



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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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
F 226	<p>Continued From page 1</p> <p>Interview on 4/29/15 at 11:10 a.m. with the administrator confirmed there had been no files completed for the above contracted employees.</p> <p>Review of the provider's revised August 2013 Supplemental Staffing Service agreement for Nursing Staff policy revealed "The Parties will comply with all applicable federal and state laws, as well as applicable requirement of third party payers."</p> <p>Review of the provider's undated Resident's Bill of Rights for Skilled Nursing Facilities booklet given to all new admissions revealed the provider must have developed and implemented written policies and procedures. Those policies were to have prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Surveyor: 28057 3. Review of the Checklist for Licensed Pool Staff for registered nurse (RN) E and certified nursing assistant (CNA) D revealed: *RN E had signed the sheet on 12/21/14. *CNA D had signed the sheet on 4/22/15. *The checklist had not included a reference or background check. *It had not addressed if either of the above employees had a history of abuse.</p> <p>Review of a Standard Facility Contract dated 4/13/15 revealed: *It was an agreement with the company RN E worked for and the provider. *It had been signed by the administrator. *It had not been signed by the RN.</p>	F 226	<p>3. The Business Office Manager will complete and forward to the Quality Assurance and Performance Improvement (QAPI) Coordinator focus audits of documentation for new contract employees weekly for a month to verify the onboarding process was completed. The focus audits will continue once per month after the first month until the QAPI committee determines the process is sustainable.</p>	<p>4/13/15</p>

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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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	
F 226	<p>Continued From page 2</p> <p>*It had not addressed background or reference checks related to history of abuse by the contract employee.</p> <p>Review of the provider's August 2013 Supplemental Staffing Service Agreement for Nursing Staff revealed under Qualifications: *Nurses would possess a valid, current license. *Nursing assistants were to be currently registered with the nursing assistant registry in the governing state. *A full background check of past and current criminal history was to be conducted by the contract agency. *That information was to have been shared with the provider by the contract agency.</p> <p>Review of the provider's revised March 2014 Background Investigations Policy and Procedure revealed: *The provider would verify and certify information provided by the employee. *The means to verify and/or certify that information could include criminal conviction and professional licensing and or certification investigations. *This policy was intended to meet the federal requirements for the appropriate screening of employees.</p> <p>Interview on 4/29/15 at 12:25 p.m. with the administrator confirmed: *She had no information on RN E other than the unsigned contract. *She had no proof of the RN's license. *She had no information for CNA D other than her timekeeping slips. *She had no proof of the CNA's certification. *She had become the administrator</p>	F 226			

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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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
F 226	Continued From page 3 approximately three weeks ago. *There had not been an employee in the human resources department to ensure employees files had been completed per the policies. *She agreed the policies had not been followed when the above contracted employees had been hired.	F 226		
F 371 SS=D	483.35(i) 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  This REQUIREMENT is not met as evidenced by: Surveyor: 28057  Surveyor: 35237 Based on observation, interview, and policy review, the provider failed to ensure one of one cook (A) washed her hands appropriately during two of two observed meals. Findings include:  1. Random observations on 4/28/15 from 8:45 a.m. through 12:40 p.m. of cook A during breakfast and lunch preparation and serving revealed: *She washed her hands multiple times and each time did the following:	F 371	F371  1. Education was provided for cook A on handwashing procedures.  2. The Dietary Manager participated in providing a mandatory all-staff in-service on 05/22/2015 to quiz staff on handwashing procedures and conduct competency testing.	

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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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
F 371	Continued From page 4 -Scrubbed her hands with soap and water for a total of five to eight seconds. *She had touched multiple surfaces including door handles, serving utensils, refrigerator handles, and her apron while she prepared and served the meals.  Interview on 4/28/15 at 4:50 p.m. with the dietary services supervisor revealed: *She would have expected hand washing to be done properly. *Hand washing should have been done for at least twenty seconds.  Review of the provider's February 2013 Handwashing Technique Policy and Procedure revealed: *The purpose was to provide guidelines regarding infection control and food-borne illness. *The directions were: -"1.c. Use warm water (water temperature should be no less than 100 degrees) and lather hands with 5 cc of soap (remembering to scrub thumb) and wrists well for 20 seconds." -"2. Wash hands:" -"c. After touching any contaminated object (face, hair, body or clothing; garbage; or dirty utensils, phone, linen, or money)." -"h. Before dirty and clean dish handling."	F 371	3. Members of the Handwashing Performance Improvement Project (PIP) team will complete and forward to the Quality Assurance and Performance Improvement (QAPI) Coordinator focus audits involving observations of handwashing by five staff per week on multiple shifts for a month to verify the competency of those staff. The focus audits will continue once per month after the first month until the QAPI committee determines the competency skills of staff are sustainable.	
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.	F 441		6/18/15

