

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

ORIGINAL

PRINTED: 12/17/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/03/2014
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY TYNDALL			STREET ADDRESS, CITY, STATE, ZIP CODE 2304 LAUREL STREET TYNDALL, SD 57066		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/1/14 through 12/3/14. Good Samaritan Society Tyndall was found not in compliance with the following requirements: F221, F226, F281, F323, F425, and F441.	F 000	Addendums noted with an asterisk per 1/15/15 telephone to facility administrator. PE/SDDOH/MF		
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 Based on observation, interview, record review, and policy review, the provider failed to ensure initial and periodic assessments for appropriate use of positioning bars had been completed for two of two sampled residents (2 and 7) with positioning bars. Findings include:  1. Random observations from 12/1/14 through 12/3/14 of resident 7's bed revealed one positioning bar up on the top half of the bed.  Interview on 12/2/14 at 10:30 a.m. with resident 7 revealed she had been unsure if she used the positioning bar. She stated "what do I do next?"  Review of resident 7's medical record revealed: *She had been admitted on 12/17/09.	F 221			

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

*Julie B Schankel*

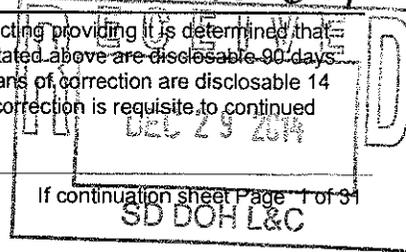
TITLE

*Administrator*

(X6) DATE

*12-26-14*

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.



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F 221	<p>Continued From page 1</p> <p>*A diagnosis of progressive dementia (decreased mental ability).</p> <p>*She had limited physical mobility.</p> <p>*No mention on her care plan of the positioning bar on her bed .</p> <p>*No initial or periodic assessments had been completed for the appropriate use of the positioning bar.</p> <p>Interview on 12/2/14 at 2:00 p.m. with certified nursing assistant A revealed resident 7 "uses the positioning rail on the bed to move in and to get up from bed."</p> <p>Surveyor: 35120 Preceptor: 33265</p> <p>2. Random observations from 12/1/14 through 12/3/14 of resident 2's bed revealed one positioning bar up on the top half of her bed.</p> <p>Review of resident 2's medical record revealed:</p> <p>*She had limited physical mobility.</p> <p>*No mention on her care plan of the positioning bar on the bed.</p> <p>*No initial or periodic assessments had been completed for the appropriate use of the positioning bar.</p> <p>3. Interview on 12/2/14 at 2:25 p.m. with the Minimum Data Set coordinator revealed:</p> <p>*She had been unable to find an initial assessment for the positioning bar for resident 7.</p> <p>*No periodic assessments to show appropriate use for positioning bars had been completed for any residents.</p> <p>*She agreed assessments should have been done for any residents with positioning bars.</p> <p>Review of the provider's October 2013 physical</p>	F 221	<p>F-221</p> <p>1. Residents #2 and #7 were assessed on 12-22-14. using the Physical Device and Restraints Assessment [redacted]. These devices were added to the care plan.</p> <p>2. All current residents using assistive devices will have Physical Device and Restraint assessment completed by DNS or designee by January 22, 2014. All residents using an assistive device will be assessed using the Physical Device and Restraint [redacted] prior to the use of the device and then quarterly to determine if the device remains appropriate and safe by charge nurses.</p>	
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F 221	Continued From page 2 restraint policy revealed "If the device, material, or equipment is not a restraint, it must be reviewed with a significant change in condition and quarterly in conjunction with the care plan to ensure that it continues to not be a restraint for the resident."	F 221		
F 226 SS-B	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and procedure review, the provider failed to: *Submit required incident reports to the South Dakota Department of Health (SD DOH) for two of five residents' (5 and 16) reports reviewed. *Submit required incident reports in a timely manner to the SD DOH for one of five residents' (17) reports reviewed. Findings include:  1. Review of resident 5's 1/14/14 incident report revealed: *An injury of unknown origin had occurred. *SD DOH had not been notified. *No additional report had been filed nor was abuse/neglect allegation marked as substantiated (proven) or not as required.  2. Review of resident 16's 5/22/14 incident report	F 226	3. All nursing staff will be educated on the appropriate use of an assistive device on 12-29-14 by the DNS and the <del>██████████</del> PERSDOH/MF consultant. A review of Assistive Devices GSS #A.14, Physical Restraint Alternatives # II.R.12d, Policy and Procedure Bed Rails/Side Rails and Physical Restraints, and the Physical Device and Restraint Assessment and Review <del>██████████</del> PERSDOH/MF will be used and copies provided to staff.  4. The DNS or designee will review all residents using an assistive device to assure an assessment has been done and the device is appropriate, safe, and documented on the care plan. These audits will be done monthly X4 and the DNS will report the audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed.	1-22-15

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F 226	Continued From page 3 revealed: *An unwitnessed fall with injury had occurred. *SD DOH had not been notified at the time of the initial incident report. *Neither social services nor the ombudsman had been notified. *No mention of abuse/neglect substantiation had been made.  3. Review of resident 17's 7/4/14 incident report revealed: *The resident had been struck by another resident. *SD DOH had been notified on 7/7/14. Notification should have been completed within twenty-four hours.  4. Interview on 12/3/14 at 2:10 p.m. with the director of nursing confirmed the above incidents had not been reported as required. The investigations could have been more complete.  Review of the provider's June 2014 abuse and neglect procedure revealed: "4 c. Notify the designated agencies in accordance with state law, including the state survey and certification agency. You may need to notify more than one agency to fulfill federal and state regulations. Document the notifications."	F 226	F-226 1. Unable to go back and report resident 5 and 16's incident reports to the SD DOH. 2. All incident reports related to injuries of unknown origin, injuries requiring outside medical attention, resident to resident abuse, or any type of abuse or neglect will be reported to the SD DOH within 24 hours by charge nurse. The administrator or designee will be informed immediately. The administrator, DNS, and Social Service will meet daily to review incident reports and assist in investigation. DNS/Adm or designee will be responsible to complete and report the investigation to the SD DOH within 5 days. SS will maintain the investigation reports.	
F 281 SS=E	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:	F 281	3. The administrator and <del>_____</del> PUSDDHMF consultant will provide education to all staff on 12-29-14 reviewing the policy II.A.1- Abuse and Neglect, the procedure II.A.1a- Abuse and Neglect and will provide copies to staff.	

