressure ulcers from developing.</p> <p>Review of resident 5's wound documentation revealed: *On 2/7/14 a pressure ulcer had developed on her right heel. *That pressure ulcer had not been resolved at the</p>	F314	<p>interventions to resolve pressure ulcers and hopefully avoid future pressure ulcers. The licensed nurse will continue to monitor the wound daily with treatment and complete the wound data flow for anyone with pressure ulcers or wounds and the RN will do a weekly wound assessment to determine progress and notify physician per GSS policy and procedure.. The MDS nurse will code the MDS according to the RAI manual Section M for wound accuracy.</p> <p>3. Education: All licensed and unlicensed nursing staff will be in-serviced by 8/26/14 on the topic of being able to identify residents that are at risk for developing pressure ulcers, interventions to relieve pressure to area and repositioning. The licensed nurses will be re-educated per GSS policy and procedure for Pressure ulcer prevention/management, Braden Assessment and scoring and Wound data collection tool and RN assessment.</p>	8/26/14

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
(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	<p>Continued From page 15 time of the survey. *Measurements of the right heel pressure ulcer were as follows: -On 2/7/14 the length had been 1.5 centimeters (cm) and the width had been 1.0 cm. The depth had been unknown. -On 2/11/14 the length had been 1.5 cm and the width had been 1.0 cm. The depth had been unknown. -On 2/16/14 the length had been 1.5 cm and the width had been 1.0 cm. The depth had been unknown. -On 2/25/14 the length had been 1.5 cm and the width had been 1.5 cm. The depth had been unknown. -On 3/4/14 the length had been 1.5 cm and the width had been 1.75 cm. The depth had been unknown. -On 3/11/14 the length had been 1.5 cm and the width had been 2.0 cm. The depth had been unknown. -On 3/18/14 the length had been 1.25 cm and the width had been 2.0 cm. The depth had been unknown. -The next week had no date documented. The length had been 1.25 cm and the width had been 2.0 cm. The depth had been unknown. -On 4/1/14 the length had been 1.75 cm and the width had been 1.25 cm. The depth had been unknown. -On 4/8/14 the length had been 1.75 cm and the width had been 1.25 cm. The depth had been unknown. -On 4/15/14 the length had been 1.25 cm and the width had been 1.25 cm. The depth had been unknown. -On 4/22/14 the length had been 1.7 cm and the width had been 1.8 cm. The depth had been unknown.</p>	F 314	<p>4. Audits: The DNS and/ or designee along with the QAPI director will audit that the Braden assessment was completed, also that the Braden assessment matched MDS coding and if the care plan was updated to reflect the current condition. The audit will include the completion of the GSS wound data collection tool and RN assessment completion per GSS policy. The audits will be completed weekly x one month, monthly x 3 and quarterly x 1 quarter Any areas of concern will be addressed immediately and corrections implemented as appropriate to ensure compliance is achieved. Audit findings will be submitted to the QA committee. Results and trend of the audits will be reviewed by the QAPI committee monthly for further recommendations, identified root cause and to monitor compliance. <i>x by DNS or designee. P/SDDH/MF</i></p>	

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

CMD NO. 0930-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 18.</p> <ul style="list-style-type: none"> <li>-On 4/29/14 the length had been 1.75 cm and the width had been 2.0 cm. There had been nothing documented for the depth.</li> <li>-On 5/6/14 the length had been 1.75 cm and the width had been 1.75 cm. There had been nothing documented for the depth.</li> <li>-On 5/13/14 the length had been 1.74 cm and the width had been 1.8 cm. There had been nothing documented for the depth.</li> <li>-On 5/20/14 the length had been 1.5 cm and the width had been 1.75 cm. There had been nothing documented for the depth.</li> <li>-On 5/27/14 the length had been 1.25 cm and the width had been 1.75 cm. There had been nothing documented for the depth.</li> <li>-On 6/3/14 the length had been 1.0 cm and the width had been 1.5 cm. There had been nothing documented for the depth.</li> <li>-On 6/10/14 the length had been 1.0 cm and the width had been 1.25 cm. The depth had been 2.0 millimeters (mm).</li> <li>-On 6/17/14 the length had been 1.2 cm and the width had been 1.7 cm. The depth had been 3.0 mm.</li> <li>-On 6/24/14 the length had been 1.0 cm and the width had been 1.7 cm. The depth had been 2.0 mm.</li> <li>-On 7/1/14 the length had been 0.8 cm and the width had been 1.5 cm. The depth had been 3.0 mm.</li> <li>-On 7/8/14 the length had been 1.4 cm and the width had been 0.6 cm. There had been nothing documented for the depth.</li> <li>-On 7/15/14 the length had been 1.2 cm and the width had been 0.8 cm. There had been nothing documented for the depth.</li> <li>-On 7/23/14 the length had been 1.5 cm and the width had been 1.0 cm. The depth had been 0.3 cm.</li> </ul>	F 314		

