

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/29/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>
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F 000	INITIAL COMMENTS  Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/27/15 through 7/29/15. Good Samaritan Society Canistota was found not in compliance with the following requirements: F280, F281, F371, and F441.	F 000	<i>Addendum noted with an asterisk per 9/8/15 telephone to facility DON. JK/5200H/JJ</i>	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review,	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Dylan Spal</i>	TITLE  <i>Administrator</i>	(X6) DATE  <i>8/20/15</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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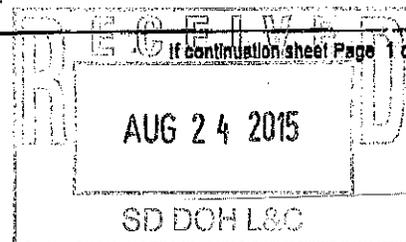
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F 000	INITIAL COMMENTS  Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/27/15 through 7/29/15. Good Samaritan Society Canistota was found not in compliance with the following requirements: F280, F281, F371, and F441.	F 000	Initial Comments Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review,	F 280	F 280 1. As of 8/17/15, residents 2, 3, & 8's care plans were reviewed and appropriate revisions	

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

TITLE

(X6) DATE

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Continued From page 1  
and policy review, the provider failed to ensure 3 of 12 sampled residents' (2, 3, and 8) care plans had been reviewed and revised to reflect those 3 residents needs. Findings include:

- Review of resident 3's medical record revealed:
  - \*An admission date of 11/11/09.
  - \*Diagnoses of personality disorder (difficulty dealing with others), depression (sadness), visual loss, dementia (forgetfulness), and failure to thrive (unable to gain weight).
  - \*She had been on comfort care (end of life) with hoapice care.
  - \*She had required staff assistance for transfers and bed mobility (moving from place to place and repositioning in bed), personal hygiene, and dressing.
  - \*She had a history of pressure ulcers (injury to skin usually from pressure and frequently over a bony area) to her left heel.

Observation on 7/28/15 from 8:05 a.m. through 8:45 a.m. revealed:

- \*She had been resting in bed.
- \*Certified nursing assistants (CNA) C and M had assisted her with morning care and getting out of bed.
- \*She had been laying on a Tabs monitor (alarming device to alert the staff when a resident attempted to transfer themselves).
- \*She had not been able to assist the CNAs with moving in bed, personal hygiene, dressing, and transferring from the bed to her wheelchair (w/c).
- \*The CNAs had used a mechanical device to transfer her from the bed to her w/c.
- \*That mechanical device:
  - Had a sling that she sat in.
  - Lifted her entire body off of the bed and placed

F 280

made to reflect current care and treatment required.  
Resident 3's care plan reviewed and updated. TABS monitor was removed from resident's bed, bed mobility was changed to reflect total dependence and total lift was added to be used with bed mobility and transfers, ambulate to meals was removed, and resident was placed on a repositioning program and pillow placement between legs with care plan and POC updated to reflect this.  
Resident 2's care plan was reviewed and updated on 8/18/15 to reflect current care and condition. Orthostatic blood pressures added to be done with falls or if Ativan added in the future.  
Resident 8's care plan was reviewed and updated on 8/17/15 to reflect resident's behavior of inappropriate sexual behavior.  
2. For all other potential residents care plans were reviewed and updated as indicated on 8/17/15 to reflect their current condition.

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F 280	Continued From page 2 her in the w/c. *She had not been observed standing or walking at anytime during her morning cares or to .  Review of resident 3's current care plan revealed: *On 9/19/14: -Focus: "The resident has an ADL (activities of daily living) self care performance deficit with self care R/T dementia E/B [evidenced by] needs extensive assist. -Intervention: "Bed Mobility: Resident requires 1 staff participation extensive assist to reposition and turn in bed. Dressing: Resident requires 1 staff participation to dress." *On 12/9/14: -Focus: "The resident has had an actual fall." -The interventions had failed to identify the use of a Tabs monitor (personal alarm to alert staff if a resident tries to get up without assistance) while the resident was resting in bed. *On 1/8/15: -Focus: "The resident has potential for constipation R/T [related to] decreased mobility. -Intervention: "Encourage to ambulate to meals with FWW [front wheeled walker] and 1 assist." *On 3/24/15: -Focus: "The resident has potential impairment to skin integrity R/T Braden Scale [special type of skin assessment] below 18, diabetes [uncontrollable blood sugar levels], and decreased mobility." -The interventions had failed to identify a repositioning program for the resident. *On 6/18/15: -Focus: "The resident has limited physical mobility R/T weakness." -Goal: "Resident will demonstrate the appropriate use of adaptive device(s) to increase mobility by the review date. Device: Wheelchair and limited	F 280	3. IN-SERVICE: Education will be provided by the DNS/Staff Development Nurse to include GSS policy and procedure for care planning including reviewing, evaluating and updating care plans with a significant change in resident's condition. 4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly times 4 weeks, monthly times 2 months and quarterly times 3 quarters. Audits will include ensuring that each resident has an individualized care plan and that the interdisciplinary team is meeting to review care plans regularly. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root cause.	8/25/15	