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F 281	<p>Continued From page 4 Surveyor: 35121 Preceptor: 33488 A. Based on observation, interview, record review, and policy review, the provider failed to properly investigate falls and provide interventions to prevent future falls for four of five sampled residents (2, 3, 7, and 11) who had fallen. Findings include:</p> <p>1. Review of resident 11's medical record revealed: *On 5/30/14's unwitnessed fall: -"Resident came in from outside with dirt on his arms and clothes and was wet." -"Stated he fell outside, unable to tell me if he fell on one side rather than the other. Denies hitting his head." *On 9/2/14's unwitnessed fall: -"Resident stated he fell on the sidewalk outside and scratched his knee." *On 9/6/14's unwitnessed fall: -"Resident sitting on ground near a tree outback of this care facility." -He had said he had been holding onto a branch and fell to the ground on his knees. -He had a small cut on his left knee. *There was no documentation of interventions on the care plan for the above falls or to prevent future falls..</p> <p>Surveyor: 35120 Preceptor: 33265 2. Review of resident 2's complete medical record revealed: *She had documented falls on the following dates; 6/9/14, 7/7/14, 8/11/14, 8/30/14, and 9/7/14.</p>	F 281	<p>4. The QAPI coordinator or designee will review all incident reports in the Risk Management portal of the EMR to assure all incidents related to injuries of unknown origin, abuse/neglect, injuries needing outside medical attention have been reported to the SD DOH within 24 hours and that an investigation had taken place and those results had been reported to the DOH within 5 days. These audits will be done weekly X4 and then monthly X3 and reported to the QAPI committee monthly, the committee will determine if further auditing is needed.</p>	1-22-15

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F 281	<p>Continued From page 5</p> <p>*Two sections of the care plan identified her fall risk: -Limited physical mobility with revisions on 3/20/14, 4/4/14, and 9/14/14. -High risk for falls with revisions on 3/20/14 and 4/4/14.</p> <p>*No revisions concerning plans/ideas to prevent further falls were made in other sections after any of the above five documented falls.</p> <p>Surveyor: 34030</p> <p>3. Random observations from 12/1/14 through 12/3/14 of resident 7 revealed she: *Used a wheelchair for getting around and needed the Sit-to-Stand lift to help her transfer. *Was confused and frequently asked "What do we do now?"</p> <p>Review of resident 7's medical record revealed: *An admission date of 12/17/09. *Diagnosis of progressive dementia (decreased mental ability). *She had been unsteady when up. *She did not walk and used a wheelchair. *She had four falls since January 2014. *Psychoactive (medication used to treat behavior issues) medication had been started on 4/26/14 but had not been placed on the care plan until July. *Tabs (a personal monitoring alarm system) had been started on 2/27/14 to notify staff when she moved from her chair or bed unassisted.</p> <p>Review of resident 7's 1/19/14 and 1/23/14 Fall Risk Evaluation and Progress Notes report revealed: *No fall post assessment and evaluation follow-up had been completed.</p>	F 281	<p>F-281</p> <p>1. Resident 11 has had interventions related to falls added to his care plan, unable to add documentation to past falls. For resident #7, unable to amend past documentation with Falls Risk Evaluation and Progress Note. Resident 2 has had interventions added to the care plan with attempts to prevent further falls. Resident 3 has had the care plan updated to reflect interventions to prevent future falls, unable to amend documentation or add investigation. Residents # 14, 18, 19- unable to amend documentation related to the information of their death.</p>	
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F 281	<p>Continued From page 6</p> <p>*No interventions had been made or teaching done to help prevent future falls.</p> <p>Review of resident 7's 2/25/14 Fall Risk Evaluation and Progress Notes report revealed: *Neither the post assessment and evaluation follow-up nor the review and recommendations section had been completed. ***No" was checked for teaching or training to help prevent future falls. *The start of the Tabs monitor on 2/27/14 was not reflected as an intervention.</p> <p>Review of resident 7's 10/13/14 Fall Risk Evaluation and Progress Notes report revealed: *The evaluation and assessment had been incomplete: -There had been no mention of her fall history, underlying medical conditions, use of psychoactive medications, functional status, or neurological status. All of these effect the residents' ability to function. *No post assessment and evaluation follow-up had been done. *Evaluation and recommendations mentioned "Resident forgets that she can not walk and raises her lift chair to the highest position and then slides out onto..." However no teaching or intervention had been done to address that issue.</p> <p>Surveyor: 33488 4. Random observations from 12/1/14 through 12/3/14 of resident 3 revealed she: *Walked by herself with a walker. *Wandered throughout the facility. *Was often confused on where she was or who staff were. *Was observed on several occasions dancing with her walker.</p>	F 281	<p>The Investigation Team: administrator, DNS, and Social Service will review each fall daily including factors that may have led to the fall. At the time of the fall the nursing staff will go to the site of the fall and try to determine what may have contributed to the fall and include these in the documentation. The Falls Risk Data Collection and the Falls Risk Evaluation will be completed thoroughly by nursing staff. The Interdisciplinary team will work together to develop interventions to assist in the prevention of further falls and add these to the care plan. If a death occurs nursing will report the status of the respirations and heartbeat to the physician and document physician response.</p>		

