

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

**ORIGINAL**

PRINTED: 02/17/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/04/2015
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CORSICA		STREET ADDRESS, CITY, STATE, ZIP CODE 455 NORTH DAKOTA CORSICA, SD 57328		
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
<p>F 000 INITIAL COMMENTS</p> <p>Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/3/15 through 2/4/15. Good Samaritan Society Corsica was found not in compliance with the following requirement: F281.</p> <p>F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET SS=D PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Preceptor: 33488 A. Based on observation, interview, record review, manufacturer's instruction review, and policy review, the provider failed to follow manufacturer's instructions for application of a dressing for one of two observed residents (2) receiving dressing changes. Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation on 2/4/15 at 10:05 a.m. with registered nurse (RN) A and Minimum Data Set (MDS) assessment coordinator during a dressing change on resident 2's pressure ulcer (an open area that forms when there is too much pressure applied to an area of skin) revealed: *RN A applied the MEDIHONEY calcium alginate 2 inch by 2 inch dressing (a special type of dressing ordered by a physician) over the top of the pressure ulcer and surrounding skin. She then covered it with a bordered foam type of</li> </ol>	<p>F 000</p> <p>F 281</p>	<p>Addendums noted with an asterisk per 3/3/15 telephone to facility administrator &amp; DON. SB/SDOH/MF</p> <p>*because the dressing order has been discontinued. SB/SDOH/MF</p> <ol style="list-style-type: none"> <li>1. Resident 2's dressing was changed 2/4/15 following an appointment with wound specialist. Unable to change order to reflect to how to apply dressing according to manufacture instructions</li> <li>2. Any resident receiving dressing changes to wound, the orders will be reviewed to ensure that dressings are being applied according to physicians orders and manufactures instructions.</li> <li>3. All licensed nurses will be educated by 3/3/15 on the policy regarding wound dressing change and importance of following manufactures instructions. With completion of Wound Care 101: Selecting a dressing- on the Good Samaritan Society Learning Center *see page 8. SB/SDOH/MF</li> </ol>	<p>3/3/15</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator \_\_\_\_\_ (X6) DATE 2-25-15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 30 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.

**RECEIVED**  
FEB 26 2015  
continuation sheet Page 1 of 6  
SD DOH L&C

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F 281 Continued From page 1 adhesive dressing.  
\*The pressure ulcer had slough (dead tissue that is usually white, yellow, brown, or tan in color) and the surrounding skin was noted to be purple-like in color.  
\*The purple-like area appeared to be the same size and shape as where the previous MEDIHONEY dressing was removed from.

Review of resident 2's medical record revealed:  
\*She:  
-Was admitted to the facility on 12/12/14.  
-Had the pressure ulcer on admission.  
-Had been seen by a wound specialist on 1/14/15 who ordered the MEDIHONEY alginate and foam daily to her pressure ulcer on the right buttock.  
\*A Wound Data Collection assessment dated 2/3/15 for the resident's right buttock pressure ulcer revealed:  
-Measurements of 1.5 centimeter by 1 centimeter.  
-Slough noted to one hundred percent of the ulcer.  
-Surrounding skin was reddened and indurated (a hardened area of tissue).  
\*A Wound RN Assessment dated 2/2/15 for the resident's right buttock pressure ulcer revealed:  
-It was an unstageable (depth of ulcer unable to be determined due to slough that was present) pressure ulcer.  
-It was being debrided by an enzymatic (refers to the application of a substance to break down the slough).

Review of the manufacturer's instructions for the MEDIHONEY calcium alginate dressing, copied on 2/4/15 at 10:20 a.m. by the director of nursing (DON) from the package insert of the box revealed the following directions for use:

F 281 4. DNS or designee will audit \* all slough/wound dressing change orders and technique to assure that application of dressing is being done according to physician orders and per manufactures guidelines weekly x 4 and then monthly x 3. The DNS will report audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed.