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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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	
F 441	<p>Continued From page 5</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, and procedure review, the provider failed to ensure proper handwashing or hand hygiene had been completed during three of three observations by two of two certified nursing assistants (CNA) (B</p>	F 441	<p>F441</p> <p>1. Education was provided for certified nursing assistants (CNAs) B and C on handwashing procedures.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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	
F 441	<p>Continued From page 6 and C). Findings include:</p> <p>1. Observation on 4/29/15 at 8:00 a.m. revealed CNA C had been assisting resident 12 with morning care. During that time she had missed handwashing or hand hygiene opportunities four times: *She had not washed her hands between residents. *She had not washed her hands before putting on gloves. *She had not washed her hands after removing her gloves. *She had not washed her hands before preparing mouth care supplies after she had touched numerous soiled surfaces in the bathroom.</p> <p>Interview with the CNA at that time revealed this had been her usual practice.</p> <p>Surveyor: 23059</p> <p>2. Observation on 4/29/15 at 8:07 a.m. revealed CNA B entered resident 8's room to assist him with morning care. She did not wash her hands upon entering the room but did put on gloves. With those gloved hands she: *Checked the resident's brief. *Assisted him to sit on the side of the bed. *Assisted him into the stand-lift with the help of another CNA. *Touched multiple surfaces within the room including the resident's oxygen tubing. *Toileted the resident and wiped his bottom. After the above she: *Removed her gloves and did not wash her hands. *Continued to provide care for the resident including shaving him. *Did not wash her hands before leaving the room.</p>	F 441	<p>2. The Administrator and Staff Development Coordinator/Infection Preventionist participated in providing a mandatory all-staff in-service on 05/22/2015 to quiz staff on handwashing procedures and conduct competency testing. The Director of Nursing (DON) was not present as she had resigned from her position. The Interim DON was not available for the in-service.</p>		

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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 7</p> <p>Interview with CNA B at that time revealed the above had been her usual practice of performing or assisting a resident with care.</p> <p>Surveyor: 35237 3. Observation on 4/29/15 at 7:50 a.m. revealed CNA B assisted resident 13 with morning care. During that time she had missed handwashing or hand hygiene opportunities four times: *She had not washed her hands before putting on gloves. *She had not washed her hands after removing her gloves following private area care for the resident. -She touched multiple surfaces in the resident's room after the above care. *She applied new gloves without washing her hands and performed mouth care for the resident. *She exited the resident's room without performing hand hygiene.</p> <p>Review of the provider's revised November 2014 Hand Hygiene and Handwashing guidelines and procedure revealed: *To "wash hands with plain soap and water or with anti-microbial soap and water." -"If hands are visibly soiled (dirty)." -"If hands are visibly contaminated with blood or bodily fluids." -"Before eating." -"After using the restroom." *To use an alcohol-based hand rub for routinely cleaning hands when hands are not visibly soiled or contaminated with blood or bodily fluids: -"Before having direct contact with residents." -"After having direct contact with a resident's skin."</p>	F 441	<p>3. Members of the Handwashing Performance Improvement Project (PIP) team will complete and forward to the Quality Assurance and Performance Improvement (QAPI) Coordinator focus audits involving observations of handwashing by five staff per week on multiple shifts for a month to verify the competency of those staff. The focus audits will continue once per month after the first month until the QAPI committee determines the competency skills of staff are sustainable.</p>	6/18/15
-------	--	-------	---	---------

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

PRINTED: 05/12/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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	
F 441	Continued From page 8 . -"After having contact with body fluids, wounds or broken skin." -"After touching equipment or furniture near the resident." -"After removing gloves." *"Alternatively, hands may be washed with an anti-microbial soap and water in clinical situations described above." **"Wash hands with soap and water when a "build up" of emollients is felt on hands (usually after five to 10 applications of a gel."	F 441			