*on 5 Care Plans discussed*

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F 280	<p>Continued From page 3 walker use." -Intervention: "Ambulation: Resident requires weight bearing support to ambulate, gait belt, transfers."</p> <p>Interview on 7/29/15 at 9:50 a.m. with the director of nursing revealed: *The interdisciplinary care team and nursing staff had been responsible for the reviewing and revising of the care plans. *She agreed all of the above areas of concern for resident 3 should have been updated. *Resident 3's care plan had not reflected the current level of care that she required.</p> <p>Surveyor: 35237 2. Review of resident 2's medical record revealed: *He was admitted on 5/8/15. *He had a Brief Interview for Mental Status (BIMS) (memory test) score of 14 that indicated he did not have a memory issue. *His diagnoses included Schizophrenia (serious brain disorder that affects how a person thinks, feels, and acts), diabetes (disease that affects sugar levels in the blood), anxiety (anxiousness), insomnia (trouble sleeping), orthostatic hypotension (a drop in blood pressure when changing positions), anemia (low iron in blood), hypertension (high blood pressure), paranoid state (suspiciousness), and tobacco use disorder (smoker). *He had falls on: -8/11/15 at 9:00 a.m. trying to get into bed by himself. -8/13/15 at 10:10 a.m. trying to fix his bed. -8/13/15 at 12:30 p.m. he was found kneeling on the floor next to his bed.</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>*Occurrence reports from the above falls revealed the corrective action to prevent recurrence of falls included:</p> <p>-On 6/11/15 it was resident education. That education was "reminded the resident to look behind him before laying down to ensure he is on the bed."</p> <p>-On 6/13/15 at 10:10 a.m. it was employee and resident education, and to monitor his blood pressures and update the physician. The back of the report also stated the resident had seen the physician and medications were on hold.</p> <p>-On 6/13/15 at 12:30 p.m. it was employee and resident education, and he would see the physician on 6/15/15. The back of the report also stated he was hypotensive (low blood pressure), and his medications were on hold.</p> <p>*Faxes to the physician regarding the falls on 6/11/15 and 6/13/15 revealed he also had laboratory (blood and urine) tests that were ordered by an on-call physician.</p> <p>*A clinic referral sheet from his physician visit on 6/15/15 revealed he had changed blood pressure and anxiety medications and had an EKG (heart monitoring) test done.</p> <p>Random observations of resident 2 during the survey from 7/27/15 through 7/29/15 revealed he was independent with ambulation with a steady gait (good balance) throughout the building.</p> <p>Review of resident 2's current care plan related to falls revealed:</p> <p>*His last fall was on 6/13/15.</p> <p>*The interventions had not been revised since his admission date of 5/8/15.</p> <p>Interview on 7/29/15 at 1:30 p.m. with the director of nursing (DON) regarding resident 2 revealed:</p>	F 280			

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F 280 Continued From page 5

- \*She was aware he had the above falls.
- \*They had made changes in his care related to those falls.
- \*She agreed those changes in his care had not been updated and revised on his care plan.

3. Review of resident 8's medical record revealed:

- \*She was admitted on 7/18/14.
- \*Her diagnoses included delirium (a quick change between mental states, alertness to confusion), depressive disorder (sadness), breast cancer, dementia with behaviors (memory problems), senile dementia with delusions (memory problems with false beliefs), and psychosis (severe mental disorder where thought and emotions are impaired).
- \*She had a history of sexual behaviors towards male residents including holding hands, sitting closely to them, touching, kissing, and rubbing their arms.
- \*She had an incident on 7/5/15 with resident 10 that was more than the above sexual behaviors.
- \*Staff had separated the residents and notified their families.
- \*Her physician increased her Seroquel (antipsychotic medication) dose on 7/8/15 due to the increase in her sexual behaviors.
- \*Her behaviors had improved since the dose increase.

Random observations of resident 8 from 7/27/15 through 7/29/15 revealed:

- \*She was able to ambulate independently with a four-wheeled walker.
- \*She was pleasant and spoke to other residents and staff.
- \*During meal observations she sat at her own table sometimes and at resident 10's table

