

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

ORIGINAL

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY WAGNER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 W HWY 46 WAGNER, SD 57380	
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/23/15 through 3/25/15. Good Samaritan Society Wagner was found not in compliance with the following requirements: F280, F281, F425, F431, F441, and F520.	F 000	Addendums noted with an asterisk per 487115 telephone to facility administrator. DK/SDDCH/ME	
F 280 SS=E	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: 26180	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Admin. GSS Wagner* (X6) DATE: *04/16/15*

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.

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F 280	<p>Continued From page 1 Surveyor: 35120 Based on record review, observation, interview, and policy review, the provider failed to update and revise care plans after a change in resident condition for three of twelve sampled residents (1, 2, and 10). Findings include:</p> <p>1. Review of resident 2's medical record revealed: *An admission date of 6/6/14. *Diagnoses of: -Lewy body dementia (impaired thinking with slowed movement and muscle tremors). -Muscle weakness. -Depression. -Psychosis (loss of connection with reality). -Pressure ulcer (sore over a bony area from consistent pressure). -Hyperlipidemia (high cholesterol). *His two recent falls were on 2/3/15 and 2/13/15.</p> <p>Review of resident 2's 2/13/15 Minimum Data Set (MDS) assessment revealed: *He had a brief interview for mental status (BIMS [test for memory, a score of 13-15 shows no impairment]) score of 14. *He required extensive assistance with the help of one staff member for walking, dressing, bathing, and transferring (moving from one area to the next). *He used a walker and a wheelchair. *He had two or more falls since his last MDS on 11/24/14. *He had been on an antipsychotic medication (used to help manage psychosis) and an antidepressant medication (used to help manage depression).</p> <p>Review of resident 2's 11/13/14 care plan</p>	F 280	<p>1. Resident 2's care plan has been updated with new fall prevention interventions. Resident 10's care plan has been updated to reflect the change in order for the pressure dressing. Resident 1's care plan has been updated to reflect the discontinuation of the merri-walker.</p> <p>2. All residents will have their care plan updated with changes to reflect their current care needs.</p> <p>3. The DNS and SDC will provide education to nursing staff and interdisciplinary team on 04/20/15 at 7 am and/or on 04/23/15 at 2:30 p.m. regarding the need to update the care plan as resident needs change, after a fall to incorporate new fall prevention interventions, changes in physician order, new problems identified. Nursing staff will initiate changes on the care plan when the change is noted.</p> <p>4. The DNS or designee will audit care plans to assure new focuses, goals, and interventions are added to the care plan when the changes and/or problems are seen. This audit will be done weekly X4 and then monthly X3. The DNS or designee will report findings to the QAPI</p>		