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F 281	<p>Continued From page 7</p> <p>Review of resident 3's medical record revealed she: *Had been admitted on 5/21/14. *Had diagnoses of macular degeneration (eye disease that might cause blindness), osteoporosis (brittle bones), dementia with behaviors (mental impairment and mood changes), delusions (false beliefs), and anxiety. *Had a history of falls including falls with some injuries.</p> <p>Review of incident reports regarding resident 3's falls revealed: *On 10/9/14 at 5:55 a.m.: -Found sitting on the floor with a blood drop noted on the floor, and she was barefoot. -Injuries were a bruise on her right hip and an injury to her face. -She was disoriented. -No documentation to say what injury was noted to her face or where the blood was thought to have come from. -Predisposing factors check-marked on the incident report were: a. Flooring type. b. Poor lighting. c. Confusion. d. Drowsy. e. Impaired memory. f. Impaired vision. g. Incontinent. h. Gait imbalance (problems walking). i. Recent change in medication/new. -She was taken to the clinic later that day. -A CT scan (computer images of skull and brain) of her head showed a nasal fracture. -No investigation was made into the cause of the fall.</p>	F 281	<p>3. The <del>██████████</del> <sup>* PERSONAL TIME</sup> consultant will provide education to all staff on 12-29-14 regarding the investigation of falls including looking at factors leading up to the fall, going to the site of the fall and determining what may have contributed to the fall. The P/P-Prevention and Management of Falls- Practice Guidelines II.F.1 will be reviewed along with Procedure II.F. 2- Fallen or Injured Resident, II.F.2a-A Fall Occurs Now What?, copies of these will be provided for staff. The Falls Risk and Data Collection and Falls Risk Evaluation <del>██████████</del> <sup>* PERSONAL TIME</sup> will be reviewed with emphasis placed on the need to complete thoroughly and timely. A review of Procedure- II.I.4a- Incident Reports will be reviewed regarding the investigation team and the need for the care plan to be updated with new interventions put in place. A review of Policy II.D.1 Death and Dying will be reviewed regarding proper notification of</p>	
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F 281	Continued From page 8 -No interventions were placed on her care plan to prevent future falls. *On 11/5/14 at 9:09 p.m.: -Was found on the floor in her bathroom lying on her back with her head by the toilet. "No obvious signs of injury." -Similar predisposing factors from her previous fall were check-marked. -Was not taken to the hospital. -No investigation was made into the cause of the fall. -No interventions were placed on her care plan to prevent future falls. *On 11/6/14 at 2:56 a.m.: -Was found sitting on her buttocks with legs extended straight, spinning herself in circles. -Had been fully dressed. -Denied pain and laughed at staff. -No apparent injury had been noted. -Predisposing environmental factors check-marked on the incident report were: a. Disoriented. b. Confused. c. Impaired memory. d. Recent change or new medication. -No investigation was made into the cause of the fall. -No interventions were placed on her care plan to prevent future falls. *On 11/10/14 at 10:25 p.m.: -Was found on the floor in her room on her back. She was alert and told staff she had hit her head when she lost her balance and had fallen backwards. -Injury was noted to the back of her head. She complained of knee pain. No other description of the fall with an injury was given. -Predisposing factors check-marked on the incident report were:	F 281	the resident status when respirations and heartbeat cease, copies of this will be shared with staff.  4. The QA coordinator or designee will review all incident reports in the Risk Management module to assure all falls have been investigated and documentation is thorough and complete regarding the actual fall and investigation. The care plan will be reviewed by investigation team to assure interventions have been added to assist in preventing further falls. The QA coordinator will review documentation of any deaths in the center to assure nurses reported the cessation of vital signs to the physician and documented the physician response. These audits will be done weekly X4 and then monthly X3, QA coordinator or designee will report findings monthly to the QAPI committee and the committee will determine if further auditing is needed.	1-22-15.

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F 281	<p>Continued From page 9</p> <p>a. Drowsy.</p> <p>b. Impaired memory.</p> <p>c. "Nylon stockings without shoes making traction a problem."</p> <p>-Was not taken to the hospital.</p> <p>-No investigation was made into the cause of the fall.</p> <p>-No interventions were placed on her care plan to prevent future falls.</p> <p>*On 11/25/14 at 7:30 a.m.:</p> <p>-Had been found lying on her stomach holding her chin up with her hands.</p> <p>"I don't know what happened; I got up and boom I fell."</p> <p>-No injuries were observed.</p> <p>-Predisposing factors check-marked on the incident report were:</p> <p>a. Confusion.</p> <p>b. Use of a walker.</p> <p>-Was not taken to the hospital.</p> <p>-No investigation was made into the cause of the fall.</p> <p>-No interventions were placed on her care plan to prevent future falls.</p> <p>*On 11/25/14 at 12:40 p.m.:</p> <p>-Had fallen off her chair in the dining room.</p> <p>-Another resident who sat across from her said she had stood up, covered her eyes, yelled, and fell.</p> <p>-No injuries were noted.</p> <p>-She had one reported predisposing factor check-marked on the incident report which had been confusion.</p> <p>-No investigation was made into the cause of the fall.</p> <p>-No interventions were placed on her care plan to prevent future falls.</p> <p>Review of resident 3's current care plan revealed:</p>	F 281			

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F 281	<p>Continued From page 10</p> <p>*Areas of focus were:</p> <ul style="list-style-type: none"> <li>- "Has impaired cognition due to dementia."</li> <li>- "Requires cues/supervision."</li> <li>- "NOT oriented to time, place, or situation and requires supervision and direction from staff."</li> <li>- "Requires assistance every 2 hours to toilet."</li> <li>- "Will independently transfer at times and forget walker."</li> <li>- "History of falls, wandering, and not able to make safe decisions, forgets to use walker frequently."</li> </ul> <p>*Interventions dated 5/21/14 for falls were:</p> <ul style="list-style-type: none"> <li>- "Keep room free from clutter. Educate on importance of using walker/gait belt."</li> <li>- Ensure she was wearing appropriate footwear.</li> <li>- Bed low to floor.</li> </ul> <p>*She "will lay on floor" related to back pain.</p> <p>No updated interventions were placed since her time of admission.</p> <p>Interview on 12/2/14 at 11:00 a.m. with licensed practical nurse B regarding resident 3's care plan revealed:</p> <ul style="list-style-type: none"> <li>*She agreed the care plan had not been updated to reflect interventions needed to prevent her from future falls.</li> <li>*Nursing staff were able to update the care plan but had not routinely done so.</li> </ul> <p>Interview on 12/3/14 at 2:40 p.m. with the director of nursing regarding resident 3 revealed she agreed the care plan had not been updated and individualized to reflect interventions to prevent falls.</p> <p>Review of the provider's September 2012 Prevention and Management of Falls Practice Guidelines policy revealed an interdisciplinary team should have reviewed factors leading up to the falls and the prevention of future falls.</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TYNDALL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2304 LAUREL STREET TYNDALL, SD 57066</b>		
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F 281	Continued From page 11  B. Based on record review, interview, and policy review, the provider failed to ensure nurses had not declared a resident's death for three of four residents' (14, 18, and 19) closed records reviewed. Findings include:  1. Review of resident 14's medical record revealed: *He had died on 8/26/14. *The nurses note on the above date regarding his death revealed: -At 1:43 a.m.: "Resident deceased. Son [name] notified of resident death." -At 2:33 a.m.: A call had been placed to the local hospital and a message had been left "notifying Dr. [name] of the time of death."  2. Review of resident 18's medical record revealed: *He had died on 11/18/14. *The nurses note on the above date regarding his death revealed: -At 3:31 a.m.: "Resident passed away." -At 3:44 a.m.: "Dr. [name] was notified that the resident had passed away at 3:29 a.m." -At 3:49 a.m.: "Administrator was notified that resident had passed away."  3. Review of resident 19's medical record revealed: *She had died on 11/3/14. *The nurses note on the above date regarding her death revealed: -At 6:30 p.m.: "Registered nurse [RN] auscultated [listened] for breath or heart sounds. None heard. Time of death 6:30 p.m." -At 6:37 p.m.: "Call placed to [name] physician's assistant [PA] to inform of resident's death."	F 281			