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

GMS NO. 0838-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  438087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012	
(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	<p>Continued From page 17</p> <p>*On 2/14/14 a pressure ulcer had developed on her bottom.</p> <p>-That pressure ulcer had been resolved on 4/1/14.</p> <p>*Measurements of the pressure ulcer on her bottom were as follows:</p> <p>-On 2/14/14 the length had been 2.2 cm and the width had been 2.0 cm. The depth had been 0.1 cm.</p> <p>-On 2/18/14 the length had been 2.0 cm and the width had been 2.0 cm. The depth had been 0.1 cm.</p> <p>-On 2/25/14 the length had been 2.0 cm and the width had been 1.5 cm. The depth had been 0.1 cm.</p> <p>-On 3/4/14 the length had been 1.0 cm and the width had been 1.0 cm. The depth had been 0.1 cm.</p> <p>-On 3/11/14 the length had been 1.0 cm and the width had been 0.5 cm. The depth had been 0.1 cm.</p> <p>-On 3/18/14 the length had been 0.5 cm and the width had been 0.25 cm. The depth had been 0.1 cm.</p> <p>-On 3/26/14 the length had been 0.25 cm and the width had been 0.25 cm. There had been nothing documented for the depth.</p> <p>-On 4/1/14 it had been healed.</p> <p>*On 2/18/14 a pressure relieving cushion was put into her wheelchair.</p> <p>Review of resident 5's 1/29/14 care plan revealed</p> <p>*A concern for skin integrity related to a decrease in mobility.</p> <p>*The approaches or interventions were:</p> <p>-To monitor and report changes in skin.</p> <p>-Extensive assistance of two staff with toileting on the commode.</p> <p>-Extensive assistance with personal care.</p>	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
(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	<p>Continued From page 18:</p> <ul style="list-style-type: none"> <li>-Offer back rub every evening and as needed.</li> <li>-Encourage resident to shift weight.</li> <li>-Provide personal pads and change linens as needed.</li> </ul> <p>*On 2/21/14 after the two pressure ulcers had developed staff added 8 ounces of milk at 3:00 p.m. and with the bedtime medication pass.</p> <p>*On 2/27/14 after the two pressure ulcers had developed staff added the following interventions:</p> <ul style="list-style-type: none"> <li>- "Air mattress to the bed."</li> <li>- "Float right heel when in bed."</li> <li>- "Encourage to lay down one hour per day."</li> </ul> <p>Review of resident 5's 4/18/14 and 7/17/14 care plans revealed the same approaches and interventions as mentioned above for nutritional and skin integrity. There were no additional interventions listed.</p> <p>Interview on 7/31/14 at 8:30 a.m. with the director of nursing regarding resident 5 revealed she believed the current ulcer on her right heel was due to pressure. She referred this surveyor to speak with the MDS coordinator regarding the pressure ulcers.</p> <p>Interview on 7/31/14 at 8:55 a.m. with the MDS coordinator regarding resident 5 revealed:</p> <ul style="list-style-type: none"> <li>*The two pressures ulcers mentioned above had been acquired at the facility.</li> <li>*Upon admission she should have been identified as at risk for developing pressure ulcers due to her mobility issues.</li> <li>*The Braden assessments completed upon admission had not accurately reflected the resident's risk of developing pressure ulcers.</li> <li>*Positioning interventions should have been started upon admission.</li> <li>*Pressure relieving devices should have been</li> </ul>	F 314			

