

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DE SMET	STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVENUE NW DE SMET, SD 57231
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/26/16 through 1/28/16. Good Samaritan Society DeSmet was found not in compliance with the following requirements: F323 and F327.</p>	F 000	<p><i>*Addendums noted with an asterisk per 3/15/16 per telephone with facility administrator. PE/SDDOTHEL</i></p>	
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to ensure chemicals had been secured and were not accessible to residents for: *Three of three housekeeping carts. *One of one beauty shop. Findings include: 1. Observation on 1/26/16 at 7:15 a.m. of housekeeper D revealed she was working in the hallway outside the dining room. Residents were going to and from the dining room. Her housekeeping cart remained unlocked in the hallway. Observation of the unsecured cabinet in the cart revealed:</p>	F 323	<p>1. New housekeeping cart locks were ordered on 2/10/16 and will be installed upon arrival. A lock was installed to one of the cabinets in the beauty shop on 2/11/16 to secure chemicals. 2. All housekeeping carts will have chemicals stored, locked, and unavailable to residents. All rooms that may contain chemicals or items that could cause harm will be locked when personnel are not present. 3. The Administrator or designee will provide education to all staff on 2/16/16 regarding the policy and procedure on maintaining a safe a secure environment for residents, visitors, and staff. This will include general safety rules as well as departmental safety rules and the need to keep chemicals locked up and inaccessible to residents, including the chemicals in the housekeeping carts.</p>	2/26/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Katherine Johnson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2/16/16</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 parts 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 1</p> <p>*A container of Iron Out rust stain remover. Review of product information revealed, "Caution: eye irritant, harmful if swallowed, vapor harmful, keep out of reach of children."</p> <p>*A bottle of Spitfire RTU Power Cleaner. Review of product information revealed, "Avoid contact with eyes, skin and clothing. Do not taste or swallow."</p> <p>*A can of United Laboratories Cherry Insecticide spray. The label stated, "Hazardous to humans and domestic animals. Do not take internally. Avoid breathing mist or vapor. Avoid contact with eyes, skin, clothing."</p> <p>Interview at that time with housekeeper D revealed: *She did not know where the housekeeping cart key was. *She did not routinely lock the cart when she was not present. *The maintenance supervisor was working on getting a key for the cart.</p> <p>Observation on 1/27/16 at 10:30 a.m. of housekeeper E revealed she was working in a resident room in the 300 hall. Her housekeeping cart remained in the hallway, unsecured. Interview with her at that time revealed: *She did not have a key to the cart. "He [the maintenance supervisor] is working on it." *Both housekeeper D and E carried the same chemicals in each cart. *There was a third cart used by a part-time housekeeper. She did not believe that cart had a key. *She tried to move the cabinet against the wall when she was not present, so it would not be accessible to residents.</p>	F 323	<p>The DNS re-educated the beautician on 2/11/16 and the barber on 2/12/16 on the need to have the beauty shop door locked and the chemicals locked up when they are not present in the shop.</p> <p>4. The Environmental Services Director will audit the housekeeping carts to assure chemicals are locked in compartments in the housekeeping carts. The Administrator will audit the beauty shop to assure chemicals are locked and the door is locked when the shop is not in use. Audits will be done weekly for 4 weeks and then monthly for 3 months. The Environmental Services Director and Administrator will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>5. Corrective action will be completed by 2/26/2016.</p>		

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F 323	<p>Continued From page 2</p> <p>2. Observation on 1/26/16 at 2:50 p.m. of the beauty shop revealed:</p> <ul style="list-style-type: none"> *The door had been unlocked. *A jar of Barbicide (used to disinfect combs and other hair care equipment) sat on the counter. *An unsecured cabinet at floor level stored: <ul style="list-style-type: none"> -A container of Barbicide. The label stated, "Corrosive - causes irreversible eye damage", and "Harmful if swallowed." -A can of United Laboratories Cherry Insecticide spray. -A bottle of CREW multisurface cream cleanser. The label advised to get medical attention if swallowed or if breathing became difficult. *The beauty shop door remained unlocked at 5:30 p.m. on 1/26/16. *The beauty shop door was unlocked on 1/27/16 when checked at 7:30 a.m. but was found secured at 10:40 a.m. *No hair care activity was noted between 1/26/16 at 2:50 p.m. and 1/27/16 at 10:40 a.m. <p>3. Interview on 1/27/16 at 4:45 p.m. with the maintenance supervisor and the director of nursing revealed:</p> <ul style="list-style-type: none"> *They agreed the door to the beauty shop should have remained secured when not being used. *They agreed housekeeping chemicals should have remained secured from residents. <p>Review of the provider's September 2012 Housekeeping and Laundry Departments Safety Rules Policy revealed:</p> <ul style="list-style-type: none"> *"Keep cleaning equipment properly stored and locked when not in use. Never leave cart unattended." *"Do not leave any chemicals unattended in resident rooms or in any area to which residents have access. Store chemicals in a locked area." 	F 323		

