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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 12/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 |
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| F 000 | INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/8/14 through 12/10/14. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F279, F281, F309, F323, F332, F441, and F514. | F 000 | <p>Addendums noted with an asterisk per 1/11/15 telephone to facility DON. JTSDDOH/MF</p> <p>*and all residents could be at risk. JTSDDOH/MF</p> | |
| 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). This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, and | F 279 | <p>Resident #17^A On 12/10/14 the resident's care plan was updated to include specific contact precautions that CNA's could access on the Kiosk. Additional signage, without specific resident information, was posted outside of resident's door to alert all staff and visitors of what personal protective equipment to use upon entering and exiting the room. Staff made aware of precautions.</p> <p>Admission checklist updated to cue staff to care plan infections. Nursing staff will be trained on care planning specific to infections and isolation. The Medicare Coordinator^A reviews admission orders and will alert the MDS staff of any isolation or precautions for care planning and communication with staff.</p> <p>Nurse and CNA training 1/6/15, 1/15/15 and 1/27/15. *see page 2 JTSDDOH/MF</p> | *1/14/15 JTSDDOH/MF |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rennis D. Sub</i> | TITLE <i>Administrator</i> | (X6) DATE <i>Jan 2 2014</i> |
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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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| F 279 | <p>Continued From page 1</p> <p>interview, the provider failed to develop a comprehensive care plan to include contact precautions and treatment for one of one resident (17) who had an infection.</p> <p>1. Random observations throughout the survey from 12/8/14 through 12/10/14 revealed an isolation cart (containing personal protective equipment to be used when caring for someone with an infection) in the hallway outside resident 17's door.</p> <p>Interview on 12/8/14 at 3:15 p.m. with registered nurse (RN) A during the initial tour revealed resident 17:</p> <p>*Had been admitted on 12/6/14 with clostridium difficile (c. difficile), a common cause of antibiotic-associated diarrhea that could spread easily from one resident to another.</p> <p>*Was placed on contact isolation to prevent the infection from spreading to other residents.</p> <p>Review of resident 17's medical record revealed:</p> <p>*A diagnosis of clostridium difficile.</p> <p>*There was nothing on the 12/6/14 care plan to:</p> <ul style="list-style-type: none"> -Indicate the resident had c. difficile. -Indicate the resident required contact precautions. -Instruct staff how to care for a resident on contact precautions. <p>*The kiosk Kardex (an electronic screen which the certified nursing assistants used to direct their care of the residents) had not included the resident had c. difficile or required contact precautions.</p> <p>Interview on 12/10/14 at 8:50 a.m. with the director of nursing revealed her expectations were the care plan and the Kardex should have</p> | F 279 | <p>To monitor that precautions are care planned, the QAPI Coordinator will delegate audits to facility team members. Audits will be conducted monthly for 3 months and quarterly for a year. Results will be reported to QAPI Coordinator. The Coordinator will report to the QAPI Committee monthly. The QAPI Committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the QAPI Committee will make recommendations to continue or discontinue audits.</p> <p><i>*(continued from bottom of page 1) by the Director of Nursing on isolation/contact precautions. JTK/DDH/ME</i></p> | | |

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| F 279 | Continued From page 2 included information of the c. difficile and how to care for a resident with contact precautions. Review of the provider's September 2012 Care Plan policy revealed: **"An initial/temporary care plan will be developed by nursing upon admission as soon as a problem is identified." *The care plan would deal with the relationship items or services required and facility responsibility for providing these services. **"Use pre-admission data collection and other admission assessments to develop a temporary care plan that includes interventions including, but not limited to, transfer interventions, falls prevention, pain, pressure ulcer prevention, infections and other clinical monitoring." | F 279 | | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure professional standards for: *Notifying the physician following a medication error for 1 of 17 sampled residents (8). *Completing an assessment and documenting at the time of death for 1 of 2 sampled residents (20). Findings include: 1. Review of resident 8's nurse's progress notes | F 281 | | | |