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F 281	Continued From page 12  4. Interview on 12/3/14 at 2:40 p.m. with the director of nursing regarding the above residents' medical records revealed she agreed they needed better documentation regarding resident deaths. Nurses were not to have pronounced death.  Review of the provider's September 2012 Death and Dying Policy revealed the nurse was to have notified the physician when a resident's heartbeat and respirations had stopped. The physician's response should have been documented by the nurse.  Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 724, revealed documentation of end of life includes the name of the health care provider who certified death.  Review of South Dakota Codified Law 34-25-18 and 34-25-18.1 revealed: *The signing of the death certificate is a medical act by a physician, physician's assistant, or nurse practitioner. *Since the Legislature did not provide that the act was delegable to anyone else the South Dakota Board of Nursing did not believe a licensed nurse could officially pronounce death.	F 281			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.	F 323			

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F 323	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by:                      Surveyor: 35121                      Preceptor: 33488                      Based on observation, interview, and record review, the provider failed to monitor and document the exit and return for one of seven cognitively impaired (decreased mental ability) resident (11) reviewed who left the facility on unsupervised outings. Findings include:</p> <p>1. Observation on 12/3/14 at 1:43 p.m. of resident 11 revealed:                      *He exited the facility through the staff door by the dining room.                      *The exit door had been alarmed.                      *The exit door had a red bypass button that disabled the alarm.                      *No alarm was audible at that time.</p> <p>Review of resident 11's medical record revealed:                      *He was admitted on 3/7/83.                      *A diagnosis of mild intellectual disabilities related to mental retardation.                      *A physician's order dated 11/11/14 stated he could leave the facility as desired.                      *The 10/7/14 Minimum Data Set assessment revealed a score of four out of fifteen on the Brief Interview for Mental Status assessment (BIMS).                      *A BIMS score below seven showed severe mental impairment.</p> <p>Review of resident 11's fall incident reports revealed:                      *On 5/30/14's unwitnessed fall:</p>	F 323	<p>F-323</p> <p>1. Resident 11 has a current physician order that allows him independence to leave the facility as he wishes. The facility will provide a token that the resident will keep on his person that the resident will turn in to his charge nurse to indicate when he leaves the center. The nurse will have resident sign and nurse will indicate time and where resident is going. The resident will sign back in with the nurse upon return to the Center. The center will discuss this with resident 11's family and physician and make changes as needed with resident 11's plan of care. Any future falls will be investigated and documented with interventions added to the care plan.</p>	
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F 323	<p>Continued From page 14</p> <p>- "Resident came in from outside with dirt on his arms and clothes and was wet." - "Stated he fell outside, unable to tell me if he fell on one side rather than the other. Denies hitting his head." - No investigation was made into the cause of the fall. *On 9/2/14's unwitnessed fall: - "Resident stated he fell on the sidewalk outside and scratched his knee." - No investigation was made into the cause of the fall. *There was no documentation of interventions on his care plan for the above falls or to prevent future falls.</p> <p>Review of resident 11's nurse's notes dated 9/6/14 revealed: *"Resident sitting on ground near a tree outback of this care facility." *He had said he had been holding onto a branch and fell to the ground on his knees. *He had a small cut on his left knee. *No investigation was made into the cause of the fall. *There was no documentation of interventions on his care plan for the above fall or to prevent future falls.</p> <p>Review of resident 11's care plan interventions documented on 8/10/12 revealed: *He had been allowed to go to the family farm. *"Goes and comes on his own." *"Remind to let staff know he is leaving."</p> <p>Interview on 12/3/14 at 9:20 a.m. with licensed practical nurse B regarding resident 11 revealed: *He had not been notifying staff when he left the facility.</p>	F 323	<p>2. All resident with cognitive impairment will have a specific, interdisciplinary plan in place for cares based on their current needs with input from the resident and family members to ensure the residents safety and yet continue to promote the residents independence and wishes.</p> <p>3. The administrator and <del>DELS</del> <sup>DELS</sup> <del>COHINE</del> consultant will provide education for all staff on 12-29-14 to review the system that will be used for resident 11 when he leaves the center. Nurses will be educated on the need for assessment, investigation, and documentation of all falls using the GSS II.F.2-Fallen or Injured Resident and II.F.2a- A Fall Occurs Now What documents, copies of these will be available for staff.</p>		

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F 323	<p>Continued From page 15</p> <p>*Staff had no knowledge of how long he had been gone.</p> <p>*A log sheet had been available to document visitors and residents entering and exiting the facility.</p> <p>*He had not used the log sheet.</p> <p>*She remarked "He would not be able to sign himself out on the log sheet."</p> <p>*She agreed staff had no way to know:</p> <p>-When he had left the facility</p> <p>-How long he had been gone.</p> <p>-Where he had gone.</p> <p>*She was unaware of a policy or procedure regarding cognitively impaired residents who left unsupervised.</p> <p>*She stated they "would probably need to make some sort of plan."</p> <p>Interview on 12/3/14 at 1:03 p.m. with certified nursing assistant C regarding resident 11 revealed:</p> <p>*He was not in his room.</p> <p>*His coat was gone.</p> <p>*He "probably went uptown for ice cream."</p> <p>Interview on 12/3/14 at 2:40 p.m. with the director of nursing regarding resident 11 revealed she had been aware he had fallen while he had been absent from the facility.</p> <p>The provider had no policy or procedure regarding cognitively impaired residents who would leave the facility unsupervised.</p>	F 323	<p>4. DNS or designee will review the system to assure resident is using it. DNS will audit all falls for resident 11 to assure investigation and assessments were done by nursing reflected in their documentation. These audits will be done weekly X4 and then monthly X3, the DNS or designee will report audit findings to the QAPI committee monthly and the committee will determine if further audits are needed.</p> <p><i>*The facility will alter the front door alarm to require a code to be entered in order to bypass the alarm. The current button will be eliminated. The vendor has been contacted to make the necessary changes to alarm system. PEJSB00H/MF</i></p>	1-22-15	
F 425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain</p>	F 425			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 425	<p>Continued From page 16</p> <p>them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on observation, interview, record review, and procedure review, the provider failed to maintain one of one emergency drug kit (E-kit) with fully stocked, nonexpired, and identified medications. Findings include:</p> <p>1. Observation and record review on 12/3/14 from 10:20 a.m. to 11:30 a.m. with licensed practical nurse (LPN) K of the storage and contents of the E-kit revealed: *Two lists of the medications that did not match. The list on the lid of the E-kit listed only the name and the location (top tray, middle tray, bottom area) of the medication in the box. The second list was in the E-kit notebook and was the checklist used by the pharmacist to identify and</p>	F 425	<p>F-425</p> <ol style="list-style-type: none"> <li>1. The facility now has 2 matching lists of medications for the top of the E-kit and the E-kit notebook. All trays of the E-kit are secured with the plastic lock. The lorazepam left out of the refrigerator was destroyed on 12/10/14. The count for roxanol, was corrected. Expired medications were replaced by the pharmacist as of 12-23-14. The pharmacist has provided the E-kit checklist and placed in the E-kit notebook. Unable to go back and account for the discharged resident's medications.</li> <li>2. The facility will have matching lists of medications for the E-kit, one placed on the top of the E-kit and one in the E-kit notebook. All drawers of the E-kit will be secured with a plastic lock, when opened the nurse will document the date, time, and action taken on the lock out log sheet. The E-kit Inventory will be checked</li> </ol>	