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F 280	<p>Continued From page 6</p> <p>sometimes.</p> <p>*When talking to resident 10 she occasionally touched his shoulder or hand.</p> <p>Review of resident 8's current care plan revealed:</p> <p>*A focus area for behavior symptoms related to her dementia that included target behaviors of:</p> <ul style="list-style-type: none"> <li>-Wandering.</li> <li>-Kissing male residents.</li> <li>-Hallucinations (false or distorted sensory experiences).</li> </ul> <p>*Interventions for that focus area included:</p> <ul style="list-style-type: none"> <li>- "Remove from situation and take to alternate location as needed."</li> <li>- "Re-direct if in others room."</li> <li>- "_____ is not to be alone in male resident rooms and to be separated if kissing other residents."</li> </ul> <p>*There had been no updates or revisions to that focus area since 3/27/15.</p> <p>Interview on 7/28/15 at 2:50 p.m. with the social services designee regarding resident 8 revealed:</p> <p>*Staff tried to keep a close eye on resident 8 in general and redirect her as needed.</p> <p>*She was aware of the incident on 7/5/15 between resident 8 and resident 10.</p> <p>*She stated resident 8's behaviors had gotten worse prior to the incident and had gotten better since her Seroquel had been increased.</p> <p>Interview on 7/29/15 at 8:10 a.m. with the staff development/infection control/quality assurance nurse regarding resident 8 revealed:</p> <p>*The resident liked to have male friends and especially liked resident 10.</p> <p>*She confirmed resident 8 was cognitively impaired (memory issues and lack of insight) and had a history of sexual type behaviors.</p> <p>*She had been aware of the incident on 7/5/15</p>	F 280		
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F 280	<p>Continued From page 7 with residents 8 and 10.</p> <p>*Both resident's families had been aware of the resident's history of behaviors and were okay with them being in public areas holding hands and talking.</p> <p>*She stated the families felt the 7/5/15 incident went too far.</p> <p>*She assisted with care plans at times, but the director of nursing and social services would have done the care plan for the behavior section</p> <p>Interview on 7/29/15 at 10:05 a.m. with the administrator regarding resident 8 revealed:</p> <p>*She spent a lot of time in his office with him.</p> <p>*She was usually the instigator when it came to behaviors towards male residents.</p> <p>*He stated usually resident 8's behaviors toward resident 10 were holding hands, touching his shoulder, and sitting by him in the dining room.</p> <p>*On 7/5/15 the behavior went farther than her usual behaviors.</p> <p>*He stated he did not know what else they could change related to her behavior.</p> <p>*Staff watched her closely and redirected her as needed.</p> <p>*She spent a lot of time in his office while he was working.</p> <p>*She had a short attention span and had cognition (memory and insight) issues.</p> <p>*She usually did not like activities.</p> <p>*He was aware the physician had increased her Seroquel dose due to the increase in behaviors.</p> <p>Interview on 7/29/15 at 10:30 a.m. with the Minimum Data Set (MDS) assessment nurse revealed:</p> <p>*She worked on resident care plans related to their MDS assessments and as needed.</p> <p>*The charge nurses would make revisions and</p>	F 280			

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F 280	<p>Continued From page 8</p> <p>updates to care plans in between MDS assessments with help from the interdisciplinary team as needed.</p> <p>*She agreed updates on care plans sometimes did not get completed.</p> <p>*She agreed the 7/5/15 incident for resident 8 was more than the sexual behaviors listed on her care plan.</p> <p>*She was aware they had changed resident 8's Seroquel dose with the increase in her behaviors.</p> <p>*She confirmed there had been no revisions to resident 8's care plan following the 7/5/15 incident.</p> <p>Interview on 7/29/15 at 11:20 a.m. with registered nurse (RN) N regarding resident 8 revealed:</p> <p>*She had been working on 7/5/15 when the incident between resident 8 and 10 had occurred.</p> <p>*She had updated both resident's families and the administrator right away.</p> <p>*Staff had moved resident 10 to a different room that night, since resident 8 would maybe have tried to go back to his room again.</p> <p>*Resident 8's family had not been surprised but asked if there was a medication that could take away her "sex drive."</p> <p>*She was aware resident 8's Seroquel dose was increased by the physician, and her behaviors had improved since that time.</p> <p>*She agreed there should have been changes to resident 8's care plan following the 7/8/15 incident since it was more than her past sexual behaviors.</p> <p>*She stated the provider had recently started training the nurses on care plans but usually the nurses did not revise care plans.</p> <p>4. Review of the provider's September 2012 Care Plan policy revealed:</p> <p>*"Each resident will have an individualized</p>	F 280			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 9 comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs." *"Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition and/or in accordance with state guidelines. This plan of care will be modified to reflect the care currently required/provided for the resident."	F 280			
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: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure proper positioning for 1 of 12 sampled residents (3) while she had been resting in her bed. Findings include:  1. Review of resident 3's medical record revealed: *An admission date of 11/11/09. *Diagnoses of personality disorder (difficulty dealing with others), depression (sadness), visual loss, dementia (forgetfulness), and failure to thrive (unable to gain weight). *She had: -Been on comfort care (end of life) with hospice care, -Required staff assistance for transfers and bed	F 281	F 281  1. As of 8/17/15 resident 3's care plan was reviewed and updated to reflect a repositioning program and to utilize a pillow between resident 3's legs to prevent skin breakdown. POC has been updated to reflect repositioning program and repositioning device to prevent skin breakdown. 2. For all other potential residents identified to be at risk, by utilizing the Braden Scale were evaluated for repositioning programs.		

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
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F 281	Continued From page 10 mobility(moving from one location or changing position), personal hygiene, and dressing. -Decreased range-of-motion in her legs. -A history of pressure ulcers (injury to skin from pressure and frequently over a bony area) to her left heel.  Observation on 7/27/15 at 4:30 p.m. of resident 3 revealed: *She had been resting in her bed, *The top part of her body from the waist up had been facing the wall with her back partially on the bed. *Her bottom and legs had been laying flat on the bed. *There had not been any repositioning devices such as pillows or wedges observed behind her back or between her legs. Those devices would have ensured she was laying on her right side and free from skin-to-skin pressure on both of her knees. *Both of her feet were in pressure relieving boots.  Observation on 7/28/15 at 7:50 a.m. of resident 3 revealed: *She had been resting in her bed. *She had been laying in the same position as observed above. *The top part of her body from the waist up had been facing the wall with her back partially on the bed. *Her bottom and legs had been laying flat on the bed. *There had not been any repositioning devices observed in her bed to prevent pressure.  Observation on 7/28/15 at 11:30 a.m. of resident 3 revealed she had been resting in her bed in the same position as observed above.	F 281	3. IN-SERVICE: Education will be provided by the DNS/ Staff Development Nurse to include GSS policy and procedure on Mobility Support & Repositioning, skin breakdown prevention, interventions, and use of Braden scale. 4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly times 4 weeks, monthly times 2 months and quarterly times 3 quarters. Audits will include residents having an individualized repositioning program. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root cause.	8/25/15	