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F 280	<p>Continued From page 2 revealed: *He had an alarm placed on his chair and bed to detect when he tried to stand up. *There were no new interventions put into place after his falls in February 2015.</p> <p>Random observations of resident 2 from 3/23/15 through 3/25/15 showed he had tremors and required some assistance with walking.</p> <p>Interview on 3/23/15 at 7:05 p.m. with registered nurse (RN) C about resident 2 revealed he had: *Parkinson's disease (affects movement and causes tremors). *A history of falls.</p> <p>Interview on 3/25/15 at 8:40 a.m. with RN A about resident 2 revealed: *He had a chair alarm. *She would have liked his room to be closer to the nurses station so staff would be able to hear his alarm at all times. *She had been unsure if he was on a toileting schedule.</p> <p>Interview on 3/25/15 at 9:10 a.m. with certified nursing assistant (CNA) B about resident 2 revealed: *He had a chair alarm and it had went off a lot during the day. *The chair alarm was the only thing they did as a fall prevention for him.</p> <p>Interview on 3/25/15 at 10:27 a.m. with the MDS coordinator regarding resident 2 revealed: *She was the one who usually updated the care plans. *She agreed his care plan had not been updated since November 2014 and there had not been</p>	F 280	<p>committee monthly and the committee will determine if further auditing is needed. 5. Date certain is</p>	5/13/15
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F 280	<p>Continued From page 3 any new fall interventions put into place for him.</p> <p>2. Review of resident 10's medical record revealed: *An admission date of 12/29/11. *He had diagnoses of: -Cancer of the kidneys. -End stage renal disease (ESRD [longstanding disease that leads to kidney failure]). -Prostate hypertrophy (enlargement of the prostate gland that makes it difficult to urinate). -Cerebrovascular disease (affects circulation of the blood to the brain).</p> <p>Review of resident 10's 2/6/15 MDS assessment revealed he: *Had a BIMS score of 15. *Was on dialysis (removes waste and excess water from the blood).</p> <p>Review of resident 10's 1/14/2014 care plan revealed: *He had dialysis on Monday, Wednesday, and Friday. *Staff were to remove his pressure dressing (bandage) six hours after returning from dialysis.</p> <p>Review of resident 10's 3/1/15 through 3/31/15 treatment record revealed: *He was to have his pressure dressing removed one day after dialysis. *The pressure dressing removal had an order date of 6/30/12.</p> <p>Interview on 3/25/15 at 2:13 p.m. with RNA revealed: *She knew how to care for resident 10 after dialysis from the communication sheet the dialysis center sent back with him.</p>	F 280		

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F 280	<p>Continued From page 4</p> <p>*The treatment nurse removed his pressure dressing the day after dialysis.</p> <p>Interview on 3/25/15 at 2:47 p.m. with the MDS assessment coordinator revealed she agreed: *The order had been changed on 6/30/12 for the pressure dressing to stay on for one day after dialysis. *The care plan had not been updated to reflect the new order.</p> <p>Review of the provider's June 2014 A Fall Occurs: Now What? diagram revealed: **"Review and update Care Plan for all prevention approaches and individualize to meet the resident's needs." **"Communicate care plan modifications with staff." **"Monitor resident's condition and document the effectiveness of interventions put in place to prevent further falls."</p> <p>Surveyor: 35625 3. Review of the resident 1's complete medical record revealed: *The merri-walker (a walker with four sides and a seat) had been ordered on 10/22/14. *The merri-walker was discontinued on 1/14/15 because the resident was no longer able to use it safely. *The 3/24/15 care plan listed continued use of the merri-walker under fall prevention and use of restraint sections.</p> <p>Interview on 3/25/15 at 3:50 p.m. with the director of nursing regarding the updating of the care plan revealed her expectation was that the updated 3/24/15 care plan should have had the</p>	F 280			

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F 281	<p>Continued From page 6</p> <p>*On 10/10/15 the resident received: -10 mg at 8:00 a.m. for "obvious pain as seen by facial grimacing and restlessness." -20 mg at 12:00 noon. The reason had not been documented. The medication was documented as "effective" at 1:00 p.m. the same day. -10 mg at 5:46 p.m. The reason had not been documented. The medication was documented as "ineffective at 6:00 p.m. the same day. -10 mg at 6:23 p.m., "given per hospice nurse, one time only." The medication was documented as "ineffective", resident was "grimacing". -20 mg at 7:46 p.m. The medication was documented as effective at 7:16 p.m. *The resident expired at 8:25 p.m.</p> <p>Interview on 3/25/15 at 3:50 p.m. with the director of nurses (DON) revealed: *She agreed the three orders for MS had the same instructions. *Hospice had not completed any education for the staff on how to assess for pain at end of life or how to accurately use the multiple orders for MS to control pain.</p> <p>Policies and procedures about the oversight of pharmacy services were requested from the DON on 3/25/15 at 11:25 a.m. The DON stated all medication policies were online. Neither access to the online medication policies or hard copies were provided by the end of the survey on 3/25/15.</p> <p>Surveyor: 35625 B. Based on record review, and interview, the provider failed to ensure complete and accurate documentation after a fall for 1 of 12 sampled residents (1).</p>	F 2814	<p>4. SDC or designee will audit all ^{all} physician orders that have more than 1 dose ^{more than 1 dose} to assure the physician is aware and to get clarification to assure proper administration of that medication. Audits will be done weekly X4 and then monthly X3 with the SDC or designee reporting findings to the QAPI committee monthly. The committee will determine if further audits are needed. The SDC or designee will audit progress note and vital sign charting to assure proper dates and times are correct and coincide with the event being charted. Audits will be done weekly X4 and then monthly X3, SDC or designee will report findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>5. Date certain</p>	05/13/15