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| F 281 | <p>Continued From page 3 revealed: *On 4/18/14 at 11:04 p.m. "Writer was counting the narcotics at the end of shift with another nurse on 4/18/14 and it was found that resident received 150 mg [milligrams] of Morphine 9 (for pain) at HS [hour of sleep]. This was a medication error as the resident was scheduled to receive 120 mg of morphine at HS." *There was no documentation of the physician having been notified.</p> <p>Interview on 12/9/14 at 3:30 p.m. with the director of nursing (DON) regarding resident 8 revealed: *She was unable to find any documentation that the resident's physician had been notified of the above medication error. *It was their policy to notify physicians when a medication error occurred.</p> <p>Review of the provider's September 2012 medication error policy revealed "When a medication error occurs, it will be reported to the attending physician promptly."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed, St. Louis, MO, 2013, pp. 583, revealed "When an error occurs, the patient's safety and well-being become the top priority. The nurse first assesses and examines the patient's condition and notified the health care provider of the incident as soon as possible."</p> <p>2. Review of resident 20's entire medical record revealed she had been discharged from the facility on 8/28/14 at the time of her death.</p> <p>Review of resident 20's progress notes revealed: *On 8/28/14 at 8:35 p.m. "Family informs staff</p> | F 281 | <p>Resident # [redacted] and all residents could be at risk. JTS/DDH/MF</p> <p>1. Upon notification of the finding, the physician was notified on 12/16/14 of the medication error. Nurse made aware of medication error procedure. * 1/24/15 JTS/DDH/MF</p> <p>2. Nurse interviewed regarding missing documentation of time of death. Nurse had assessed the resident and confirmed absence of vital signs but had not documented her findings. Nurse aware of procedure and counseled on importance of documentation. * JTS/DDH/MF</p> <p>Nurse will be in-serviced 1/6/15 and 1/15/15 on medication error procedures and assessment of vital signs at end of life *by the Director of Nursing. JTS/DDH/MF</p> <p>To monitor that physicians are notified of medication errors and assessments of vital signs at end of life are documented, the QAPI Coordinator will delegate audits to facility team members. [redacted] will be conducted monthly for 3 months and quarterly for a year. Results will be reported to QAPI Coordinator. The Coordinator will report to the QAPI Committee monthly. The QAPI Committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the QAPI Committee</p> | |

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F 281 Continued From page 4
that resident has passed away. Several family members at bedside."
-At 10:13 p.m. "Verbal rx [treatment] noted from on call [name of physician] to release [name of resident] to the mortuary."
*There was no documentation the nurse had assessed the resident and confirmed the resident had expired.

Interview on 12/10/14 at 2:15 p.m. with the DON regarding resident 20 revealed the nurse should have assessed and documented at the time the resident expired. She confirmed that had not been done.

Review of the provider's September 2012 Death and Dying policy revealed it had not addressed the assessment or documentation the nurse should have done at the time of death.

Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed, St. Louis, MO, 2013, pp. 724, revealed "Documentation of a death provides a legal record of the event. Follow agency policies and procedures carefully to provide an accurate and reliable medical record of all assessments and activities surround a death."

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 281
will make recommendations to continue or discontinue audits.

** (continued from page 4) Resident #20 and all residents could be at risk. JTSDDH/MF*

** (continued from bottom of page 4) All audits of medication errors and death assessments JTSDDH/MF*

F 309 Resident #14
MDS Coordinator updated Hospice care plan on 12/12/14 so both care plans are coordinated and comprehensive.

Care plans for other residents receiving Hospice services reviewed with hospice and updated as needed.

** 1/24/15
JTSDDH/MF*

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| F 309 | Continued From page 5 This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to update and combine the hospice plan of care with the provider's plan of care for one of one sampled resident (14) who had been receiving hospice service. Findings include: 1. Review of resident 14's medical record revealed a 10/16/02 admission date and a change to hospice care on 9/19/14. Review of resident 14's 11/21/14 care plan revealed: *"Resident has a terminal prognosis..." *"Work with nursing staff to provide maximum comfort for the resident. Asera Care Hospice nurse will visit 1-2x [one to two times per] week and PRN(as needed)." *"Bathing: resident requires 1 staff participation with bathing. Uses 2 [staff] assist to transfer onto the shower chair. Bath(e)s will be provided by Asera Hospice CNA [certified nursing assistant] 3x/wk." Interview on 12/10/14 at 8:15 a.m. with registered nurse A and CNA E regarding resident 14 revealed: *They were both familiar with the resident's cares and that he was on hospice. *They had been unaware the hospice CNA was to have given any baths. *When shown the care plan regarding the above they stated "That's not right, we give the baths." *They were unsure of who was doing what care | F 309 | To ensure the facility care plan and the hospice care plan are fully integrated, the MDS nurses will attend the Hospice care plan meeting which includes the Hospice representative, resident, family, facility staff. Hospice organization made aware facility need to have an integrated care plan. Request made of Hospice to notify MDS nurses of any changes to care plan. In-services for nursing: 1/6/15, 1/15/15, 1/27/15 *by the Director of Nursing on integrated care plans between the facility and hospice. JTS/BDH/MF To monitor that Hospice and facility care plans remain intergrated, the QAPI Coordinator will delegate audits to facility team members. [redacted] will be conducted monthly for 3 months and quarterly for a year. Results will be reported to QAPI Coordinator. The Coordinator will report to the QAPI committee monthly. The QAPI committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the QAPI committee will make recommendations to continue or to discontinue audits. *All audits of Hospice care plans for full integration JTS/BDH/MF | | |