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

**ORIGINAL**

PRINTED: 05/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/29/15. Good Samaritan Society Selby 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 upon correction of the deficiencies identified at K062 and K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, record review, and interview, the provider failed to ensure the automatic sprinkler system was being tested, maintained, and inspected, quarterly and annually in accordance with requirements of NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include:  1. Observation at 2:15 p.m. on 4/29/15 revealed the facility's water main shutoff for the sprinkler	K 062	K062  1. A lock will be put on the post-indicating valve (PIV) and the looking glass will be cleaned to allow for visual inspection of the valve. An inspection of the automatic sprinkler system was verified as conducted in January 2014 by Prairie Suns Inc.	

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

*Becky Wilkin*

TITLE

*Administrator*

(X6) DATE

*5/22/15*

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.

MAY 28 2015

If continuation sheet Page 1 of 4

SD DOH L&C

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

PRINTED: 05/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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 062	<p>Continued From page 1</p> <p>system also known as a post-indicating valve (PIV) located near the east entrance to the facility. The PIV is required to be locked or have valve supervision to ensure that valve is maintained in the open position. A threaded carabineer was being used to hold the valve handle in place. A lock should have been used to hold the handle in place.</p> <p>Further observation at the same time revealed a looking glass was used see the interior indicator. That looking glass was clouded over on both sides making it unable to see if the valve was open or not.</p> <p>Interview with the environmental services director at the time of the above observations confirmed those conditions. He indicated he was unaware of those requirements. He revealed the valve was not being properly exercised every year during the annual inspection of the sprinkler system. He indicated the valve might have been shut off once or twice during the almost twenty years he had worked at the facility.</p> <p>Document review revealed an annual inspection report prepared by Western States Fire Protection dated November 13, 2014. The report indicated the PIV was properly locked at time of inspection, and the report did not indicate if the valve was tested.</p> <p>2. Document review of the inspection report prepared by Western States indicated an unknown date for when the last five year internal obstruction investigation had been conducted. Interview with the environmental services director indicated he believed that investigation was conducted when a portion of the sprinkler system</p>	K 062	<p>2. A schedule will be established with a contractor to inspect and test the wet and dry automatic sprinkler systems along with the PIV quarterly and annually, and to conduct a five year internal obstruction investigation.</p> <p>3. The Director of Environmental Services will provide a quarterly report to the Quality Assurance and Performance Improvement (QAPI) committee regarding the inspections of the PIV and automatic sprinkler system. This will be an ongoing report.</p>	<p>4/18/15</p>

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

PRINTED: 05/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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 062	Continued From page 2 had been installed in 2013. It was unclear what or if an investigation had been conducted as no documentation could be found.  Further document review at the same time revealed no quarterly maintenance and testing was being conducted for the sprinkler system. Quarterly water flow tests for the wet sprinkler system and quarterly low air alarm tests for the dry system should have been conducted. Interview with the environmental services director at the time of document review indicated he was unaware of that requirement. A copy of referenced publication NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems was available for his use. He indicated he was unaware the information was provided in that referenced publication.  This deficiency has the potential to affect seven of seven smoke compartments.	K 062		
K 211 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100,	K 211		

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

PRINTED: 05/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVENUE SELBY, SD 57472</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 211	<p>Continued From page 3 460.72, 482.41, 483.70, 483.623, 485.623</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to properly install alcohol based hand rub (ABHR) containers at several randomly observed locations (physical therapy (PT) room and multiple resident rooms in 100 wing) by locating them over or adjacent to light switches or electrical receptacles. Findings include:</p> <p>1. Observation beginning from 11:00 a.m. to 3:00 p.m. on 4/29/15 revealed ABHR containers installed over a light switch in the PT room and over multiple light switches in the residents' rooms on the 100 wing. Interview with the environmental services director at the time of the observations confirmed those findings. He stated he was unaware of the requirements for appropriate locations for ABHR containers.</p>	K 211	<p>K211</p> <ol style="list-style-type: none"> <li>1. The Alcohol Based Hand Rub (ABHR) dispensers in all rooms will be moved, as needed, so that they are not installed over or adjacent to an ignition source.</li> <li>2. The Director of Environmental Services will provide a weekly report to the Administrator and every month to the Quality Assurance and Performance Improvement (QAPI) committee until all ABHR dispensers have been moved.</li> </ol>	6/18/15