on resident 3 and 5 randomly selected residents 08/15/2015

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F 281	<p>Continued From page 11</p> <p>Random observations on 7/28/15 from 1:30 p.m. through 5:30 p.m. of resident 3 revealed she had been resting in her bed in the same position as observed above. She had not been observed in any other position during that time frame.</p> <p>Review of resident 3's current care plan revealed: *She had been at risk for skin breakdown. *It failed to identify any repositioning program for her.</p> <p>Interview on 7/28/15 at 2:05 p.m. with certified nursing assistant (CNA) C regarding resident 3 revealed: *The resident had not been feeling well and had refused to get out of bed for the noon meal. *She had been instructed to let her rest. She stated "She is on comfort care and if she wants to rest we are to let her." *She had gone into the resident's room every two hours to check her incontinent brief and changed the brief when it was soiled. She had considered that to be repositioning. *She was not aware if the resident should have been moved to a different position.</p> <p>Interview on 7/29/15 at 10:10 a.m. with the director of nursing regarding resident 3 revealed: *She was not aware the staff: -Had not been repositioning her from side-to-side and to her back every two hours. -Were not using any repositioning devices when the resident was resting in bed. *She agreed there should have been repositioning devices used to: -Assist the resident with proper body alignment. -Reduce the risk of pressure ulcers. *She stated "Proper repositioning was a standard</p>	F 281			

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F 281	Continued From page 12 of practice." "She agreed the care plan should have identified a repositioning program for the resident.  Review of the provider's November 2013 Mobility Support and Positioning policy revealed: *Purpose: -"To support the resident's ability to change position which promotes comfort, support and proper body alignment." -"To support the resident's ability to move from side to side, up in bed, supine to seated on the edge of bed." -"To assist the resident who has a limited/decreased functional ability to change position." -"To reduce the risk of pressure ulcers, skin tears, shearing [skin rubbed off]." -"To sustain [maintain] and improve the resident's health with frequent mobilization." -"To position those residents unable to position/reposition independently in a manner which prevents formation of contractures, provides comfort, and maintains skin integrity." "Developing an individualized repositioning schedule is recommended based on an evaluation of risk factors and on observation of the resident's skin over a period of time."	F 281		
F 371 SS=D	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371. 1. Cooks A and B were immediately educated by Administrator on 7/27/15 regarding the proper use of gloves and handling of ready-to-eat foods.	

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F 371	Continued From page 13  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure appropriate glove use and handling of ready-to-eat food items had been done by two of two observed cooks (A and B) while preparing and serving one of two meals (supper). Findings include:  1. Observation on 7/27/15 at 5:00 p.m. of cook A revealed: *She had set-up to prepare buttered bread. *She had washed her hands and put on clean gloves. With those clean gloves she had: -Retrieved a plastic bag off of a rack that a food truck had delivered to the facility. The plastic bag had contained several slices of bread. -Opened that plastic bread bag and removed several slices of bread. -Placed those slices of bread on top of an empty bread bag that had contained bread. -Continued to butter and slice those pieces of ready-to-eat buttered bread with those soiled gloves.  2. Observation on 7/27/15 from 5:20 p.m. through 6:00 p.m. of cooks A and B revealed: *Both cooks had prepared to serve the supper meal. *Cook B had washed her hands and put on clean gloves. With those clean gloves she had performed the following tasks: -Opened two cupboard doors and retrieved several glass bowls for the soup.	F 371	2. For all potential residents the cooks will use gloves properly and handle ready-to-eat foods in a safe and sanitary manner according to GSS policy and procedure. 3. IN-SERVICE: Education will be provided by Dietary Manager/Staff Development Nurse to include GSS policy and procedure regarding Infection Control, proper glove use and proper hand washing. 4. AUDITS: The Dietary Manager/QAPI Nurse/designee will complete audits weekly times 4 weeks, monthly times 5 months and quarterly times 2 quarters. Audits will include sanitary prep and service of food. The Dietary Manager/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root cause.	8/25/15
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*on 2 dietary staff a week jkl/smith/jb*