*\* (continued from page 1) directed by the director of nursing services. SB/SD/DON/MF*  
*\* all residents with dressing changes to SB/SD/DON/MF*

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F 281	<p>Continued From page 2</p> <p>**Use an appropriately sized MEDIHONEY calcium alginate dressing.</p> <p>**For deep or heavily exuding wounds, loosely pack and ensure that the dressing does not overlap the wound margins.</p> <p>Interview on 2/4/15 at 1:00 p.m. with RN A revealed she had:</p> <ul style="list-style-type: none"> <li>*Completed resident 2's dressing change many times in the past.</li> <li>*Used the full 2 inch by 2 inch MEDIHONEY dressing that was supplied by the provider.</li> <li>*Not reviewed the manufacturer's instructions.</li> <li>*Not been aware that dressing was a type of debridement (helps to remove the slough in a pressure ulcer but could be harmful to normal skin).</li> </ul> <p>Interview on 2/4/15 at 1:15 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> <li>*She had not reviewed the manufacturer's instructions.</li> <li>*She was not aware that dressing was a type of debridement dressing.</li> <li>*She agreed the manufacturer's instructions should have been followed.</li> </ul> <p>Review of the provider's revised November 2013 Wound Dressing Change Procedure revealed:</p> <p>**11. Assess wound and surrounding area to ensure the selection of the appropriate sized dressing."</p> <p>Review of the provider's September 2012 Pressure Ulcer Policy revealed:</p> <p>**A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing."</p>	F 281	<p><i>*The director of nursing services obtained new orders on 2/11/15. SJS/SSB/HMF</i></p>	

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F 281	<p>Continued From page 3</p> <p>Surveyor: 33488 B. Based on observation, interview, record review, and policy review, the provider failed to obtain an order to crush medication for 1 of 25 randomly observed medication administrations. Findings include:</p> <p>1. Observation on 2/3/15 at 4:50 p.m. with medication aide B administering medication to resident 12 revealed: *He had an order to administer two Tylenol 325 mg by mouth twice daily. *She proceeded to place the two tablets of Tylenol in the crusher and crushed the medication. *She crushed the medication, because his wife wanted them crushed. *She administered the crushed medication to the resident.</p> <p>Review of resident 12's physician's orders revealed: *There was no order to crush any of his medication. *He also had physician's orders to administer Flomax (prostate medication) and Metoprolol Succinate ER (extended release) (high blood pressure medication) daily. *Those medications were listed on the provider's "DO NOT CRUSH" list, located in the bottom drawer of the medication cart.</p> <p>Interview on 2/4/15 at 12:25 p.m. with resident 12 and his wife revealed: *Prior to his admission on 1/29/14 she had been administering his medications at home. *She would "always crush his medication as he</p>	F 281	<p>1. Resident 12's orders have been changed to may crush if appropriate. Resident 12's medications were reviewed and medications were changed to be able to be crushed if appropriate after reviewing medications with physician. *see page 5. SB/SDDDH/MF</p> <p>2. All residents orders will be reviewed to assure that an order for crush medication if appropriate is on residents requiring crushed medication administration. Medications will also be reviewed to assure that only medications that are able to be crushed are being crushed.</p> <p>3. All licensed nurses and medication aides will be educated by 3/3/15 on policy regarding crushing medications. Review of 'DO NOT CRUSH' list. And completion of Medication Administration-avoiding common errors- on the Good Samaritan Society Learning Center *see page 5. SB/SDDDH/MF</p>	3/3/15