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F 281	Continued From page 7 1. Review of the resident's complete medical record and interview with the director of nursing (DON) on 3/25/15 at 3:50 p.m. revealed and confirmed: *An incident report had been completed for a fall with an injury on 12/24/14 at 1:50 p.m. *The DON stated that vital signs and neuro checks should have been done during the first 72 hours after the fall. *Eight neuro checks were completed with a date of 12/22/14 and 12/23/14. *No fall or other event requiring vital signs or neuro checks was documented as having happened on 12/22/14. *The DON reviewed the above eight entries and stated she believed the dates were not correct. Ruth A. Craven and Constance J. Hirnle, Fundamentals of Nursing, 6th Ed., Philadelphia, Pa., 2009, p. 203, revealed, "Nurses are responsible for accurate, complete, and timely documentation and reporting."	F 281			
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425	1. Unable to change the events noted in observation number 1. In this case the local Pharmacy had a procedure where they noted on card expiration of pill and a pill discard date. Unable to change the events noted in observation number 2, however, in this case the ekit clearly is marked with a sticker showing the earliest date of expiration in the ekit was 7/10/15. No medication was expired in the ekit upon review. Ekit Pharmacy has policy where date of earliest medication expiration (note 7/10/15		

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F 425	<p>Continued From page 8 the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and record review the provider failed to ensure a consultant pharmacist was overseeing pharmacy services, including monitoring of E-Kit (emergency drugs), medication cart reviews, and tracking of scheduled (highly addictive medications) medications. Findings include:</p> <p>1. Observation and interview on 3/25/15 at 10:20 a.m. with registered nurse (RN) F reviewing the blue medication cart revealed: * Six of eleven medication punch cards randomly reviewed had two different dates for expiration or discard. *Twelve of twenty-six medication punch cards in the locked box with the blue medication cart had two different dates for expiration and discard. *The expiration date was at times earlier than the discard date. *The discard date was not always one year from the repackaged date. *RN F had not been able to explain why two different dates were listed or which date should be used.</p> <p>2. Observation and interview on 3/25/15 at 10:45</p>	F 425	<p>has not yet occurred) is on E-kit box and there is a ekit medication list on the back of the ekit noting the contents and expiration date of each content. Unable to change the events noted in observation number 3. Unable to change observation number 4. Observation number 5 is an over-view-unable to change as noted above. Observation item 6 is review of item 1 and 4. As noted above we are unable to change these. Unable to change observation number 7, however a PharMerica Pharmacy Policy and Procedure Manual was present in the facility upon state review.</p> <p>2. DON, Administrator, Pharmacist Pharmacy Consultant will meet and review practices noted and will determine if other residents are affected.</p> <p>3. The Pharmacy consultant will be in the center on a monthly basis and available via phone or e-mail at other times. The pharmacy consultant will assist in establishing documentation that identifies what is done by consultant each month. Pharmacy consultant will ensure center continues to have records of receipt and disposition of all controlled drugs. Pharmacy consultant will ensure that medication are properly labeled</p>		