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F 371	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-Pulled a cart over by the steam table. On the cart were several slices of lettuce sitting on tinfoil with tomatoes on top of them.</li> <li>-Removed several steam wall lids and started to serve supper.</li> <li>-Handled multiple diet cards. Some of those diet cards had small pieces of yellow paper attached to them.</li> <li>-Removed several of those yellow pieces of paper from the diet cards.</li> <li>-Retrieved a potholder and used it to remove a coffee cup from inside of a steam wall. The coffee cup contained gravy.</li> <li>-Touched ready-to-eat food items (lettuce and tomato) with her soiled gloves.</li> <li>*She had not been observed washing her hands or changing her gloves prior to handling the ready-to-eat food.</li> <li>*Cook A had washed her hands and put on clean gloves. With those clean gloves she had performed the following tasks:             <ul style="list-style-type: none"> <li>-Removed the plastic off of a container holding egg salad sandwiches.</li> <li>-Handled multiple diet cards handed to her by cook B. Some of those diet cards had the small pieces of paper still attached to them.</li> <li>-Removed several of those yellow pieces of paper from the diet cards.</li> <li>-Touched a ready-to-eat food item (egg salad sandwich) several times with her soiled gloves. She had removed them from the container and cut them in half prior to being served.</li> </ul> </li> </ul> <p>Interview on 7/29/15 at 8:40 a.m. with the dietary manager who was also cook A confirmed: *Cook B and herself should not have handled ready-to-eat foods after handling and touching unclean surfaces. *She should have:</p>	F 371		
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F 371	Continued From page 15 -Removed her gloves and washed her hands after opening the bread bags. -Not placed the bread slices on a different soiled bread bag. -Used a clean cutting board to prepare the buttered bread slices. *The above observations and tasks had not been performed in a sanitary manner.  Review of the provider's February 2013 Food Preparation policy revealed: *Purpose: "To ensure food is kept free of contamination." *Policy: "Staff will practice techniques in food preparation that protect against food-borne illness."  Review of the provider's February 2013 Food Handling policy revealed: *Purpose: "To limit contamination of food served to a highly susceptible population." *Policy: "Food will be handled in a manner that minimized the risk of contamination."	F 371			
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,	F 441	F441 1. CNA C & CNA F were verbally educated by DNS on 8/17/15 regarding glove use while performing personal hygiene, catheter care, changing of leg bag, donning TED hose and hand washing.		

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F 441	<p>Continued From page 18 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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 isolate the resident. (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. (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: 35237</p> <p>Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for: *Two of two sampled residents (3 and 4) who received personal care by two of four certified nursing assistants (CNA) (C and F). *The disinfecting process of a whirlpool (w/p) tub by one of one CNA ( D). *Two of five observed disposable (throw away)</p>	F 441	<p>CNA D was educated on cleaning and disinfecting of whirlpool tub on 8/12/15 by DNS.</p> <p>On 8/13/15, 5 disposable razors in 3 drawer cart in tub room were disposed of in sharps container, a sharps container was placed in tub room by maintenance supervisor, a supply of disposable one time use razors were placed in 3 drawer cart and bath aides were verbally educated on single use razor and disposal of used razor into sharps container.</p> <p>Baskets were placed in 3 drawer cart to separate pens, highlighters, and qtips, and personal care items.</p> <p>Razors found in oxygen storage room were cleaned, disinfected, and placed in proper resident's rooms on August 13, 2015. All CNAs were verbally instructed by DNS at that time to store all</p>		

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F 441 Continued From page 17  
razors in the w/p tub room.  
\*The storage and cleaning for four of six personal electric razors observed in the oxygen storage room.  
Findings include:  
1. Observation on 7/28/15 from 8:05 a.m. through 8:45 a.m. of resident 3's personal care with CNAs C and M revealed:  
\*The resident was laying in her bed.  
\*CNA C washed her hands and applied gloves to her hands. With those clean gloves she had:  
-Uncovered the resident to start personal care.  
-Opened a package of cleansing wipes sitting on her bedside table.  
-Retrieved several cleansing wipes.  
-Cleaned the resident's bottom with those cleansing wipes.  
-Removed a moderate amount of bowel movement from the resident's bottom.  
\*CNA C had not removed her gloves and washed her hands after cleaning the resident's bottom.  
\*With those same soiled gloves CNA C had:  
-Closed the package of cleansing wipes and opened a drawer in the bedside table.  
-Placed the package of cleansing wipes inside of that drawer and closed it.  
-Removed her gloves and washed her hands.  
\*With those clean hands CNA C had:  
-Finished dressing the resident.  
-Assisted CNA M with transferring the resident into her wheelchair.  
-Re-opened the soiled bedside table drawer and retrieved a tube of chapstick.  
-Opened the tube of chapstick and applied some to the resident's lips.  
  
Interview on 7/29/15 at 10:25 a.m. with the infection control nurse and director of nursing

F 441 electric razors in resident's rooms.  
2. For all other potential residents the CNA's will appropriately clean and disinfect the whirlpool tub according to manufacturer directions and GSS policy and procedure. Razors will be cleaned disinfected and placed in proper residents' rooms. CNA's will follow appropriate hand hygiene and glove use per GSS policy and procedure.  
3. IN-SERVICE:  
Education provided by DNS/Staff Development Nurse to include GSS policy and procedure regarding infection control as it pertains to glove use, hand washing, storage of supplies, cleaning & storage of electric razors, use and disposal of disposable razors, and whirlpool tub cleaning and disinfection.