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| F 309 | <p>Continued From page 6 for the resident.</p> <p>Interview on 12/10/14 at 8:30 a.m. with the Minimum Data Set coordinator revealed she: *Would have a conference with the hospice provider regarding care for a resident and then add information to the facility care plan. *Agreed resident 14's care plan had not been up-to-date to reflect the current care given by hospice providers. *Agreed it was difficult for facility staff to know what care they were to have given and what care hospice was to have given. *Agreed the care plan had not been specific for the resident.</p> <p>Review of the provider's September 2010 Hospice Services provided in Skilled Nursing Facility policy revealed: "A coordinated comprehensive plan of care shall be jointly developed by the center and hospice. Hospice participation in the care plan conference and input from the hospice representative is required."</p> <p>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: 34030</p> | F 309 | <p><i>*Resident #4 and all residents could be at risk. JT/SDDH/MF</i></p> <p>F 323 Upon notification of finding, the Emergency Cart inventory list was located, updated and replaced on both carts.</p> <p>New procedure in place 12/10/14: Night nurses will inspect carts nightly against inventory list that all equipment and supplies are on the emergency cart. The Central Supply Coordinator will inspect(contd)</p> | <p><i>*1/24/15 JT/SDDH/MF</i></p> |

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| F 323 | <p>Continued From page 7</p> <p>Based on observation, interview, and record review, the provider failed to monitor supplies and to test equipment on two of two crash carts (supply carts with emergency equipment). Findings include:</p> <p>1. Random observations from 12/8/14 to 12/10/14 revealed:</p> <ul style="list-style-type: none"> *Two crash carts in the facility, one in the City View area and one in the Sunrise area. *Various emergency supplies including a suction machine was on the carts. *There was no checklist showing that supplies or equipment had been monitored to make sure they were present and in working condition. <p>Interview on 12/9/14 at 9:30 a.m. with certified nursing assistant D who worked in the central supply area revealed:</p> <ul style="list-style-type: none"> *She stocked the crash carts after they were used. Otherwise the nurses did it. *She worked during the day. *The crash cart supply list was located in central supply and had not been checked on a routine basis. <p>Review of resident 4's medical record revealed she was to have been resuscitated if she quit breathing, therefore she would have required emergency equipment in that situation.</p> <p>Interview on 12/10/14 at 8:40 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *The facility had crash carts for nineteen years. *Supplies and equipment on the crash carts had not been monitored or tested on a routine basis. *No policy or procedure for monitoring the crash carts had existed. | F 323 | <p>(contd from pg 7)</p> <p>supplies and check equipment monthly that the equipment remains in proper working order. Will clean cart monthly. When the cart has been used, the Central Supply Coordinator will restock. If after hours, the Charge Nurse will inspect the cart against the inventory list and restock supplies and equipment.</p> <p>Nursing Inservices: 1/3/15, 1/5/15, 1/6/15* by the Director of Nursing on the new emergency cart procedure. JMS/MLM</p> <p>To monitor that the emergency carts remain stocked and equipment in working order, the QAPI Coordinator will delegate audits to facility team members. Audits will be conducted monthly for 3 months and quarterly for a year. Results will be reported to QAPI Coordinator. The Coordinator will report to the QAPI committee monthly. The QAPI committee will evaluate the plan for continued compliance and effectiveness. Based on findings, the QAPI committee will make recommendations to continue or to discontinue audits.</p> | |