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F 425	<p>Continued From page 17</p> <p>document the amount and expiration date of each medication.</p> <p>*The medications in the top tray were not secured by the plastic lock. The middle tray and bottom area required the breaking and removal of a numbered plastic tag lock which was tracked.</p> <p>*A partially used vial of lorazepam (antianxiety medication) that should have been refrigerated, and not left at room temperature.</p> <p>*Roxanol (narcotic medication requiring tracking) sign out sheet did not have accurate documentation for the dispensing and restocking of the medication.</p> <p>*Two expired medications.</p> <p>*Only one completed E-kit checklist for the year was in the pharmacy/E-kit notebook.</p> <p>Interview and record review on 12/3/14 at 2:30 p.m. with LPN K revealed she agreed:</p> <p>*The medications in the top tray were not secured with the plastic lock as the two other areas were.</p> <p>*The two medication lists had not matched.</p> <p>*The partially used vial of lorazepam should have been stored in the refrigerator.</p> <p>*There were more medications in the E-kit than were listed on either of the E-kit lists.</p> <p>*It was difficult to follow the tracking sheet for Roxanol and identify where the last bottle was for sure.</p> <p>*The E-kit contained expired medications.</p> <p>-Was not able to identify if a medication identified as expiring in December 2014 expired on 12/1/14 or on 12/31/14.</p> <p>*There was only one completed checklist by a pharmacist for the present year in the notebook.</p> <p>Interview on 12/3/14 at 10:57 a.m. with pharmacist G per telephone revealed:</p> <p>*The E-kit was checked monthly by the</p>	F 425	<p>against the master list quarterly by the pharmacist at least quarterly. Medications needing refrigeration will be stored and returned to the refrigerator after use. Pharmacy and nursing will track all controlled medication for the E-kit correctly. The pharmacist will remove all medications prior to expiration to assure safety for resident use. The pharmacist will complete the E-kit checklist monthly with a copy left in the E-kit notebook. The medication storage room will be kept at a temperature between 59-86 degrees. The temperature will be monitored and recorded daily on a calendar that is posted in the medication room. All residents discharging will have an accurate record of medication disposal.</p> <p>3. The consultant pharmacist and the <del>consultant</del> consultant will provide education to licensed nursing staff on 12-29-14 related to the use of the E-kit using the procedure Using Emergency Drug Kit and the GSS procedure Emergency Drug Boxes.</p>	
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F 425	<p>Continued From page 18</p> <p>pharmacist. *She would expect medications about to reach their expiration dates would be exchanged when they did the monthly check. *She would send out a pharmacist to answer questions regarding the E-kit.</p> <p>Interview on 12/3/14 from 11:12 a.m. to 11:28 a.m. with pharmacist F at the facility revealed: *He thought there should have been a November 2014 checklist, but he could not locate the form in the notebook. *He was unsure of how to interpret the Roxanol tracking sheet. After review of the form he stated the last entry had an error. There should have been another entry showing the medication had been restocked. *He had not realized the list on the E-kit cover and the list he used in the notebook had not matched. *He believed the medication expired on the last day of the month but would locate the policy and fax it to the facility. *He had not changed the medications that were going to expire on 11/30/14 when he was at the facility in early November, because they had not expired yet. *He agreed some medications had expired on 11/30/14 and had not been replaced. He was returning tomorrow (12/4/14) and would replace the medications then.</p> <p>Interview and record review on 12/3/14 at 3:05 p.m. with the director of nursing (DON) revealed: *She agreed the two medication lists should have matched. *Medications needing to be stored in the refrigerator should have been in the refrigerator. *She agreed there should not have been extra</p>	F 425	<p>Education will include the need for matching lists of medications, the need for securing the E-kit after use, review of medications needing refrigeration, controlled substance medications stored in the E-kit, the monitoring of expiration dates on medications, E-kit monthly checklist. The staff will be educated on the need for proper temperature control of the med storage room. GSS procedure Disposition of Medications will be reviewed. Copies of all procedures will be available for staff.</p> <p>4. The DNS or designee will audit the E-kit to assure the list of medications match, that all drawers of the E-kit are secured with a plastic lock, that nurses document whenever the E-kit is opened, that medications are stored properly, that controlled medications are tracked for the E-kit correctly, that all meds in the E-kit have not expired, that the pharmacist has completed the E-kit checklist monthly with a copy in the E-kit notebook.</p>		

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F 425	<p>Continued From page 19 unlisted medications in the E-kits. *She agreed the Roxanol tracking sheet had not clearly identified where the last bottle of the medication was located nor if it had been restocked. *She agreed there should not have been expired medications in the E-kit. *E-kit medications were to be checked monthly by the pharmacist.</p> <p>Review of the provider's September 2012 Emergency Drug Boxes procedure revealed: *A list of emergency medications including the amounts, dosages/strengths was to have been posted on the outside of the box. *The pharmacist was responsible for monitoring the expiration dates. *Record keeping was to be in accordance with the pharmacy system.</p> <p>Review of the provider's 7/26/13 procedure for Using Emergency Kit revealed: *Staff were to verify from the master list in the pharmacy/E-kit notebook in the medication room that the necessary drug was in the E-kit before unlocking/opening the E-kit. *The lock out log sheet was to be filled out each time the emergency kit was opened and a new lock was to be put in place. *The E-kit inventory was to be checked against the master list at a minimum of quarterly.</p> <p>Review of the provider's 12/3/14 procedure for Using Emergency Kit that was faxed to the facility from the pharmacy revealed an updated version with the following changes: *The E-kit inventory was to be checked against the master list at a minimum of quarterly if not monthly by consultant pharmacist.</p>	F 425	<p>The audit will include the temperature of the medication storage room. The HIM coordinator will audit the discharged records to assure proper disposition of medications. These audits will be done weekly X4 and then monthly X3. The DNS or designee and the HIM coordinator will report the audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p><i>*Health Information Manager REJSDOH/MF</i></p>	1-22-15.