8/25/15

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F 441	<p>Continued From page 18</p> <p>(DON) confirmed the above process to provide personal care for resident 3 had not been done in a sanitary manner. They agreed CNA C should have removed her gloves and washed her hands after cleansing the resident's bottom.</p> <p>Surveyor: 35237</p> <p>2. Observation and Interview on 7/28/15 at 9:45 a.m. of resident 4's personal care with certified nursing assistants (CNA) F and L revealed: *The resident was lying in bed on his back. *CNA F: -Put on gloves. -Uncovered the resident to start the personal care. -Performed private area care for him with a wash cloth. -Performed catheter (tube inserted into the bladder to drain urine) care. -Changed the catheter drainage bag (large bag used to collect urine) to a leg bag (smaller bag used to collect urine that can be hidden under the clothes). -Applied TED hose (special stocking used for swelling) to the resident's right leg. -Removed his gloves. -Washed his hands. -Proceeded with personal care for the resident. *CNA F had used the same gloves during the above cares. -He had not performed hand hygiene in between the above care for the resident.</p> <p>Interview on 7/29/15 at 10:30 a.m. with the Minimum Data Set (MDS) assessment nurse/assistant DON confirmed infection control had not been maintained in the above observation. She agreed there was a potential for cross-contamination when CNA F used the same</p>	F 441	<p>4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly times 4 weeks, monthly times 5 months and then quarterly times 2 quarters. Audits will include proper glove use and hand washing as it pertains to personal cares, ensuring razors are maintained properly, the whirlpool is disinfected properly and resident items are kept separate from facility items. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root cause.</p>	
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*on 1 staff member per week during whirlpool tub disinfecting and personal cares*

*JK/SPOOK/ST*

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F 441	Continued From page 19 gloves for the above care.  Surveyor: 92355 3. Observation on 7/28/15 at 9:00 a.m. of CNA D revealed: *She had: -Prepared to disinfect the w/p tub after a resident had been given a bath. *Pressed on a knob attached to the tub. That knob had allowed the disinfectant to automatically fill the tub through the air jets. *Filled the tub with the disinfectant just past the w/p tub plug (keeps the solution or water inside) and into the foot wall. *After she had put the disinfectant in the tub she turned on the water and air jets. *She had: -Filled the tub half full of water. -Scrubbed all of the surfaces with a brush and let the surfaces remain wet for ten minutes before draining the tub and rinsing with water.  Interview on 7/28/15 with CNA D at the time of the observation revealed: *She had always cleaned the w/p tub as observed above. *The representative for the w/p tub had trained her on how to clean it. *She had been told the Penner disinfectant that automatically filled the tub was not mixed with water. *She did not know the correct amounts of disinfectant and water to be used to successfully disinfect the w/p tub. She had assumed the process she used was correct.  Review of the Penner Whirlpool Disinfectant Cleaner Instructions revealed for proper cleaning the staff should use 2 ounces of the cleaner with	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  436087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2015
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 20 1 gallon of water.</p> <p>Review of the manufacturer's undated System Cleaning directions for the w/p tub revealed: "On the Aqua-Aire Tubs, press and hold the disinfect button located on the left side of the tub." "As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets." "Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub."</p> <p>Interview on 7/29/15 at 10:40 a.m. with the infection control nurse and DON revealed: "They had not observed or done any audits of the staff cleaning the w/p tub." "They were unaware CNA D had not been cleaning the w/p tub according to the manufacturer's recommendations.</p> <p>4. Observation on 7/28/15 at 8:50 a.m. in the w/p tub room revealed: "A three drawer plastic caddy sitting next to the w/p tub." "In the top drawer of the caddy had been resident use items." "Those items had been: -Five disposable sharp razors. Two of those razors had been used and were full of hair. -An open package of clean Q-tips (cotton tipped applicators). -A box of alcohol wipes. -Equipment to clean and trim the resident's fingernails and toenails. -Several pens and yellow highlighters.</p> <p>Interview on 7/28/15 with CNA D at the time of the</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2015
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 441	<p>Continued From page 21</p> <p>observation revealed:</p> <ul style="list-style-type: none"> <li>*The disposable sharp razors had been used to shave some of the residents.</li> <li>*She had been re-using the two opened and dirty razors per resident request.</li> <li>*She agreed:                             <ul style="list-style-type: none"> <li>-The used razors should have been thrown away into the sharps container.</li> <li>-She should not have re-used them.</li> <li>-The dirty razors and pens and highlighters should not have been co-mingled with the other resident use items.</li> </ul> </li> <li>*She had confirmed the above observation had not been sanitary and created the potential of cross-contamination (transfer of bacteria from one person to another) for the residents.</li> </ul> <p>Interview on 7/29/15 at 10:40 a.m. with the infection control nurse and DON revealed:</p> <ul style="list-style-type: none"> <li>*They had been:                             <ul style="list-style-type: none"> <li>-Aware the staff had been using disposable sharp razors to shave some of the residents.</li> <li>*Unaware the staff had been saving those razors and re-using them.</li> <li>*The staff should have disposed of the razors in a sharps container after using them once.</li> <li>*The pens and highlighters should not have been stored with the resident use items above.</li> <li>*They agreed the above observation was not sanitary and created the potential for cross-contamination to the residents.</li> </ul> </li> </ul> <p>Observation on 7/28/15 at 11:20 a.m. of the oxygen storage room revealed:</p> <ul style="list-style-type: none"> <li>*There had been a shelf attached to one of the walls.</li> <li>*On that shelf had been six electric razors.</li> <li>*Those razors had been:                             <ul style="list-style-type: none"> <li>-Stored all together.</li> </ul> </li> </ul>	F 441		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

435087

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

07/29/2015

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY CANISTOTA

STREET ADDRESS, CITY, STATE, ZIP CODE

700 WEST MAIN ST  
CANISTOTA, SD 57012

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID  
PREFIX  
TAG

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)

(X5)  
COMPLETION  
DATE

F 441

Continued From page 22  
-Individually labeled with resident's names.  
\*When those razor heads had been opened four  
of them contained a large amount of gray hair  
shavings.