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F 327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced and any additional residents at risk for dehydration will also be audited. REF: 2016/02/16</p> <p>by: Surveyor: 35237</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (5) had been identified, had interventions implemented, and had her care plan revised to reflect her risk for dehydration (not having enough fluids). Findings include:</p> <p>1. Observation on 1/26/16 from 4:50 p.m. through 5:50 p.m. of resident 5 in the dining room revealed: *She had an eight ounce glass of water on the table in front of her. *At 5:13 p.m. an unidentified dietary employee placed an eight ounce glass of apple juice in front of her. *At 5:23 p.m. she was served her meal. *She ate her food but made no attempts to drink the water or juice. *No staff assisted or encouraged her to eat or drink.</p> <p>Observation on 1/27/16 at 8:00 a.m. of resident 5 revealed: *She was in the dining room eating breakfast. *She had a cup of coffee and eight ounce glasses of water and cranberry juice on the table in front of her. *There were no staff assisting or encouraging</p>	F 327	<p>1. The care plan of resident 5 was updated on 1/27/2016 to identify that the resident is at a risk for dehydration as well as interventions to help increase fluid intake.* Resident 5 was also added to the nutrition at risk list on 2/15/16 per procedure "Residents at Risk for Dehydration/Fluid Maintenance" to be monitored by the registered dietitian and the nutrition at risk committee.</p> <p>2. All residents with a nutrition or hydration risk will be placed on the Nutrition at Risk list and reviewed weekly by the Nutrition at Risk committee and reviewed monthly by the RD. The care plan for these residents will reflect this focus and interventions will be in place so staff are aware of this risk.</p> <p>3. The Administrator or designee will provide education to all staff on 2/16/16 regarding the procedure for Residents at Risk for Dehydration/Fluid Maintenance including the symptoms which can lead to dehydration. 2/16/2016</p> <p>4. The MDS Coordinator or designee will audit to assure that the interventions noted on the care plan for resident 5 are being followed. These audits will be done weekly for 4 weeks, and then monthly for 3 months. The MDS Coordinator or designee will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>5. Corrective action will be completed by 2/16/2016.</p>	2/16/2016

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F 327	<p>Continued From page 4 her.</p> <p>Further observation on 1/27/16 at 8:45 a.m. of resident 5 revealed: *She was sleeping in the chair at the dining room table. *She had drank approximately half of the cranberry juice, approximately one-third of the coffee, and none of the water. *There were no staff assisting or encouraging her.</p> <p>Interview on 1/27/16 at 9:46 a.m. and at 10:25 a.m. with the director of nursing (DON) regarding resident 5 revealed: *She sat at an encouragement table but not an assisted table for meals. *She needed reminders to drink more fluids and did not usually drink much. *When she seemed to get more confused she usually needed more fluids. *Fluid intakes were not documented on residents unless they were on the nutrition risk program. -Resident 5 had come off the nutrition risk program in December 2015, because her weight had been stable.</p> <p>Observation on 1/27/16 from 11:40 a.m. through 12:25 p.m. of resident 5 in the dining room revealed: *She had an eight ounce glass of water on the table in front of her. *Three staff came to her table to deliver items to her tablemates from 11:40 a.m. through 12:15 p.m., and none of those staff encouraged her to take a drink. *At 12:15 p.m. an unidentified employee sat down by her right side. *That employee did not encourage her to take a</p>	F 327		

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F 327	<p>Continued From page 5</p> <p>drink until 12:20 p.m. when she moved the water glass nearer to her.</p> <p>-Resident 5 looked at the glass but made no attempt to pick it up.</p> <p>*At 12:21 p.m. an unidentified dietary employee placed an eight ounce glass of orange juice in front of her.</p> <p>*The unidentified employee to her right stated the resident did not like to drink but usually ate well.</p> <p>-She encouraged her to take a drink, and the resident then took one small drink of the orange juice.</p> <p>Random observations of resident 5 from 1/26/16 through 1/28/16 revealed she sat in the television lounge area frequently and had no drinks within reach during those times.</p> <p>Interview on 1/27/16 at 4:50 p.m. with the Minimum Data Set (MDS) assessment coordinator regarding resident 5 revealed:</p> <p>*She usually ate well but did not drink fluids well.</p> <p>*Her labs (laboratory tests, blood work) had been good and did not indicate dehydration.</p> <p>*She confirmed:</p> <p>-The resident was at risk for dehydration due to several risks factors including her diagnosis of dementia, medication side effects, need for encouragement to drink, and history of not drinking enough.</p> <p>-She had not triggered for dehydration from her MDS assessments but still could have been at risk.</p> <p>-Her care plan had not included her dehydration risk factors or interventions for fluid intake.</p> <p>Review of resident 5's medical record revealed she:</p> <p>*Had diagnoses that included: vascular dementia</p>	F 327		