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F 425	<p>Continued From page 20</p> <p>*The expiration dates were good until the last day of the month.</p> <p>Review of the provider's undated procedure for Using Emergency Drug Kit located in the pharmacy/E-kit notebook front cover had no information on how often the inventory was to be checked, who was responsible for checking the inventory, or when medications expired.</p> <p>B. Based on observation and interview, the provider failed to monitor the temperature for one of one medication storage rooms. Findings include:</p> <p>1. Observation on 12/3/14 from 10:20 a.m. to 11:30 a.m. with LPN K of the medication storage room revealed the temperature was between 80 and 81 degrees Fahrenheit (F).</p> <p>Interview on 12/3/14 at 2:30 p.m. with LPN K revealed she: *Had no knowledge of needing to monitor or record the temperature of the medication storage room. *Agreed the temperature was between 80 and 81 degrees F at this time.</p> <p>Interview on 12/3/14 at 3:05 p.m. with the director of nursing revealed: *She had no knowledge of needing to monitor or record the temperature of the medication storage room. *There was no policy regarding the temperature of the medication storage room.</p> <p>C. Based on interview and record review, the provider failed to account for all medications upon discharge for one of two discharged residents</p>	F 425			

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TYNDALL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2304 LAUREL STREET TYNDALL, SD 57066</b>		
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F 425	Continued From page 21 (15) reviewed. Findings include:  1. Review of resident 15's complete medical record revealed two medications were not accounted for following the resident's discharge.  Interview and record review on 12/3/14 at 3:05 p.m. with the DON revealed she agreed two medications were not accounted for following resident 15's discharge.  Surveyor requested any procedure or policy that concerned medications on discharge of a resident from the DON. No policy or procedure concerning that was received.	F 425			
F 441 SS=F	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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			

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F 441	<p>Continued From page 22</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: 33488 A. Based on observation, interview, manufacturer's instruction review, and policy review, the provider failed to ensure: *One of one whirlpool and one of one shower had been cleaned and disinfected according to manufacturer's instructions. *Seven of seven randomly observed EZ-stand lifts (mechanical equipment used to transfer a resident from one surface to another) were clean and free from dirt and debris. Findings include:</p> <p>1. Observation and interview on 12/2/14 at 12:45 p.m. with certified nursing assistant (CNA) D regarding the cleaning and disinfection of the whirlpool tub revealed: *She was the main bath aide for the facility. *She had proceeded to clean and disinfect the tub in the following order:</p>	F 441	<p>F441</p> <ol style="list-style-type: none"> <li>Timers and clocks have been added to both the tub room and shower room as of 12-23-14. The most recent version of the manufacturer instructions on cleaning/disinfecting will be posted and dated. The Virex II 256 bottles have all been updated to include instructions highlighting the 10 minute contact before rinsing. EZ way stands have been thoroughly cleaned by nursing staff. A second glucometer will be made available to each nurse to allow proper waiting time while cleaning surface. Pill crushers have been washed in dishwasher weekly. Wipes with appropriate EPA approved disinfectant will be used for cleaning between each use. Pre-packaged pudding is being used for medication passes with longer range expiration dates.</li> <li>A second shower chair has been ordered to allow proper disinfectant time between</li> </ol>	

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F 441	<p>Continued From page 23</p> <p>-With her un-gloved hands she plugged the drain with the stopper.</p> <p>-She pressed the Disinfect Jets button and held it until there was an inch of water in the bottom of the tub.</p> <p>-She then proceeded to clean the tub with the brush.</p> <p>-She stated she would wait ten minutes and then rinse out the tub.</p> <p>*When asked how she would know it had been ten minutes she stated she "had not been sure, but that it takes about that much time to dress a resident."</p> <p>*She did not have a watch on.</p> <p>*There was a clock in the room, but it was out of sight behind the curtain.</p> <p>*When asked if all her residents took the same amount of time to get dressed she replied "well, no, some are faster."</p> <p>*She agreed there was no way of knowing if the disinfectant remained in the tub for the contact time of ten minutes according to manufacturer's instructions.</p> <p>*When asked if she had the appropriate amount of disinfectant solution in the tub she said she was unsure but had "watched a video and it looked the same."</p> <p>*She had a posted set of instructions next to the whirlpool tub.</p> <p>*Sixty of seventy-one residents received whirlpool tub baths.</p> <p>Review of the provider's undated Cascade whirlpool tub manufacturer's guidelines for cleaning revealed:</p> <p>**Place the chair back into the tub for cleaning.</p> <p>*Close and lock the door.</p> <p>*Press the tub fill button and turn the temperature control knob all the way to the left to its warmest</p>	F 441	<p>residents by alternating chairs used. Timers will be used to ensure the 10 minute contact time is used for disinfecting. Nurses will be educated on rotating use of glucometers and proper disinfecting between each use. DNS is washing pill crushers weekly.</p> <p>3. DNS or designee will provide education to bathing staff will have education and demonstration on proper cleaning procedures on 12-29-14. Designated nursing staff will be educated regarding proper cleaning procedures on 12-29-14.</p> <p>4. DNS or designee will audit pill crushers, EZ stands, and glucometers and pudding dates weekly x 4 weeks, and monthly x 3 months thereafter and reported at the monthly QAPI meeting. QA coordinator will audit weekly x 4 weeks the tub cleaning process and then monthly x 3 months and reported to QAPI quarterly.</p>	1-22-15	