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

UNIT NO. 0930-0591

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
(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	<p>Continued From page 18 used upon admission.</p> <p>*From 2/27/14 through 5/7/14 there had been one documented communication with the physician regarding a normal visit. No changes had been made at that time.</p> <p>*On 5/7/14 the physician had referred the resident to a wound clinic.</p> <p>*On 5/9/14 the wound clinic had ordered the pressure relieving boots to be worn.</p> <p>*The MDS coordinator had not been sharing the wound clinic documentation with the physician.</p> <p>*A multi-vitamin had been started on 5/21/14.</p> <p>*On 5/11/14 there was an order to discontinue the multi-vitamin.</p> <p>*The MDS coordinator had not known why the physician had discontinued the multi-vitamin.</p> <p>*On 5/14/14 Silvadene cream had been ordered for the treatment of the right heel pressure ulcer.</p> <p>*That treatment had not changed and was still being used at the time of the survey.</p> <p>Review of the provider's March 2007 Pressure Ulcers policy revealed the provider was to have utilized prevention and assessment interventions. Those interventions were to ensure a resident who entered the facility without pressure ulcers had not developed pressure ulcers.</p> <p>Review of the provider's June 2014 Skin Assessment and Pressure Ulcer Prevention policy revealed:</p> <p>*Residents would be assessed for their risk of developing pressure ulcers upon admission using the Braden assessment tool.</p> <p>*For residents determined to be at risk the Braden assessment tool would be completed for the first four weeks following admission.</p> <p>*Residents who were unable to reposition themselves independently should have been</p>	F 314			

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE COMPLETION DATE
F 314	<p>Continued From page 20</p> <p>repositioned as directed by the care plan approaches.</p> <p>*Development of an individualized repositioning schedule was recommended based on observation of the resident's skin over a period of time.</p> <p>F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332</p> <p>Surveyor: 32335 Based on observation and interview, the provider failed to have chemicals securely locked up in two of two housekeeping carts and in one of one whirlpool tub room. Findings include:</p> <p>1. Observation on 7/29/14 at 9:20 a.m. in the A wing hallway revealed the housekeeping cart was unlocked and opened with four bottles of cleaning chemicals exposed. There was no housekeeper in view.</p> <p>Observation on 7/30/14 at 10:00 a.m. in the A wing hallway revealed the housekeeping cart was unlocked with the key in the lock. There were four bottles of cleaning chemicals in the cart. There</p>	F 314	<p>F- 323</p> <p>Free of Hazards/Supervision/ Devices</p> <ol style="list-style-type: none"> <li>From this date moving forward, chemicals will be stored safely and securely away from a resident reach.</li> <li>Education: was provided by housekeeping supervisor to housekeeping staff on 8/7/14 regarding securely locking up their housekeeping carts when they are not in plain view of them. DNS or designee will provide education to bath aides by 8/26/14 regarding the proper storage of chemicals in the whirlpool room.</li> <li>Audits: Housekeeping supervisor or designee will audit weekly x 4 week and, monthly x 3 and quarterly x 1 quarter to ensure chemicals are being stored safely and housekeeping carts are being locked. Audit findings will be submitted to the QA committee. Results and trend of the audits will be reviewed by the QAPI committee monthly for further recommendations, identified root cause and to monitor compliance. * by housekeeping supervisor or designee. [Signature]</li> </ol>	8/26/14

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0091

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
(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 323	<p>Continued From page 21 was no housekeeper in view.</p> <p>Observation on 7/30/14 at 10:43 a.m. in the B wing hallway revealed the housekeeping cart was unlocked with the key in the lock. There were five bottles of cleaning chemicals in the cart. There was no housekeeper in view.</p> <p>Surveyor 32332 2. Observation on 7/29/14 at 9:20 a.m. of the tub room on the 400 wing revealed: *The tub room door was unlocked and open approximately four inches. *The tub room was unoccupied. *The closet door in the tub room was unlocked. *The bottom shelf of the closet contained five (3.2 quart) containers of Penner whirlpool disinfectant.</p> <p>Surveyor 32335 3. Random observations from 7/29/14 through 7/30/14 revealed there were residents in the facility that walked up and down the hallways in the A and B wings.</p> <p>Observation and interview on 7/31/14 at 10:00 a.m. with the maintenance supervisor in charge of housekeeping revealed the housekeeping cart on A wing was unlocked with the key in the lock. He agreed the carts should have been locked with the key taken out and secured. The tub room door should have been locked. The provider had no policy on the securing of chemicals.</p>	F 323			