*x by the director of nursing services and the mds coordinator SB/SDDDH/MF*

*\*including medication aide B SB/SDDDH/MF*

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F 281	<p>Continued From page 4</p> <p>had problems getting them stuck in his throat." *She had told staff to crush his medications. *She was unaware some of his medications were not to be crushed.</p> <p>Interview on 2/4/15 at 1:15 p.m. with medication aide B revealed she: *Always "crushed his medications because his wife says so and she did it before they came here." *Was not aware that some of his medications were not to be crushed. *Knew where to find the "DO NOT CRUSH" list of medications. *Stated she should have consulted with a licensed nurse prior to crushing his medications.</p> <p>Interview and record review on 2/4/15 at 1:00 p.m. with the director of nursing regarding resident 12's medications revealed she: *Could find no order to crush his medications. *Was not aware the medication aide and all other staff responsible for administering his medication had been crushing them. *Expected her staff to: -Contact the physician if staff felt there was a need to crush a resident's medication. -Refer to the DO NOT CRUSH list for any questions concerning the appropriateness of crushing a medication. -Assess the resident to see if there indeed had been a reason he needed to have his medications crushed (example: swallowing difficulties).</p> <p>Review of the provider's September 2012 Crushing Medications policy revealed: *Some medications are not to be crushed or chewed.</p>	F 281	<p>4. DNS or designee will audit medication pass on day and evening shift weekly x 4 then monthly x 3 to assure proper administration of medications to residents. DNS will report audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed.</p> <p><i>* (continued from page 4, #1) Flomax is no longer being crushed. Metoprolol was changed from extended release to a crushable form. S01SDDH/MF</i></p> <p><i>* (continued from page 4, #3) directed by the director of nursing services. S01SDDH/MF</i></p>	

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F 281 Continued From page 5  
\*Consult with a drug handbook or pharmacist to verify they could be crushed.  
\*Obtain an order from the resident's physician stating the medication may be crushed in order to help with administration.

F 281

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<p><b>K 000 INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/03/15. Good Samaritan Society Corsica was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K033, K038, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> <p><b>K 033 NFPA 101 LIFE SAFETY CODE STANDARD SS=D</b></p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, the provider failed to maintain a protected path of egress from the basement to the exterior of the building. Two of three basement stairways (from the basement boiler room) discharged onto the main level (one at the dietary area and one at the C wing exit) and were not provided with a one hour fire resistive enclosure to the exterior of the building.</p>	<p><b>K 000</b></p>	<p><i>Addendums noted with an asterisk per 3/9/15 telephone to facility administrator. CHSDDO/HMF</i></p> <p><b>K 033</b></p> <ol style="list-style-type: none"> <li>Regarding observations made on <b>3/24/15</b> 2/3/15, as stated by surveyor, the swinging door down C-wing leading to the stairs that go to the boiler room will have a door latch installed.</li> <li>To maintain compliance the administrator will educate all staff on importance of door latch.</li> <li>The environmental supervisor will ensure compliance by ensuring proper maintenance on the door to ensure a door latch is permanently in place.</li> </ol>		

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

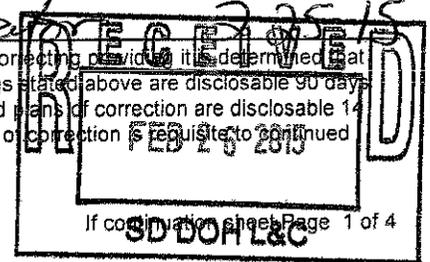
*Rocky T. Brown*

TITLE

*Administrator*

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided 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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K 033 Continued From page 1  
Findings include:

1. Observation beginning at 2:30 p.m. on 2/03/15 revealed a basement egress stairway west of the dining room discharged into the corridor on the main level and did not provide a one hour protected path of egress to the exterior of the building. The discharge from that point was not readily visible and identifiable from the point of discharge from the exit.

Further observation revealed a second stair from the boiler room to the exterior of the building by way of the cellar doors. Continuing observation revealed a third stair (the main access to the basement and boiler room) discharged into a vestibule on the north side of the C wing. The corridor door for the vestibule was a solid wood core door equipped with a wired-glass panel. The door was not equipped with latching hardware. The exit discharge for the stair enclosure from the basement boiler room could be considered in compliance with the installation of latching hardware on the corridor door at the C wing.