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F 425	<p>Continued From page 9</p> <p>a.m. with RN F in the medication storage room revealed:</p> <p>*There were no monthly checks or reviews of the E-Kit completed by a pharmacist.</p> <p>*The E-kit (emergency medications locked in a container) listed that a medication expired on 7/10/15, but had not identified what expired.</p> <p>*There were actually two different medications that expired on 7/10/15 within the E-kit.</p> <p>3. Observation and interview on 3/25/15 at 11:10 am with RN F in the medication storage room revealed that scheduled (highly addictive) medications that had been discontinued were kept in the locked cupboards in the medication storage room until they could be placed in the locked drawer in the DON's office.</p> <p>4. Observation and interview on 3/25/15 at 11:17 a.m. with RN F in the medication storage room revealed:</p> <p>*A medication punch card in a bin labeled as "new medication" from a pharmacy the provider used. This medication punch card had:</p> <p>-Eight doses of the medication already punched out.</p> <p>-A label from the pharmacy on top of another label from a different pharmacy.</p> <p>*RN F stated the pharmacies they were using changed and the medication punch card went to the new pharmacy.</p> <p>5. Interview including surveyor 35625 on 3/25/15 at 3:50 p.m. with the director of nursing (DON) confirmed and revealed:</p> <p>*She was not sure why there were two different dates reflecting expiration and or discard.</p> <p>*She confirmed the provider utilized four different pharmacies.</p>	F 425	<p>(including an expiration date).</p> <p>Local pharmacy is now making certain expiration date and discard date match on medications provided by that pharmacy. Observation number 2, E-kit provider is now replacing entire E kit monthly and documentation of monthly inspection will be completed by dispensing pharmacist. Regarding (observation number 3) controlled medication for destruction; a slot in locked cupboard in medication room will be installed. A bound journal will be used to keep track of controlled medication placed into the cupboard for destruction. Only the DNS will have a key to the locked slotted destruction cupboard.</p> <p>Observation number 4 local pharmacist has instructed her entire pharmacy staff regarding the inability to re-label any medication.</p> <p>Observation number 5 was an overview.</p> <p>Observation number 6 Admin and DON met with local pharmacy. Local pharmacy is now making certain both expiration and discard date match on each punch card.</p> <p>Observation number 7 Pharmacy policy and procedures will be available in the facility for staff to refer to. Pharmacy has provided the center with an additional P/P manual. This manual includes monitoring of the E-kit, medication cart review and the</p>	

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F 425	<p>Continued From page 10</p> <p>*The consultant pharmacist was independent and completed the monthly reviews of the residents' medications, but had nothing to do with the E-Kit.</p> <p>*No pharmacist was at the facility to review the E-Kit on a monthly basis.</p> <p>*There was a locked drawer in her office for scheduled medications that were discontinued.</p> <p>*On nights, weekends, and holidays, when she was not in the facility those medications were stored in the locked cupboards in the medication storage room.</p> <p>*The charge nurse, treatment nurse, and the medication technician all had keys for those locked cupboards.</p> <p>*There was no documentation accounting for medications put into those locked cupboards and transferred into the locked drawer in her office.</p> <p>-A medication punch card with the count sheet wrapped around it could have been removed from those locked cupboards without any record.</p> <p>6. Interview including surveyor 35625 on 3/25/15 at 4:06 p.m. with the DON and by telephone pharmacist G confirmed and revealed:</p> <p>*Pharmacist G was aware there were no policies or procedures for the provider to utilize from pharmacist G's pharmacy.</p> <p>*She stated they (the pharmacy) made the medication labels up three to six week early.</p> <p>-The discard date was a year from when the medication was repackaged.</p> <p>-The expiration date was the date the medications were to expire according to the original label on the medication container.</p> <p>*She was aware that if the medication expired before the one year discard date, the discard date should have been change to reflect the earlier date.</p> <p>*She agreed the multiple dates may have been</p>	F 425	<p>accountability and storage of scheduled medication. DON, SDC, consultant pharmacist will provide education to nurses and UAP's on 4/20/15 at 7 am and on 4/23/15 at 2:30 pm regarding pharmacy and medication handling, labeling, discarding and destruction of medication; E-kit and consultant pharmacist role in above.</p> <p>4. DON, SDC or designee, or consultant pharmacist will audit expiration and discard dates, Monthly E-kit, destruction of narcotics placement in locked medication room; relabeling not being done, and making certain P/P are availabe. Audits will be done monthly x 4 with reports given at monthly QAPI by ^{by} DNS. QAPI committee will determine if discarding ^{discarding} further auditing is needed.</p>	5/13/15
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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 425	Continued From page 11 confusing. *When Pharmacist G was asked why a label from her pharmacy was placed over a label on a medication punch card from another pharmacy Pharmacist G responded by asking why the medication was sent to her pharmacy. The DON made no response to the question. *She agreed it would not have been possible to read the original information with a second label placed over the original label.	F 425			
F 431 SS=E	7. Policies and procedures about the oversight of pharmacy services including the monitoring of E-kits, medication cart reviews, and the accountability and storage of scheduled medications were requested from the DON on 3/25/15 at 11:25 a.m. The DON stated all medication policies were online. Neither access to the online medication policies or hard copies were provided by the end of the survey on 3/25/15. 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	1. Unable to change the events noted in observation number 1, 4, 5, 6 and 7. 2. DON, Admin, Pharmacist, Pharmacy Consultant will meet and review practices noted and will determine if other residents are affected. 3. The Pharmacy Consultant will be in the center on a monthly basis and available via phone or e-mail at other times. The pharmacy consultant will assist in establishing documentation that identifies what is done by consultant each month.		