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2014
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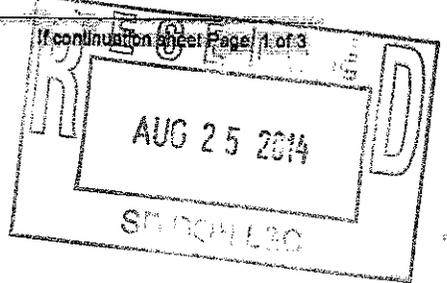
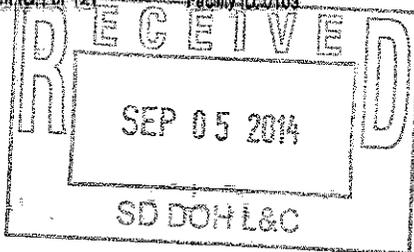
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/29/14. Good Samaritan Society Canistota was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/29/14 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column of those deficiencies identified as meeting the FSES to indicate the facility's intent to correct the deficiency identified at K038 in conjunction with the facility's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 8/20/14 telephone to facility administrator. JD/SDDOH/ME</p>	
K 02B SS-C	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on measurement and document review, the provider failed to maintain at least 32 inches of clear width for smoke barrier doors in the 100 and 200 wings. Findings include:</p>	K 02B	K 028	F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dylan Spill* TITLE: Administrator DATE: 9/3/14

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.



CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 028	Continued From page 1  1. Measurement at 10:00 a.m. on 7/29/14 revealed the cross-corridor doors to the 100 wing measured 31 inches of clear width. Further measurement revealed the cross-corridor doors to the 200 wing adjacent to the nurses station measured 30 inches of clear width. Review of the previous life safety code survey confirmed those findings.  The building meets the FBES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2  This STANDARD is not met as evidenced by: Surveyor 14180 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have a conforming exit. Findings include:  1. Observation at 10:30 a.m. on 7/29/14 revealed there was no conforming exit provided from the basement mechanical room. The only exit was a stair enclosure that discharged into the vestibule corridor system on the main level. Review of	K 032	K 032	F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012	
(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 032	Continued From page 2 previous survey data also identified that condition.	K 032		
K 038 SS=H	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.4  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at three of seven exits (the resident lounge exit, the 100 wing exit, and the 400 wing exit). Findings include:  1. Observation at 11:00 a.m. on 7/29/14 revealed the 100 wing exit and the 400 wing exit were connected to each other but did not continue to a public way. Further observation at 11:30 a.m. on 7/29/14 revealed the exit from the resident lounge only had a concrete pad. Interview with the maintenance supervisor at the time of the interview confirmed those findings.	K 038	K 038 1. The facility will install a paved path of exit discharge to the public way from the resident lounge exit, the 100 wing exit, and the 400 wing exit*  * [REDACTED] JB/SDDH/MF  Maintenance supervisor will be responsible for making sure the work has been completed and report to the QA committee following completion. JB/SDDH/MF	8/8/14 JB/SDDH/MF

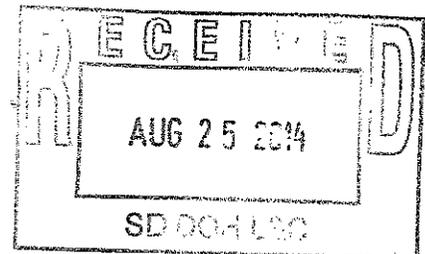
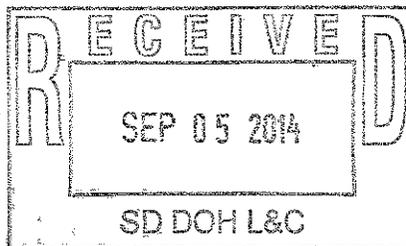
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER: **GOOD SAMARITAN SOCIETY CANISTOTA**  
 STREET ADDRESS, CITY, STATE, ZIP CODE: **700 W MAIN STREET  
 CANISTOTA, SD 57012**