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F 327	<p>Continued From page 6 (disease affecting memory and decision making), constipation, high blood pressure, and heart failure. *Had a Brief Interview for Mental Status (BIMS) assessment score of 3 which indicated severe impairment. *Sometimes had problems understanding others. *Required supervision of one staff person with eating and limited to extensive assistance with other activities of daily living (dressing, hygiene, toileting, moving around, and bathing). *Received Vesicare (medication for urinary frequency) daily. That had possible side effects of dry mouth and constipation. *Received medications for her heart and constipation daily.</p> <p>Review of resident 5's interdisciplinary progress notes from 11/17/15 through 1/26/16 revealed: *On 12/4/15, "resident will be removed from nutrition intervention program. Res [resident] sits at an assisted table for encouragement and assist of one when needed. Needs encouragement with liquids..." *On 1/4/16, "completed with annual RDN [registered dietitian nutritionist] review. Remains on a Regular diet. Weight does fluctuate some with fluid status (CHF [congestive heart failure]). No change in nutrition care suggested."</p> <p>Review of resident 5's printed 1/26/16 care plan revealed: *She had required supervision and cueing at times with eating and to "encourage fluids." *It had not addressed her risk for dehydration nor had further interventions for that problem area.</p> <p>Review of resident 5's reports for amount of fluids consumed from 12/1/15 through 1/4/16 revealed:</p>	F 327		

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F 327	<p>Continued From page 7</p> <p>*Her fluid intake from meals ranged from 115 cc (cubic centimeters, measurement of liquid) to 840 cc of fluid.</p> <p>*At no other times had fluid intake been recorded.</p> <p>Interview with the DON and administrator regarding resident 5 confirmed:</p> <p>*She did not drink enough fluids and was at risk for dehydration.</p> <p>*Her care plan had not reflected her risk for dehydration.</p> <p>*There had not been interventions documented to prevent dehydration.</p> <p>*The hydration policy had not been followed.</p> <p>Follow-up phone interview on 1/28/16 at 10:24 a.m. with the RDN from a message left during the survey revealed she:</p> <p>*Estimated daily fluid requirements for a resident at 30 cc per kilogram of body weight.</p> <p>*Had recently completed a review of resident 5 that indicated her estimated fluid needs should have been 1650 cc per day.</p> <p>*Agreed the amount of recorded fluids for resident 5 had not met her daily fluid requirements.</p> <p>*Confirmed resident 5 was at risk for dehydration.</p> <p>*Agreed dehydration should have been addressed on her care plan along with interventions that had been implemented.</p> <p>Review of the provider's revised October 2013 Residents at Risk for Dehydration/Fluid Maintenance procedure revealed:</p> <p>**Residents determined to be a hydration risk will be put on the list of residents at nutrition risk and be monitored by the registered dietitian and nutrition risk committee."</p> <p>**The plan of care will include approaches to</p>	F 327			

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F 327	<p>Continued From page 8</p> <p>encourage the resident to achieve and/or maintain hydration status if the resident has symptoms which can lead to dehydration such as the following:"</p> <p>-"Use of nine or more medications including diuretics [medication to decrease fluid] and laxatives."</p> <p>-"Cardiovascular agents [medications for heart and blood flow]."</p> <p>-"Dependence on staff for the provision of fluid intake."</p> <p>-"History of refusing fluids."</p> <p>-"Limited fluid intake."</p> <p>-"Lacking sensation of thirst."</p> <p>***Nursing staff will write the problem/goal for dehydration/fluid maintenance on the care plan. The approaches may include a variety of staff depending on the resident's individual needs..."</p> <p>Review of the provider's revised August 2015 Comprehensive Care Plan and Care Conferences policy revealed:</p> <p>***The goal is to develop an individualized care plan that does not duplicate other components of the resident's plan of care and sustains clinical excellence in the delivery of personal care and nourishes the human spirit, while also incorporating the individual's needs, previous lifestyle choices and strengths."</p> <p>***The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life."</p>	F 327		

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ORIGINAL

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/27/16. Good Samaritan Society DeSmet (Building 01) 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 K029, K067, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation for one of one hazardous areas. One nursing supply storage room was not provided with automatic door closures. Findings include: 1. Observation at 10:00 a.m. on 1/27/16 revealed the nursing supply storage room 303 was over	K 029	1. A door closure will be added to the nurse supply storage room. A grate will be installed in the door of of the locked room within the storage room. This will allow proper exhaust ventilation, as required by NFPA standards. 2. Residents will be assured safety with a self-closure door on the nursing supply storage room and proper exhaust ventilation. As indicated, this deficiency had the potential to impact 100% of the residents in the 300 wing. By adding the door closure and the grate, the potential impact for all occupants indicated will be eliminated. 3. The Administrator will educate all staff on 2/16/16 on regulation K029 and the need for self-closing doors and proper exhaust ventilation.	2/26/2016