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F 441	<p>Continued From page 24</p> <p>level. That would have heated the solution to maximize its effectiveness.</p> <p>*Remove visible tissue, residue or fluids from the tub by pressing the Shower Button and rinse the inside tub with the shower sprayer.</p> <p>*Press the fill button again to turn off the water.</p> <p>*Allow the tub to drain and place the drain plug over the drain.</p> <p>*Press and hold disinfectant button until it flows from jets and there is one to one and a half gallons of solution in the foot well of the tub.</p> <p>*Using the long handled brush, thoroughly scrub all interior surfaces including the chair. Let disinfectant stay on for ten minutes.</p> <p>*Remove the plug from the drain.</p> <p>*Rinse the tubs interior surfaces with the shower sprayer.</p> <p>*Press and hold the Rinse Jets button until clear water runs, then release the button.</p> <p>*Finish rinsing.</p> <p>*Start the air blower and allow it to run for thirty seconds and press the button again to stop it.</p> <p>*Visibly check tub was cleaned, if not repeat the steps above."</p> <p>Interview on 12/2/14 at 12:20 p.m. with CNA E in the shower half of the whirlpool tub/shower room revealed she:</p> <p>*Was the main shower aide for the facility.</p> <p>*Was given Virex II 256 cleaner to use on the shower chair. She had no instructions on how to use it or how long it was to remain on surfaces to disinfect as the bottle was re-filled by housekeeping.</p> <p>*Stated she sprayed the cleaner on the chair and had not been rinsing the chemical off prior to bathing a new resident.</p> <p>*Had thought at least five minutes had been sufficient contact time but was unsure of the</p>	F 441		

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F 441	<p>Continued From page 25 exact time.</p> <p>*Was unaware the Virex II 256 cleaner needed to be wet on surfaces ten minutes, and then rinsed thoroughly so skin would not come into contact with the solution.</p> <p>Interview on 12/2/14 at 2:00 p.m. with the infection control coordinator revealed: *She had just recently been reassigned the duties of infection control coordinator. *The two months prior to this survey she had two interim (temporary) directors of nursing, and they had assumed some of the responsibilities of her role. *She had recently audited staff concerning the whirlpool/shower cleaning and disinfecting. *A recent audit dated 11/11/14 documented staff were "compliant with procedures" relating to whirlpool cleaning and disinfecting. *She remarked she had not actually observed staff but rather had asked if they knew how to do it correctly. *When asked about what tracking and trending she had completed regarding infection control and the high number of urinary tract infections she said she had not thought of that but could see a potential connection. *She agreed proper infection control practices were needed to ensure the least risk of the spread of potential infection to residents.</p> <p>Interview on 12/2/14 at 2:30 p.m. with the housekeeping supervisor regarding the shower cleaning revealed she would refill the Virex container from the main bottle. She "had not thought about the lack of instructions for use" on the bottle given to the CNAs.</p> <p>Review of the provider's September 2012</p>	F 441		

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F 441	<p>Continued From page 26</p> <p>Whirlpool bath policy revealed staff would refer to manufacturer's instructions for operating and cleaning specific equipment.</p> <p>2. Random observations of seven EZ-way stand lifts throughout the facility from 12/1/14 through 12/2/14 revealed:</p> <ul style="list-style-type: none"> <li>*Large amounts of dirt and debris were found on the foot plates.</li> <li>*They remained unclean throughout the above dates.</li> <li>*They were actively used to transport multiple residents from a sitting to standing position.</li> </ul> <p>Interview on 12/2/14 at 2:00 p.m. with the infection control coordinator revealed:</p> <ul style="list-style-type: none"> <li>*It had been her expectation CNAs were to have been cleaning the lifts daily as needed.</li> <li>*Thorough cleaning was to have been done by housekeeping once per week.</li> <li>*She had been unaware of the visible dirt and debris found on the foot plates.</li> <li>*She agreed upon observation they needed to be cleaned.</li> </ul> <p>Interview on 12/2/14 at 2:30 p.m. with the housekeeping supervisor revealed she was:</p> <ul style="list-style-type: none"> <li>*Unaware housekeeping was to have been cleaning the lifts.</li> <li>*Believed the CNAs were responsible to clean them since it had been equipment they had used.</li> </ul> <p>Review of the provider's December 2008 Safe Resident Handling policy revealed:</p> <ul style="list-style-type: none"> <li>**Lifts should be part of the daily and weekly cleaning schedules.</li> <li>*Caregivers will be trained to wipe lifts down when soiled.</li> <li>*Housekeeping will be scheduled to clean the lifts</li> </ul>	F 441			

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F 441	<p>Continued From page 27 on a weekly basis."</p> <p>Surveyor: 33265</p> <p>B. Based on observation, interview, manufacturer's instruction review, and procedure review, the provider failed to ensure:</p> <ul style="list-style-type: none"> <li>*Cleaning of glucometer (machine used to measure blood sugar) according to the manufacturer's instructions following use for two of two observations.</li> <li>*Sanitary conditions were maintained during one of two observations where oral medication was dropped onto the medication cart.</li> <li>*Three of three medication tablet crushers had been maintained in a clean and sanitary condition prior to medication preparation and administration.</li> <li>*Ready-to-eat food that had been used with medication administration had been disposed of within the appropriate time frame to maintain sanitary conditions.</li> </ul> <p>Findings include:</p> <p>1a. Observation and interview on 12/2/14 at 11:15 a.m. of registered nurse (RN) H doing the medication pass revealed:</p> <ul style="list-style-type: none"> <li>*She had completed a blood glucose test (measure sugar in blood) using a glucometer.</li> <li>*She returned the glucometer to the tray it was kept in without cleaning it.</li> <li>*When asked about how to clean the glucometer, she was not sure what to use to clean the glucometer, but said it should probably be cleaned.</li> </ul> <p>b. Observation and interview on 12/2/14 at 5:02 p.m. of RN J doing the medication pass revealed:</p> <ul style="list-style-type: none"> <li>*She had completed a blood glucose test using a glucometer.</li> </ul>	F 441		

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F 441	<p>Continued From page 28</p> <p>*She returned the glucometer to the tray it was kept in without cleaning it.</p> <p>*When asked about how to clean the glucometer she was not sure what to use to clean the glucometer.</p> <p>c. Interview on 12/3/14 at 3:05 p.m. with the director of nursing (DON) revealed she:</p> <p>*Had copies of the glucometer's manufacturer's instructions for cleaning of the machine.</p> <p>*Would be investigating which cleaners met the manufacturer's recommendations for cleaning the glucometers.</p> <p>Review of the manufacturer's undated instructions revealed cleaning and disinfection were to have been completed using one of two options:</p> <p>*A commercially available Environmental Protection Agency registered disinfectant detergent or germicide wipe.</p> <p>*A combination of isopropyl alcohol (70% to 80%) to clean it followed by a one to ten dilution of household bleach and water to disinfect it.</p> <p>Review of the provider's September 2012 Blood Glucose Monitoring procedure revealed:</p> <p>*The manufacturer's instructions for the specific device should be followed.</p> <p>*Clean and disinfect the blood glucose monitor between each resident's use.</p> <p>2. Observation on 12/2/14 at 3:39 p.m. of medication technician I doing the medication pass revealed she:</p> <p>*Dropped an oral medication (pill) onto the top of the medication cart instead of into the medication cup.</p> <p>*Scooped the medication up off the top of the cart</p>	F 441		