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| F 332 | <p>Continued From page 9</p> <p>Review of the medical record for resident 21 revealed there was a physician's order stating after administration of the Pulmicort, the resident's mouth was to have been rinsed with water and to spit out the water after the rinse.</p> <p>2. Observation on 12/9/14 at 8:00 a.m. of a Clonidine patch (medication used to decrease high blood pressure) administration by RNA to resident 22 revealed: *RN A brought the patch into the room for administration. Upon entering the room she realized she had forgotten a scissors and went to retrieve it from the cart outside the room. *While she had been outside the room the resident proceeded to reach under her shirt and removed something from her right arm. The resident reported to RN A she had removed her patch. *RN A had not visually inspected the site of the old patch. *She proceeded to hand the resident her new patch. *The resident reached under her shirt to place the patch on her left arm. *RN A then handed the outer adhesive patch (used to keep the medication patch in place) to the resident. *The resident replied "I'm not sure if I can find where I put it [the medication patch]; there I think I've got it." *RN A had not visually observed: -The removal of the old patch, -The disposal of the removed patch. -The application of the new patch to the resident's skin.</p> <p>3. Interview with RNA immediately after the above medication administrations to residents 21</p> | F 332 | <p>(contd from page 9) make recommendations to continue or to discontinue.</p> <p><i>* (continued from page 9) of ten nurses will be completed on medication administration procedures. JT/SDDH/MF</i></p> | | |

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| F 332 | <p>Continued From page 10 and 22 revealed:</p> <p>*She agreed she should have followed the manufacturers' specifications for the Pulmicort and the Fosamax administrations.</p> <p>*With regard to the patch she agreed she should have:</p> <ul style="list-style-type: none"> -Inspected the patch that had been removed by the resident to ensure it had been removed properly. -Ensured what was removed had not been the medication itself and not just the outer adhesive patch. -Visually inspected the patch removal and application. -Administered the patch to the resident to ensure it had been placed properly. <p>Review of the September 2011 manufacturer's specifications pamphlet insert found with the Pulmicort medication revealed the resident's mouth should have been rinsed immediately after administration to prevent thrush (a fungal infection that occurs in the mouth).</p> <p>Review of the December 2013 manufacturer's specifications <http://www.fda.gov/downloads/Drugs/DrugSafety/UCM241519.pdf> accessed on 12/15/14 revealed:</p> <p>***Fosamax works only if taken on an empty stomach.</p> <p>*Take after you get up for the day and before taking your first food, drink, or other medicine.</p> <p>*Swallow the tablet with a full glass (6 to 8 ounces) of plain water only."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 595, revealed:</p> | F 332 | | |

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

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 12/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 | |
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| F 332 | Continued From page 11 *"Before applying a new patch, carefully assess the resident's skin to be sure to remove the existing patch before applying the new one." *Nurses have inadvertently left old transdermal patches on, resulting in resident's receiving an overdose of medication." Review of the provider's January 2014 Administration of Medication policy revealed: *Medications should be administered correctly. *Administer medication according to the six rights which included the right time. *Maximize the effectiveness of the medication and avoid potential medication-medication interactions. | F 332 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must | F 441 | Resident #17* and all residents could be at risk. JTSDDH/IMF Upon notification of findings, both CNA C and B were counseled and re-educated on contact precautions related to specific infection, hand washing and hand hygiene. For all other potential residents in isolation will educate staff to bag contaminated laundry in red bags. In-service education will be provided to all staff: 1/3/15, 1/5/15, 1/6/15* by the Director of Nursing on isolation/contact precautions and on hand hygiene. (contd) JTSDDH/IMF | * 1/24/15 JTSDDH/IMF |

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

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 12/10/2014 |
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| F 441 | <p>Continued From page 12</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure appropriate infection control practices were maintained for one of one resident (17) on contact precautions (used to prevent the spread of a contagious infection). Findings include:</p> <p>1. Review of resident 17's medical record revealed she was admitted with a diagnosis of clostridium difficile (c. difficile) (a common cause of antibiotic-associated diarrhea that could spread easily from one resident to another).</p> <p>Observation on 12/10/14 at 7:15 a.m. of CNA C performing morning care on resident 17 revealed: *She prepared towels and washcloths and placed them in a bag. *She put on an isolation gown and gloves, then entered resident 17's room.</p> | F 441 | <p>(contd from page 12)</p> <p>To monitor that appropriate precautions are in place for residents in isolation, the QAPI Coordinator will delegate audits to facility team members. Audits will be conducted montly for 3 months then quarterly for a year. Results will be reported to QAPI coordinator. The Coordinator will report to the QAPI committee monthly. The QAPI committee will evaluate the plan for continued compliance and effectiveness. Based on findings the QAPI committee will make recommendations to continue or to discontinue audits.</p> <p>* of ten nursing staff on infection control practices JT/SDDOHMF</p> | |