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F 431	Continued From page 12 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and record review, the provider failed to ensure medications were properly labeled with one: *Identified date for expiration. *Label with information and instructions for checking against physician orders. Findings include:	F 431	Pharmacy consultant will ensure center has records of receipt and disposition of all controlled drugs. Pharmacy consultant will ensure that medications are properly labeled by all pharmacies used in the center including the correct expiration dates. DON, SDC, Admin and pharmacy consultant will provide education to nurses and UAP's on 4/20/15 at 7 am and /or on 4/23/15 at 2:30 pm regarding pharmacy and medication handling, labeling, discarding and destruction of medication; E-kit and consultant pharmacist role in center. 4. DON, SDC or designee, or pharmacy consultant will do audits monthly x 4 and will report at monthly QAPI meeting.	5/13/15
F 441 SS=E	Refer to F 425, findings 1, 4, 5, 6, and 7. 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	F 441		

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F 441	<p>Continued From page 13</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</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: 33265 Based on observation, interview, manufacturer's instructions, and policy review, the provider failed</p>	F 441	<p>1. Unable to change the way the Blood Glucose Meter was sanitized. Unable to change the way the nebulizer equipment was cleaned.</p> <p>2. All Blood Glucose Meters will be cleansed with a Super Sani-Cloth Germicidal wipe for each Meter and disposed of after one use. The meter will be kept wet with the solution for 2 minutes and be allowed to air dry between each use. All nebulizer equipment will be disassembled after each treatment, rinsed with hot water, and allowed to air dry.</p> <p>3. The DON and SDC will provide education to nursing staff on 4/20/15 at 7 am and on 4/23/15 at 2:30 pm regarding the proper way to sanitize Blood Glucose Meters and nebulizer equipment. A demonstration will be provided during the education and staff will perform a return demonstration as to the proper way to sanitize this equipment.</p> <p>4. The QAPI coordinator or designee will monitor the sanitizing of the Glucose meters to assure proper cleaning of the meter weekly X4 and then monthly X3. The QAPI coordinator or designee will monitor the cleansing of the</p>		