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F 441	<p>Continued From page 29 using the medication cup and gave the medication to the resident.</p> <p>Interview on 12/3/14 at 3:05 p.m. with the DON revealed: *She agreed best practices to prevent infection would have been to destroy the medication that had been dropped on the top of the medication cart and get another pill to replace the destroyed one to give to the resident. *She was not aware of a policy or procedure addressing what to do with a dropped medication.</p> <p>3. Observation on 12/3/13 from 10:05 a.m. to 10:20 a.m. of the three medication carts revealed the medication tablet (pill) crushers on each cart were dirty.</p> <p>Interview on 12/3/14 at 10:10 a.m. with licensed practical nurse (LPN) K revealed she agreed that the pill crushers were dirty.</p> <p>Interview on 12/3/14 at 3:05 p.m. with the DON revealed she agreed the pill crushers needed to be routinely cleaned.</p> <p>4. Observation on 12/3/13 from 10:05 a.m. to 10:20 a.m. of the three medication carts revealed the repackaged pudding kept on ice were: *Marked with the date 11/25/14. *Eight days old.</p> <p>Interview on 12/3/14 at 10:10 a.m. with LPN K revealed she agreed the repackaged pudding was past the seven day limit for use.</p> <p>Interview on 12/3/14 at 3:05 p.m. with the DON revealed she agreed the repackaged pudding was past the seven day limit for use.</p>	F 441		

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F 441	Continued From page 30  Review of the provider's undated Shelf Life of Refrigerated Items policy and procedure revealed ready-to-use foods (repackaged pudding) had a shelf life of seven days.	F 441			

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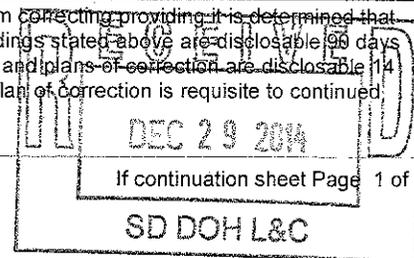
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/3/14. Good Samaritan Society Tyndall was found in compliance with 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>Julie B Schenk</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12-24-14</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.



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10695</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/03/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TYNDALL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2304 LAUREL ST TYNDALL, SD 57066</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)	(X5) COMPLETE DATE
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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 12/1/14 through 12/3/14. Good Samaritan Society Tyndall was found not in compliance with the following requirements: S166 and S270.	S 000		
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		

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

Julie B Schenkel

TITLE

Administrative Representative

(X6) DATE

STATE FORM

6899

7N0F11

DEC 29 2014

If continuation sheet 1 of 4

SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10695</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/03/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TYNDALL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2304 LAUREL ST TYNDALL, SD 57066</b>
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S 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility;</p> <p>(8) Household-type electric blankets or heating pads may not be used in a facility;</p> <p>(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</p> <p>(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: 33488 Based on observation and interview, the provider failed to ensure either a shatterproof light bulb or a lens cover had been used to cover non-shatterproof light bulbs in: *One of one resident room (211) where a floor lamp had been used. *All of the resident rooms above each bed (affixed to the room light on the wall behind the bed) that had been used as a nightlight. Findings include:</p> <p>1. Observation and interview on 12/2/14 from 3:30 p.m. through 4:00 p.m. with the maintenance supervisor during a walkthrough inspection of the facility revealed: *Room 211 had a floor lamp with a reading light bulb that protruded from the side. The bulb was not shatterproof. The bulb touched the divider curtain used between resident areas. *All resident rooms had nightlights affixed to the room light behind their beds on each side of their</p>	S 166	<p>S166 1. Shatter proof covers have been placed in all of the resident rooms on the over the bed night lights and the lamp in Room 211 has been moved away from curtain and has had Saf-T-Gard bulbs installed that are covered by the lamp shade. Maintenance will review this on their monthly preventive maintenance rounds and report to the Safety committee for the next 3 months.</p>	1-22-15
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South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TYNDALL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2304 LAUREL ST TYNDALL, SD 57066</b>
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S 166: Continued From page 2  
 room (if shared) that:  
 -Had not been covered with a lens cover.  
 -Were not shatterproof.  
 \*He agreed a lens cover should have been used with non-shatterproof bulbs.

S 166

S 271 44:04:05:01.01 ADMISSIONS TO NURSING FACILITIES

S 271

The resident's health care shall continue under the supervision of a physician. If a resident transfers from one nursing facility to another while retaining the same physician, the requirement for the physical exam shall be waived; however, the schedule for physician visits shall continue. The resident must be seen by the attending physician at least once every 30 days for the first 90 days following admission. Subsequent to the 90th day following admission, the physician shall visit the resident whenever necessary; but the time between visits may not exceed 60 days. A physician extender may conduct every other visit with the resident's permission. The resident's total care program including medications and treatments must be reviewed during the physician's visits.

This Administrative Rules of South Dakota is not met as evidenced by:  
 Surveyor: 18560  
 Surveyor 35120  
 Preceptor: 33265.  
 Based on interview, record review, and policy review, the provider failed to have a resident seen by the attending physician monthly for the first ninety days after admission for 1 of 15 sampled residents (2). Findings include:

South Dakota Department of Health

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S 271 Continued From page 3

1. Review of resident 2's complete medical record revealed:  
 \*She had been admitted on 3/20/14.  
 \*The initial physician's visit was completed on 4/7/14.  
 \*She was not seen again by her physician for 125 days (8/11/14).

Interview on 12/3/14 at 11:45 a.m. with the director of nursing confirmed:  
 \*Resident 2 had been seen by her physician once during the 3/20/14 to 6/20/14 time frame.  
 \*Their policy was for the physician to see the resident every thirty days for the first ninety days

Review of the provider's September 2012 Physician Services policy revealed "The resident will be seen personally by the attending physician at least once every 30 days for the first 90 days after admission."

S 271

S271 Facility is unable to go back and complete physician rounds with another provided for Resident #2. The HIM will coordinate all resident rounds ensuring each resident is seen by a physician every 30 days for the first 90 days and at least every other time by physician on the regular 60 day rotation. The local clinic has been notified that physician extenders may not substitute for physicians during a resident's first 90 days and may only provide visits on an alternating basis with every other visit taking place with the primary physician. The administrator will review the physician visit report from the EMR and will randomly audit at least 5 records each month for the next 3 months to ensure physician visit compliance. The administrator will report findings to the QA committee monthly for next 3 months.

1-22- 15