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

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 12/10/2014 |
|--|---|--|---|---|
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| F 441 | <p>Continued From page 13</p> <p>*She assisted the resident with putting on her socks and pants, then placed her on a portable toilet beside the bed.</p> <p>*When the resident had finished, she assisted her to standing and cleaned her bottom, removing some bowel movement with a cloth.</p> <p>*Wearing the same gloves she pulled the resident's clothing up and held her gait belt (a belt around the waist used to prevent falls), walked her to a recliner, and assisted her to sit.</p> <p>*She adjusted her in the recliner, touched the resident's clothing, the recliner, and linens on the recliner.</p> <p>*CNA C then removed the soiled gloves and put on clean gloves without washing her hands.</p> <p>*She then:</p> <ul style="list-style-type: none"> -Obtained the resident's dentures and oral supplies and assisted her with oral care. -Removed some soiled linens from the bed, made the bed, and folded blankets. -Moved the bedside table to the recliner for the resident to eat breakfast. -Rinsed out the commode. -Knotted the trash bag and closed the lavender laundry bag containing soiled laundry. -Removed her gloves and gown. -Opened the resident's door, and placed the laundry and trash bags in the appropriate containers in the hallway. <p>*She then used alcohol gel to cleanse her hands, and began to prepare towels and washcloths for performing care on another resident.</p> <p>Interview on 12/10/14 at 2:15 p.m. with the infection control nurse revealed CNA C should have:</p> <ul style="list-style-type: none"> *Removed her soiled gloves after cleansing the resident's bottom. *Washed her hands before putting on clean | F 441 | | |

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

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 12/10/2014 |
|--|---|--|---|---|
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| F 441 | <p>Continued From page 14 gloves.</p> <ul style="list-style-type: none"> *Washed her hands before leaving the resident's room. *Washed her hands after touching trash and laundry bags. *Used soap and water rather than alcohol gel for cleansing her hands. *Followed their policy for bagging soiled linen. <p>Surveyor: 33488 2. Observation and interview on 12/9/14 at 6:05 p.m. of certified nursing assistant/medication aide (CNA) B administering a medication to resident 17 revealed:</p> <ul style="list-style-type: none"> *She proceeded to enter the resident's room without putting on a gown or gloves. *She had used a spoon to administer medication to the resident. *The resident wanted to take her medication with orange juice. *Her straw was in her drinking water. *CNA B removed the straw from the water glass with her ungloved right hand and placed it in the resident's orange juice glass, contaminating her hand. *With her contaminated hand she then: <ul style="list-style-type: none"> -Handed the resident her orange juice with her ungloved hand. -Pushed the bedside table closer to the resident which had contaminated both of her hands. -Touched her scrub pants with her hands. Her clothing then became contaminated. *Once she left the room she reached into her pocket with her contaminated hand for hand sanitizer and proceeded to clean her hands. *She had not washed her hands with soap and water prior to leaving the room. *When asked why she had not put on a gown or gloves, she replied she did not need to as she | F 441 | | |

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

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 12/10/2014 |
|--|---|--|---|---|
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| F 441 | <p>Continued From page 15</p> <p>was not performing personal care.</p> <p>Review of the current Centers for Disease Control (CDC) guidelines, http://www.shea-online.org/Portals/0/CDI%20hand%20hygiene%20Update.pdf, accessed on 12/11/14, regarding hand washing and C-diff revealed "alcohol-based hand sanitizers do not kill C. difficile spores." Hand washing with soap and water is the preferred method to remove the C-diff spores.</p> <p>Surveyor: 32332</p> <p>Interview on 12/10/14 at 2:45 p.m. with the director of nursing revealed she agreed contact isolation/precaution procedures for c. difficile had not been followed for all the above findings.</p> <p>Review of the provider's October 2012 Clostridium Difficile procedure revealed:</p> <ul style="list-style-type: none"> *Contact precautions were to have been used. *Gowns were to have been worn when entering the residents' rooms and when providing care to the residents. *Gloves were to have been worn when entering the residents' room and when providing care to the residents. **"Perform hand hygiene after removing gloves. Alcohol does not kill Clostridium difficile spores: therefore, use of soap and water is more effective than alcohol-based hand rubs." "Remove gown and observe hand hygiene before leaving the resident's room." <p>Review of the provider's November 2005 Infection/Exposure Control Laundry Procedures revealed the contaminated laundry:</p> <ul style="list-style-type: none"> **"Should be placed and transported in bags or containers labeled or color-coded." **"Will be separated from other soiled laundry and | F 441 | | |