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F 441	<p>Continued From page 14 to ensure: *Glucometers (machine to measure the level of sugar in the blood) were cleaned according to manufacturer's instructions for three of three (4, 20, and 21) randomly observed residents receiving blood glucose measurements. *Nebulizers (machine that turns liquid medication into aerosol to breath into lungs) were cleaned in consistent manner for four of four randomly observed residents (16, 17, 18, and 19) receiving nebulizer treatments. Findings include:</p> <p>1. Observation on 3/24/15 at 3:45 p.m. with licensed practical nurse (LPN) D revealed: *Resident 4's blood glucose level was measured. -Glucometer was wiped off with a Super Sani-Cloth Germicidal (kills germs) disposable wipe for four seconds. -The glucometer was then placed on top of the container of lancets (sharp metal point used to prick skin for drop of blood). -The germicidal wipe was then placed on top of the medication cart.</p> <p>2. Observation on 3/24/15 at 3:50 p.m. with LPN D revealed: *Resident 20's blood glucose level was measured. *Glucometer was wiped off with the same Super Sani-Cloth Germicidal (kills germs) disposable wipe for four seconds. *The glucometer was then placed on top of the container of lancets (sharp metal point used to prick skin for drop of blood). *The germicidal wipe was then replaced on top of the medication cart.</p> <p>3. Observation on 3/24/15 at 3:55 p.m. with LPN</p>	F 441	<p>nebulizer equipment to assure it is taken apart prior to cleaning weekly X4 and then monthly X3. The QAPI coordinator or designee will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed. 5.Date Certain is</p>	5/13/15

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F 441	<p>Continued From page 15</p> <p>D revealed:</p> <ul style="list-style-type: none"> *Resident 21's blood glucose level was measured. *Glucometer was wiped off with the same Super Sani-Cloth Germicidal (kills germs) disposable wipe for five seconds. *The glucometer was then placed on top of the container of lancets (sharp metal point used to prick skin for drop of blood). *The germicidal wipe was then placed in the garbage. <p>4. Interview and review of Super Sani-Cloth manufacturer's instructions on 3/25/15 at 3:50 p.m. with the director of nursing concerning cleaning and disinfecting of the glucometers revealed she:</p> <ul style="list-style-type: none"> *Was aware the Super Sani-Cloth disposable wipes manufacturer's instructions were to keep the glucometer wet with the solution on the Sani-Cloth for two minutes then air dry. *Believed the nurses were disposing of the Sani-Cloth after each use as per manufacturer's instructions. *Agreed the glucometers were not being cleaned according to the manufacturer's instructions. <p>Review of the glucometer's manufacturer's instructions revealed the Super Sani-Cloth Germicidal disposable wipes could be used to disinfect the glucometer if product label instructions were followed.</p> <p>Review of the Super Sani-Cloth Germicidal disposable wipes label instructions revealed the object being disinfected needed to stay wet with the solution for two minutes then air dry.</p> <p>Review of the provider's November 2014</p>	F 441		
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F 441	<p>Continued From page 16</p> <p>Cleaning and Disinfecting Blood Glucose Meters procedure revealed: *The Super Sani-Cloth Germicidal disposable wipes were approved to use on the glucometers. *After the disinfecting was completed the glucometers were to be left for a few minutes to ensure it was dry.</p> <p>5. Observation on 3/24/15 at 11:15 a.m. with medication technician (MT) E revealed: *Resident 16's nebulizer treatment had ended. *MT E took the nebulizer equipment to the bathroom and rinsed the equipment while it was still assembled. -She did not take it apart to clean the individual parts. *She placed the assembled nebulizer equipment on paper towels to air dry in a plastic container with an open lid.</p> <p>6. Observation on 3/24/15 at 11:20 a.m. with MT E revealed: *Resident 17's nebulizer treatment had ended. *MT E took the nebulizer equipment to the bathroom and rinsed the equipment while it was still assembled. *She took the nebulizer equipment apart and placed individual pieces on paper towels to air dry in a plastic container with an open lid.</p> <p>7. Observation on 3/24/15 at 11:25 a.m. with MT E revealed: *Resident 18 needed to have his nebulizer treatment set up and started. *MT E assembled the nebulizer equipment pieces that had been in the plastic container on paper towels and then started the treatment.</p> <p>8. Observation and interview on 3/24/15 at 11:28</p>	F 441			