Interview with the administrator at 4:15 p.m. on 2/03/15 revealed he was unaware the corridor door needed to have latching hardware.

The deficiency affected one of numerous egress requirements for the basement boiler room.

K 038 SS=D NFPA 101 LIFE SAFETY CODE STANDARD  
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

K 033 \*4. The Environmental Supervisor will report completion of this work to the QA committee.  
CH/SDDDH/MF

K 038 1. Regarding observations made on 2/3/15, as stated by surveyor, the magnetic locks were removed immediately. **3/4/15**

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K 038	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure exits were readily accessible at all times. One of three sets of cross-corridor doors (the set to the former secure wing) was equipped with magnetic locks that were not delayed egress or access controlled locks. Findings include:</p> <p>1. Observation at 3:15 p.m. on 2/03/15 revealed the set of cross-corridor doors in the C wing (to the former secure unit area) was equipped with magnetic locks. Testing of the doors in the closed (locked) position revealed they were not delayed egress type magnetic locks. The locks were also observed to be lacking sensors to release the doors from the magnets. That indicated the doors would not comply with access-controlled egress requirements. Interview with the administrator at 4:00 p.m. on 2/03/15 revealed the secure unit had been abandoned some time in the past and the locks had not been removed.</p> <p>The deficiency had the potential to affect egress for the entire C wing smoke compartment occupants.</p>	K 038	<p>2. To maintain compliance, Administrator will meet with all departments and educate the need for a free opening corridor down C-wing.</p> <p>3. The environmental supervisor will ensure compliance by making sure magnetic locks are no longer installed on C-Wing cross corridor.</p> <p><i>* If The Environmental Supervisor will report completion of this work to the QA committee. CHISDDOH/MF</i></p>	
K 144 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>	K 144	<p>1. Regarding Observations made on 2/3/15, as stated by surveyor, the remote shut off will be installed by maintenance office away from generator.</p>	3/26/15

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K 144	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a remote shutoff switch for the generator. Findings include:</p> <p>1. Observation at 3:00 p.m. on 2/03/15 revealed the generator was situated on the exterior of the building and was not equipped with a remote shut off. Interview with the maintenance supervisor at the time of the observation confirmed that finding.</p> <p>The deficiency affected one of numerous generator installation requirements.</p>	K 144	<p>2. To maintain compliance, Administrator will educate all staff on location and purpose of Emergency remote shut off at 2/26/2015 in-service.</p> <p>3. The Administrator will ensure compliance by including the purpose and location of the remote shutoff in our annual Emergency plan training.</p> <p><i>* 4. The Environmental Supervisor will report completion of this work to the CIA committee. CH/SDDH/MF</i></p>	

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South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CORSICA	STREET ADDRESS, CITY, STATE, ZIP CODE 455 N DAKOTA AVE CORSICA, SD 57328
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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: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/03/15 through 2/04/15. Good Samaritan Society Corsica was found not in compliance with the following requirements: S130 and S166.	S 000	Addendums noted with an asterisk per 3/4/15 telephone to facility administrator. CHISDDOH/ME	
S 130	44:04:02:06 FOOD SERVICE  Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the two compartment vegetable preparation sink in the kitchen was not provided with a physical air gap on the drain line. Findings include:  1. Observation at 1:45 p.m. on 2/03/15 revealed the two compartment vegetable preparation sink in the kitchen was not provided with a one inch	S 130	<ol style="list-style-type: none"> <li>Regarding observations made on 2/3/15, as stated by surveyor, the drain line will be cut shorter to ensure a 1 inch gap between the floor drain and the drain line from the sink.</li> <li>To maintain compliance Administrator will educate all staff on the importance of a 1 inch air gap between drain lines in the kitchen area.</li> <li>The environmental supervisor will ensure compliance by doing annual checks on 2 compartment sinks to make sure a 1 inch air gap is present between the floor drain and sink drain.</li> </ol>	3/4/15