Interview on 7/28/15 at 11:25 a.m. with CNA D  
regarding the above observation revealed:  
\*The razors had not been stored in the residents'  
rooms, because they would take them apart.  
\*The staff would have used a brush to clean out  
the hair shavings after the residents used them.  
\*She had been unaware of any other cleaning  
process for the resident's razors.  
\*She agreed:  
-Four of the razors had been dirty and should  
have been cleaned.  
\*All six of the razors should not have been stored  
together.

Review of the provider's undated and typed Razor  
Cleaning policy revealed:  
"Take apart razor."  
"Brush the whiskers out with a tooth brush."  
"Clean with alcohol wipes."  
"Air dry."  
"Put razor back together."

Interview on 7/29/15 at 10:30 a.m. with the  
infection control nurse and DON revealed:  
\*They had not been aware of any resident razors  
being stored in the oxygen supply room.  
\*The razors should have been stored in the  
residents' room.  
\*The razors should not have been stored  
together. Those razors should have been placed  
in each of the resident's rooms.  
\*They agreed the storage of those six razors had  
not been done in a sanitary manner.  
\*The policy above was an expectation not an

F 441

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

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

435087

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

07/29/2015

NAME OF PROVIDER OR SUPPLIER

GOOD SAMARITAN SOCIETY CANISTOTA

STREET ADDRESS, CITY, STATE, ZIP CODE

700 WEST MAIN ST  
CANISTOTA, SD 57012

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SUMMARY STATEMENT OF DEFICIENCIES  
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PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
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DEFICIENCY)

(X5)  
COMPLETION  
DATE

F 441

Continued From page 23  
actual policy for the staff to follow.

F 441

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

**ORIGINAL**

PRINTED: 08/12/2015  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>	
(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	INITIAL COMMENTS  Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/29/15. Good Samaritan Society Canistota was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/29/15 upon correction of the deficiencies identified below.  Please mark an "F" in the completion date column of those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7  This STANDARD is not met as evidenced by: Surveyor: 25107 Based on measurement and document review, the provider failed to maintain at least 32 inches of clear width for smoke barrier doors in the 100 and 200 wings. Findings include:	K 028		

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

*Dylan Spill*

TITLE

Administrator

(X6) DATE

8/20/15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

AUG 24 2015

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2015
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 028 SS-C	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7  This STANDARD is not met as evidenced by: Surveyor: 25107 Based on measurement and document review, the provider failed to maintain at least 32 inches of clear width for smoke barrier doors in the 100 and 200 wings. Findings include:	K 028	F	F

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

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.

RL  
AUG 24 2015

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

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012	
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K 028	Continued From page 1 1. Measurement at 1:00 p.m. on 7/29/15 revealed the cross-corridor doors to the 100 wing measured 31 inches of clear width. Further measurement revealed the cross-corridor doors to the 200 wing adjacent to the nurses station measured 30 inches of clear width. Review of the previous life safety code survey confirmed those findings.	K 028		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2  This STANDARD is not met as evidenced by: Surveyor: 25107 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have two conforming exits. Findings include:  1. Observation at 12:30 p.m. on 7/29/15 revealed there was no conforming exit provided from the basement mechanical room. The only exit was a stair enclosure that discharged into the vestibule corridor system on the main level. Review of previous survey data also identified that condition.	K 032	F	F

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
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K 032	Continued From page 2  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 032			

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10603</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/29/2015</b>
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NAME OF PROVIDER OR SUPPLIER  
**GOOD SAMARITAN SOCIETY CANISTOTA**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**700 W MAIN STREET  
CANISTOTA, SD 57012**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000

Initial Comments

S 000

Surveyor: 32355  
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/27/15 through 7/29/15. Good Samaritan Society Canistota was found not in compliance with the following requirements: S210 and S236.

S 210

44:04:04:06 EMPLOYEE HEALTH PROGRAM

S 210

The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.