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F 441	Continued From page 17 a.m. with MT E revealed: *Resident 19 needed to have her nebulizer treatment set up and started. *MT E found the already assembled nebulizer equipment in the plastic container on paper towels and then started the treatment. *When asked why the equipment had not been taken apart as the last one had been she responded she was not sure. 9. Interview on 3/25/15 at 3:50 p.m. with the DON revealed she: *Agreed the nebulizer equipment should be taken apart to be cleaned and dried after use. *Was aware not all the nebulizers were being taken apart to clean and then air dry. *Stated there was a staff member on the night shift that put the pieces together so tightly the day shift personnel were not able to get the pieces apart for cleaning. Review of the provider's 11/27/13 Nebulizer procedure revealed they were to: *Disconnect nebulizer from tubing. *Rinse under hot tap water to remove any residual medication after each use. *The procedure had not provided guidance on when to take the nebulizer apart, but had documented they were to "air dry parts" on a clean paper towel.	F 441		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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F 520	<p>Continued From page 18 facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on interview, record review, and policy review, the provider failed to ensure the physician on the Quality Assurance Performance Improvement (QAPI) committee attended the meetings or reviewed the minutes in a timely manner for the third or fourth quarters of 2014. Findings include:</p> <p>1. Interview on 3/25/15 at 1:30 p.m. with the administrator revealed: *She was on the QAPI committee. *The QAPI coordinator was currently on leave. *This committee met monthly. *The physician on the committee was to review the minutes quarterly. He did not attend the</p>	F 520	<ol style="list-style-type: none"> 1. The Medical Director has reviewed and signed the minutes of the monthly QAPI meeting minutes for the past months. 2. The Medical Director will review the monthly QAPI meeting minutes on a quarterly basis after a review of these minutes by the DON and Administrator. The Medical Director will assist and guide the facilities resident care policies and implementation of these and assist in coordinating the medical care of the center. 3. The National Campus QPIC Consultant will educate the administrator and QAPI coordinator as to the requirements of the Medical Directors involvement in the QAPI committee on 4/16/15. This education will include a review of GSS policy and procedure for those required to attend the QAPI meetings. 4. The Administrator or Designee will monitor the medical director's involvement in QAPI to assure he has reviewed the meeting minutes quarterly. The audit will also include the other participants in the QAPI committee. These audits will be done monthly X6 to assure 	

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F 520	<p>Continued From page 19 meetings.</p> <p>Review of the third and fourth quarter 2014 QAPI meeting minutes revealed: *The third quarter (July, August, and September 2014) minutes dated 8/21/14 were signed by the physician on 10/17/14. *The fourth quarter (October, November, and December 2014) minutes dated 10/16/14 were signed by the physician on 12/29/14. The other two months in that quarter were signed by the physician on 1/5/14.</p> <p>Review of the provider's January 2015 Forming the Quality Committee policy revealed: *"There are three required members of the quality committee including the medical director." *"The committee must meet on a quarterly basis."</p> <p>Review of the provider's January 2015 Quality Assessment and Assurance (QAA) policy revealed: *"A facility must maintain a quality assessment and assurance committee consisting of....A physician designated by the facility." *"The quality assessment and assurance committee...meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary." *This surveyor had been directed by the administrator to a paragraph that read: -"The medical director (part of the medical director's responsibility [see F501] is to guide the facility's development and implementation of resident care policies and coordination of medical care. If the medical director is not a committee member, exchange of information with the medical director enhances the functioning of the QAA [QAPI] committee);.....</p>	F 520	<p>the meeting minutes have been reviewed by the Medical Director timely. The Administrator or Designee will report these findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>5. Date certain</p>	5/13/15

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F 520	Continued From page 20 -The medical director was the physician on the QAPI committee.	F 520		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435106	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDIG 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/24/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY WAGNER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 W HWY 46 WAGNER, SD 57380
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/24/15. Good Samaritan Society Wagner was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle Wagner</i>	TITLE <i>Admin GSS Wagner</i>	(X6) DATE <i>04/16/15</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.