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

*Rocky Akers*

STATE FORM

6899

W2211

TITLE

Administrator

(X6) DATE

<p style="text-align: center; font-size: 2em; font-weight: bold;">RECEIVED</p> <p style="text-align: center;">FEB 26 2015</p> <p style="text-align: center;">SD DOH L&amp;C</p>	R	D

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10609</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/04/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CORSICA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>455 N DAKOTA AVE CORSICA, SD 57328</b>
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S 130 Continued From page 1  
physical air gap (form of air break) in the drain line for at least one inch above the highest point of the drain receptor. The drain from the sink was an air break that extended into the floor drain below the level of the floor.  
Interview with the environmental services supervisor at the time of the observation revealed he was unaware the requirement for the physical air (break) gap on the drain line had not been met.

S 130

\*4. The Environmental Supervisor will report completion of this work and his followup checks to the QA committee. CHLO/DH/MF

S 166: 44:04:02:17(1-10) OCCUPANT PROTECTION

S 166

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

1. Regarding observations made on 2/3/15, as stated by surveyor, the egress door lock codes were removed immediately from all exit doors. Also lights in C-wing tub will have shatterproof bulbs installed and a dome shatter proof light fixture will be installed in the clean linen closet.
2. To maintain compliance Administrator will educate all staff on the importance of door lock code safety and shatterproof lights in our facility.

3/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10609	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/04/2015
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S 166 Continued From page 2

nurses' station and may not automatically silence when the door is closed;

(7) Portable space heaters and portable halogen lamps may not be used in a facility;

(8) Household-type electric blankets or heating pads may not be used in a facility;

(9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and

(10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.

S 166

3. The environmental supervisor will ensure compliance by keeping a backup supply of shatterproof bulbs available in the housekeeping closet as well as ensuring that all codes are not up on exit doors.

*\*4. The Environmental Supervisor will report completion of this work to the QA committee.  
CHISDDOH/MF*

This Administrative Rules of South Dakota is not met as evidenced by:  
Surveyor: 18087  
A. Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition for five of eight exterior doors (conference room, south exit door from the addition, north exit door from the dining room, north door from the C court stair enclosure, and the north door from the A court). Findings include:

1. Observation and testing beginning at 1:00 p.m. on 2/03/15 revealed the exterior exit door from the conference room was equipped with a delayed egress magnetic lock. A code was posted above the door that would release the magnet lock and would also silence the audible alarm required for that location. That condition also existed at the south exit from the rehabilitation addition, the north (east) exit door from the dining room, the north (east) exit door

South Dakota Department of Health

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S 166	<p>Continued From page 3</p> <p>from the A court (100 wing), and the north (west) exit door from the C court (300 wing) stair enclosure. The posted code allowed residents to input the code and leave the building without sounding the door alarm. A posted code to release the magnetic door lock is not required at a delayed egress locking mechanism.</p> <p>Review of the previous survey dated 1/08/14 revealed this out of compliance condition had been noted and discussed with the provider at that time. Interview with the administrator at 4:00 p.m. on 2/03/15 confirmed that condition.</p> <p>B. Based on observation and interview, the provider failed to equip light fixtures with covers or shatterproof lamps in one of three clean linen storage rooms (A court clean linen closet) and in one of three bathing areas (C court tub room). Findings include:</p> <p>1. Observation at 1:30 p.m. on 2/03/15 in the A wing clean linen closet revealed a compact fluoroescnet lamp overhead without a cover. Further observation revealed the lamp was not a shatterproof lamp.</p> <p>Observation at 2:30 p.m. on 2/03/15 revealed a heat lamp overhead in the C wing tub room without a cover. Further observation revealed the lamp was not a shatterproof lamp.</p> <p>Interview with the environmental services supervisor at the time of the observations revealed he was unaware the lamps did not meet the occupant safety requirements.</p>	S 166		