This Administrative Rules of South Dakota is not met as evidenced by:  
Surveyor: 35237  
Based on employee file review and interview, the provider failed to ensure four of five newly hired sampled employees (G, H, I, and K) were evaluated by a health professional to determine they were free from a reportable communicable

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

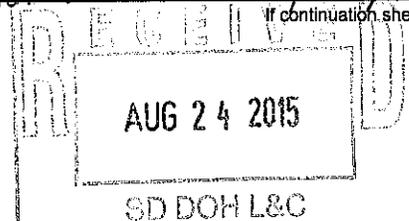
*Dylan Spal*

TITLE

Administrator

(X6) DATE

8/20/15



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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/29/2015
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 700 W MAIN STREET CANISTOTA, SD 57012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/27/15 through 7/29/15. Good Samaritan Society Canistota was found not in compliance with the following requirements: S210 and S236.	S 000	Addendums noted with an asterisk per 9/8/15 telephone to facility Do N.  JK/SOON/JJ	
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM  The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 35237 Based on employee file review and interview, the provider failed to ensure four of five newly hired sampled employaes (G, H, I, and K) were evaluated by a health professional to determine they were free from a reportable communicable	S 210	S 210  1. For staff members G, H, I, and K - the facility is unable to go back and correct the unsigned Medical History Questionnaire form. 2. All other new staff members will have the Medical History Questionnaire form signed by a licensed professional. 3. IN-SERVICE: Education will be provided by the DNS/ Staff Development Nurse to include GSS policy and procedure regarding the general orientation check list. 4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly times 4 weeks, monthly times 2 months and quarterly times 3 quarters.	8/25/15

on all new hires  
JK/SOON/JJ

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

TITLE

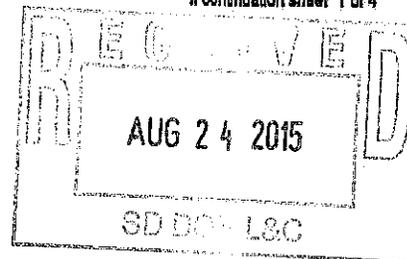
(X6) DATE

STATE FORM

6899

12LU11

If continuation sheet 1 of 4



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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/29/2015
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 W MAIN STREET CANISTOTA, SD 57012
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 210	<p>Continued From page 1</p> <p>disease. Findings include:</p> <p>1. Review of employees G, H, I, and K's employee files revealed:</p> <ul style="list-style-type: none"> <li>*They had all become employed by the provider since May 2015.</li> <li>*They had not been evaluated by a health professional to determine they were free from a reportable communicable disease.</li> </ul> <p>Interview on 7/29/15 at 1:00 p.m. with the staff development coordinator revealed:</p> <ul style="list-style-type: none"> <li>*She had been aware of that requirement.</li> <li>*She agreed the health evaluation was not completed in any of the above employees' health records.</li> <li>*The corporate forms for medical history for employees had changed in May 2015.</li> <li>-She had signed the last page of that form for one employee but not for the four listed above.</li> <li>*Their policy would have been to follow the state requirements.</li> </ul> <p>Interview on 7/29/15 at 1:20 p.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> <li>*She agreed the health evaluation was not completed in any of the above employees health records.</li> <li>*Their policy would have been to follow the state requirements.</li> </ul>	S 210	<p>Audits will include making sure the GSS #834 Medical History Questionnaire Form has been signed by a licensed professional. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root cause.</p>	
S 236	<p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(1) Each new healthcare worker or resident shall</p>	S 236	<p>S 236</p> <p>1. For staff members J and G - , the facility initiated a new Tuberculin screening.</p>	

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  07/29/2015
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 W MAIN STREET CANISTOTA, SD 57012
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S 236	<p>Continued From page 2.</p> <p>receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and policy review, the provider failed to ensure two of five sampled employees (G and J) had a two-step tuberculin (TB) screening done within fourteen days of their employment. Findings include:</p> <p>1. Review of certified nursing assistant (CNA) J's employee file revealed he had been hired on 5/14/15. He had the first part of his two-step TB skin test given on 6/11/15, and it had been read on 6/13/15. His next step had not been administered until 7/24/15, and it had been read on 7/26/15.</p> <p>2. Review of registered nurse (RN) G's employee file revealed: *She had been hired on 6/30/15. *She had no documented TB skin test given by the provider. *There were faxes from another facility that indicated:</p>	S 236	<p>2. All other new staff members will have their Tuberculin screening done within the required time frame.</p> <p>3. IN-SERVICE: Education will be provided by DNS/Staff Development Nurse to include GSS policy and procedure regarding Tuberculin screening per state agency regulations.</p> <p>4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly times 4 weeks, monthly times 2 months and quarterly times 3 quarters. Audits will include ensuring that a Tuberculin screening has been done timely for new employees. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root cause.</p>	8/25/15

*on all new hires JK/SAH/JT*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/29/2015
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 700 W MAIN STREET CANISTOTA, SD 57012		
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S 235	Continued From page 3  -A one-step skin test had been given on 1/8/15 and read on 1/12/15. -A one-step skin test had been given on 10/20/14 and read on 10/27/14.  3. Interview on 7/29/15 at 1:00 p.m. with the staff development nurse confirmed the TB skin tests for the above employees had not been completed within fourteen days of their employment.  Interview on 7/29/15 at 1:25 p.m. with the director of nursing revealed TB skin tests should have been completed within the fourteen days after having been hired. She agreed CNA J and RN G's had not been completed within fourteen days of their employment. She stated RN G should have had a two-step TB skin test given by the provider.  Review of the provider's August 2014 Tuberculin Skin Testing (TST) policy revealed: "New employees will have baseline tuberculosis (TB) screening using the TST two-step method. This involves administering the initial TST to be read in 48 to 72 hours by a nursing professional or physician. The second test is administered in one to two weeks and is read 48 to 72 hours after administration by a nursing professional or physician." "New employees with verified TST results not more than 30 days old will not be re-tested"	S 235		