(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 7/29/14 through 7/31/14. Good Samaritan Society Canistota was found not in compliance with the following requirements: S166 and S208.	S 000	Amendments noted with an asterisk per emergency telephone to facility administrator. PE/SDDOH/MF	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION  The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system must be capable of being easily activated by the resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed.	S 166	S 166 1. The north end exit door on A wing and the north end exit door on D wing will be locked. 2. These doors will remain locked until Dakota Security is able to come back and properly install them with the alarm system. 3. Administrator or designee will audit weekly times 4, monthly times 3 and quarterly times 3 quarters. 4. Results and trends will be brought to the QAPI committee* by the administrator or designee. PE/SDDOH/MF	* 8/20/14 PE/SDDOH/MF

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dylan Spal* TITLE: *Administrator* (X5) DATE: *9/3/14*  
 STATE FORM 6800 MT8711 If continuation sheet 1 of 4



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED:  07/31/2014
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NAME OF PROVIDER OR SUPPLIER: **GOOD SAMARITAN SOCIETY CANISTOTA**  
 STREET ADDRESS, CITY, STATE, ZIP CODE: **700 W MAIN STREET  
 CANISTOTA, SD 57012**

(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-166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility;                      (8) Household-type electric blankets or heating pads may not be used in a facility;                      (9) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and                      (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by:                      Surveyor: 32335                      Based on observation and interview, the provider failed to have two of five exit doors (North A wing exit door and North D wing exit door) monitored by staff or alarmed. Findings include:</p> <p>1. Observation and interview on 7/31/14 at 10:00 a.m. with the maintenance supervisor revealed the exit door on the north end of A wing and the exit door on the north end of D wing were unlocked. They were not alarmed or monitored by staff. He stated the doors were unlocked seven days a week from 8:00 a.m. through 7:00 p.m. Those two doors were not alarmed or monitored during those times. He did not have a policy for the exit doors and was not aware the doors needed to be alarmed or monitored.</p>	S-166		
S 206	44:04:04:05 PERSONNEL TRAINING	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/31/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 W MAIN STREET CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S-206	<p>Continued From page 2</p> <p>The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects:</p> <ul style="list-style-type: none"> <li>(1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff;</li> <li>(2) Emergency procedures and preparedness;</li> <li>(3) Infection control and prevention;</li> <li>(4) Accident prevention and safety procedures;</li> <li>(5) Proper use of restraints;</li> <li>(6) ...Resident rights;</li> <li>(7) Confidentiality of...resident information;</li> <li>(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;</li> <li>(9) Care of...residents with unique needs; and</li> <li>(10) Dining assistance, nutritional risks, and hydration needs of...residents.</li> </ul> <p>...Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by:                  Surveyor: 18560                  Based on annual training record review and interview, the provider failed to ensure one of ten mandatory topics (proper use of restraints) was covered for all personnel. Findings include:</p> <p>1. Review of the provider's Required Annual Training Topics policy dated February 2014 revealed the mandatory proper use of restraints topic had not been covered.</p>	S-206	<p>S206</p> <ol style="list-style-type: none"> <li>1. Deficiency corrected on 8/4/14 during all staff. Education was provided regarding the proper use of restraints.</li> <li>2. The topic of proper use of restraints was added to the yearly mandatory training topics.</li> <li>3. Staff Development Coordinator will ensure that all required topics are covered annually <i>and bring to QA annually.</i></li> </ol> <p><i>PE/SDDO4/MF</i></p>	<p>8/4/14</p>
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  07/31/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 W MAIN STREET CANISTOTA, SD 57012		
(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 206	Continued From page 3  Interview on 7/31/14 at 10:15 a.m. with the activity director confirmed the proper use of restraints topic had not been provided to all staff members. She stated she tracked all staff members training using the list from their corporate headquarters. The proper use of restraints had not been on that list.	S 206			