## South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10676</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVE SELBY, SD 57472</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) COMPLETE DATE
S 000	Initial Comments  Surveyor: 28057 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/28/15 through 4/29/15. Good Samaritan Society Selby was found not in compliance with the following requirements: S210 and S236.	S 000		
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: 32572 Based on employee record review, interview, and policy review, the provider failed to ensure two of two sampled contracted employees' records (D and E) had health evaluations and had been screened for communicable disease. Findings	S 210	S210  1. Health screening information for contracted employees D and E will be requested from the contract agencies. The contract agencies will also be requested to supply health screening information for previously contracted employees since 2015.  2. The onboarding process for contracted employees was modified to obtain verification of health screening prior to start of the first scheduled shift. If verification cannot be obtained, the Infection Preventionist will conduct a health evaluation to screen for any communicable disease.	

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

TITLE

(X6) DATE

STATE FORM

6899

*Administrative*

**RECEIVED**

GVQR11

JUN 11 2015

MAY 28 2015

SD DOH L&C

SD DOH L&C

If continuation sheet 1 of 4

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10676</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVE SELBY, SD 57472</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) COMPLETE DATE
S 210	<p>Continued From page 1</p> <p>include:</p> <p>1. Review of employees' records for contracted employees D and E revealed: *Employee files were not present for either employee.</p> <p>*Interview on 4/29/15 at 11:00 a.m. with the business office manager revealed: -She had been the one that compiled the employee files for all staff members. -There had been no files for those employees.</p> <p>Interview on 4/29/15 at 11:10 a.m. with the administrator confirmed there had been no files completed for the above contracted employees.</p> <p>Review of the provider's revised August 2013 Supplemental Staffing Service agreement for Nursing Staff policy revealed "The Parties will comply with all applicable federal and state laws, as well as applicable requirement of third party payers."</p>	S 210	<p>3. The Staff Development Coordinator will complete and forward to the Quality Assurance and Performance Improvement (QAPI) Coordinator focus audits of documentation for new contract employees weekly for a month to verify the onboarding process was completed. The focus audits will continue once per month after the first month until the QAPI committee determines the process is sustainable.</p>	4/18/15
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 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</p>	S 236	<p>S236</p> <p>1. Tuberculin screening information for contracted employees D and E will be requested from the contract agencies. The contract agencies will also be requested to supply tuberculin screening information for previously contracted employees since 2015.</p>	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10676</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVE SELBY, SD 57472</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) COMPLETE DATE
S 236	<p>Continued From page 2</p> <p>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: 32572 Based on interview, employee health file review, and policy review, the provider failed to ensure two of two contracted employees (D and E) had received the tuberculin (TB) testing within 14 days of employment. Findings include:</p> <p>1. Review of employees' records for contracted employees D and E revealed: *Medical health files were not present for either employee.</p> <p>*Interview on 4/29/15 at 11:00 a.m. with the business office manager revealed: -She had been the one that compiled the medical health files for all staff members. -There were no medical health files for either of those employees.</p> <p>Interview on 4/29/15 at 11:10 a.m. with the administrator confirmed there had been no files completed for those contracted employees.</p> <p>Review of the provider's revised August 2013 Supplemental Staffing Service agreement for Nursing Staff policy revealed "The Parties will comply with all applicable federal and state laws, as well as applicable requirement of third party payers."</p>	S 236	<p>2. The onboarding process for contracted employees was modified to obtain verification of tuberculin screening prior to start of the first scheduled shift. If verification cannot be obtained, the Infection Preventionist will conduct tuberculin testing.</p> <p>3. The Staff Development Coordinator will complete and forward to the Quality Assurance and Performance Improvement (QAPI) Coordinator focus audits of documentation for new contract employees weekly for a month to verify the onboarding process was completed. The focus audits will continue once per month after the first month until the QAPI committee determines the process is sustainable.</p>	<p>2/19/15</p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10676</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>04/29/2015</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SELBY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4861 LINCOLN AVE SELBY, SD 57472</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) COMPLETE DATE