APR 17 2015

If continuation sheet Page 1 of 1

SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10700	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY WAGNER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 W HWY 46 WAGNER, SD 57380
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S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/23/15 through 3/25/15. Good Samaritan Society Wagner was found not in compliance with the following requirement: S331.	S 000		
S 331	44:04:08:07.01 Controlled drugs kept for Emergency Use In nursing facilities, controlled drugs may be kept for emergency use under the following circumstances: (1) The pharmacist supplying the controlled drugs maintains ownership and responsibility for the drugs, including a monthly physical inventory; (2) The controlled drugs are stored in a manner that allows only those individuals authorized to administer the drugs access to them; (3) The controlled drugs are stored in a sealed emergency box or in a separate locked cabinet, with a complete and accurate record kept of the drugs in the box or cabinet and of their disposition; (4) The facility notifies the pharmacist within 36 hours after the withdrawal of a Schedule II drug and within 72 hours after the withdrawal of Schedule III and IV drugs and the pharmacist replaces the drugs within 72 hours after notification; and (5) No more than 5 different controlled drugs are stored in the emergency box, which may contain no more than 6 doses of any Schedule II controlled drug, no more than 6 doses of any Schedule III or IV injectable controlled drug, and no more than	S 331	<ol style="list-style-type: none"> 1. Unable to change events noted. 2. E-kit (for emergency use for all residents) will be checked and documented by a pharmacist monthly. 3. DON, Admin., Pharmacy Consultant will meet going over P/P and state requirements. Pharmacy will deliver a new E-kit monthly. Medications with expire dates will be attached to E-kit each month. 4. DON, Pharmacist and or designee will audit monthly X6 to ensure E-kit is replaced monthly with a list of medications and their expiration dates attached and will report at monthly QAPI meetings. 5. Date certain 	5/13/15

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

Michelle J. Jorgensen

TITLE: *Admin. GSS Wagner*

STATE FORM 6899

PTHY11

RECEIVED

APR 17 2015

SD DOH L&C

(X6) DATE
4/16/15
If continuation sheet 1 of 3

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10700	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY WAGNER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 W HWY 46 WAGNER, SD 57380
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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 331	<p>Continued From page 1</p> <p>12 doses of any oral Schedule III or IV controlled drug.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and record review the provider failed to ensure a consultant pharmacist was completing a monthly physical inventory of the E-Kit (emergency drugs locked in a container). Findings include:</p> <p>1. Observation and interview on 3/25/15 at 10:45 a.m. with RN F in the medication storage room revealed: *There were no documented monthly checks or reviews of the E-Kit completed by a pharmacist. *The E-kit listed that a medication expired on 7/10/15, but had not identified what expired. *There were two different medications that expired on 7/10/15 within the E-kit.</p> <p>Interview including surveyor 35635 on 3/25/15 at 3:50 p.m. with the director of nursing (DON) revealed: *Four different pharmacies were utilized by the provider. *The consultant pharmacist was independent and completed the monthly reviews of the residents' medications, but had nothing to do with the E-Kit. *No pharmacist was at the facility to review the E-Kit on a monthly basis.</p> <p>Policies and procedures about the oversight of pharmacy services including the monitoring of the E-Kit were requested from the DON on 3/25/15 at 11:25 a.m. The DON stated all medication policies were online. Neither access to the online medication policies or hard copies were provided by the end of the survey on 3/25/15.</p>	S 331		
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10700	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY WAGNER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 W HWY 46 WAGNER, SD 57380
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