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

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|--|--|-------------------------|--|
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 | | |
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| F 441 | Continued From page 16 placed into bags or containers which are color-coded or universal precautions can be used with alternative labeling or color coding." | F 441 | | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure 3 of 17 sampled resident (3, 7, and 8) had complete medical records including physicians' progress notes. Findings include: 1. Review of resident 3's entire medical record revealed: *She had been seen by the physician on 8/19/14. -There was not a progress note in the medical record for that visit. 2. Review of resident 7's entire medical record revealed: | F 514 | Residents 3,7,8* and all residents could be at risk. JTS/DDH/MF Upon notification of findings, HIM contacted each clinic and requested copies of progress notes. *Health Information Management JTS/DDH/MF HIM will log residents physician visits. Based on log, HIM will monitor and make requests for any missing progress notes monthly. * of ten charts per month for physician progress notes JTS/DDH/MF To monitor that physician's progress notes are received, the QAPI coordinator will delegate audits to facility team members. Audits will be conducted monthly for 3 months and quarterly for a year. Results will be reported to QAPI coordinator. The Coordinator will report to the QAPI Committee monthly. The QAPI committee will evaluate the plan for continued compliance and effectiveness. Based on the findings, the committee will make recommendations to continue or to discontinue audits. | * 1/24/15 JTS/DDH/MF | |

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

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 12/10/2014 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 | | |
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| F 514 | <p>Continued From page 17</p> <p>*She had been seen by the physician on 11/17/14. -There was not a progress note in the medical record for that visit.</p> <p>3. Review of resident 8's entire medical record revealed: *She had bene seen by the physician on 12/1/14. -There was not a progress note in the medical record for that visit.</p> <p>4. Interview on 12/10/14 at 10:35 a.m. with the director of health information management regarding residents 3, 7, and 8 revealed: *They repeatedly contacted physicians to send their progress notes. *The physicians had not sent the progress notes for those residents. *She confirmed those residents were missing progress notes. *They did not have a policy that addressed how soon progress notes would have been placed in the medical record.</p> <p>Review of the provider's September 2012 Physician Services policy revealed: *"The physician will: -Review the resident's total program of care at each required visit, which includes care that a center provides (medical services, medication management, physical, occupational and speech or language therapy, nursing care, dietary interventions, social work, activity services and discharge plan." -Write, sign, and date progress notes at each visit and sign and date all orders."</p> | F 514 | | |

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

ORIGINAL

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

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|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 12/09/2014 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 |
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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 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/9/14. Good Samaritan Society Sioux Falls Center (Building 01 original 1957 structure) was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ronnie D. Heo</i> | TITLE <i>Administrator</i> | (X6) DATE <i>Jan 2, 2014</i> |
|---|-------------------------------|---------------------------------|

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.

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

ORIGINAL

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

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|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 - 1965 ADDITION B. WING _____ | | (X3) DATE SURVEY COMPLETED 12/09/2014 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/9/14. Good Samaritan Society Sioux Falls Center (Building 02 1965 addition) was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Dennis R. Heb

TITLE

Administrator

(X6) DATE

Jan 2, 2014

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.

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

ORIGINAL

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | | |
|--|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 - 1972 ADDITION B. WING _____ | (X3) DATE SURVEY COMPLETED 12/09/2014 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 | |
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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/9/14. Good Samaritan Society Sioux Falls Center (Building 03 1972 addition) was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Dennis R. Leeb

Administrator

Jan 2, 2014

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.

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

ORIGINAL

PRINTED: 12/23/2014
FORM APPROVED
OMB NO. 0938-0391

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|--|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 04 - 2000 ADDITION B. WING _____ | (X3) DATE SURVEY COMPLETED 12/09/2014 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/9/14. Good Samaritan Society Sioux Falls Center (Building 04 2000 addition) was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Dennis R. Gorb *Administrator* *Jan 2, 2014*

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.

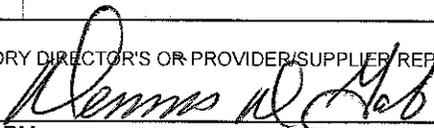
South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10679 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 12/10/2014 |
|--|--|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CE | STREET ADDRESS, CITY, STATE, ZIP CODE 401 W 2ND ST SIOUX FALLS, SD 57104 |
|--|--|

| (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: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 12/8/14 through 12/10/14. Good Samaritan Society Sioux Falls Center was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE



(X6) DATE