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

TITLE

(X6) DATE

Katherine Johnson

Administrator

2/16/16

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FEB 17 2016

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2016
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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
K 029	Continued From page 1 100 square feet in area. The room was not equipped with a closer or exhaust ventilation. Interview with the administrator at the time of the observation revealed the room was converted to storage within the past six months. She added that room use change was not submitted to the Department of Health for review.	K 029	4. The environmental services director will audit the building annually to assure all doors needing a self-closure will be installed. 5. Corrective action will be completed by 2/26/16.	
K 144 SS=D	The deficiency had the potential to affect 100% of the residents in the 300 wing. NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a remote stop button for one of one generator. Findings include: 1. Observation at 11:00 a.m. on 1/27/16 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator. All Level 2 installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover or located elsewhere on the premises where the prime mover is located outside the building (National Fire Protection Association 110, Chapter 3-5.5.6, 1999 Edition).	K 144	1. A remote emergency stop button for the generator will be installed by Aron's Electric and Cummins Central Plains according to NFPA standards. 2. This will be completed by March 18, 2016.	3/18/2016

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435074	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 1/27/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DE SMET		STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVENUE NW DE SMET, SD	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
K 067	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>Based on observation and interview, the provider failed to install relief valve piping for three of three water heaters in the boiler room. Findings include:</p> <p>1. Observation at 1:00 p.m. on 1/27/16 revealed three A.O. Smith water heaters (199,900 British thermal units input each) in the boiler room on a four inch high concrete pad. The relief valve drain piping extended to fifteen inches above the floor (approximately eleven inches above the pad). The relief valve drain piping is required to be installed between one point five inches and six inches above the finished floor. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He was not aware the relief drain piping was not in compliance.</p> <p>The deficiency affected one of numerous requirements for hot water heater installations</p> <p style="text-align: right;">1. The relief valve drain piping on three of three water heaters in the boiler room were corrected on 2/11/16 so that the draining pipes are now between 1.5"-6" above the finished floor, following the NFPA standards. 2/11/16</p>		

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

The above isolated deficiencies pose no actual harm to the residents

South Dakota Department of Health

ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DE SMET	STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVE NW DE SMET, SD 57231
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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
S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/26/16 through 1/28/16. Good Samaritan Society DeSmet was found not in compliance with the following requirement: S206.	S 000	<i>*Addendums noted with an asterisk per 3/15/16 per telephone with facility administrator. PE / SDDOT/EL</i>	
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	1. Annual training was updated on 2/3/16 to reflect required training on the following topics: Nutrition and Hydration: Your Responsibilities-Fundamentals, and Dining Assistance. *1 → next page 2. These trainings will be required of all staff annually to maintain compliance. 3. The Staff Development Coordinator is responsible for keeping track of learning center requirements and any changes to those requirements. 4. The Staff Development Coordinator will keep track of completed learning centers for all staff. Failure to complete required trainings will result in corrective action to all applicable staff. 5. This corrective action completed on 2/3/16.	2/3/2016

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

TITLE

(X6) DATE

Kathleen Johnson

Administrator

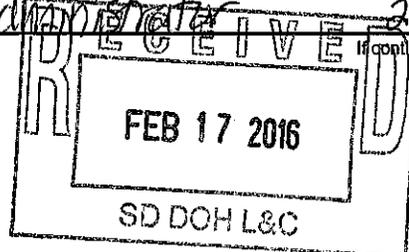
2/16/16

STATE FORM

6899

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If continuation sheet 1 of 3



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2016
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S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on interview, personnel file review, and training compliance schedule review, the provider failed to ensure annual education had been offered for dining assistance, nutritional risks, and hydration needs of residents for three of three sampled employees (A, B, and C) who had been employed for longer than one year. Findings include:</p> <p>1. Review of the personnel files for employees A, B, and C revealed: *They had not received any training for dining assistance, nutritional risks, and hydration (fluid) needs of residents in the past year. *Employee A had been employed since 7/13/99. *Employee B had been employed since 6/10/10. *Employee C had been employed since 6/18/14.</p> <p>Review of the provider's 2015 Learning Center Training Compliance Schedule revealed dining assistance, nutritional risks, and hydration needs of residents had not been included in the training sessions for employees.</p> <p>Interview on 1/27/16 at 2:40 p.m. with the administrator revealed: *The above employees had not received the above training in 2015 and should have. *She confirmed the above training had not been provided to all other employees and should have been.</p>	S 206	<p>*An inservice for all staff including staff members A, B, and C has been completed on nutrition and hydration and your responsibilities. Dining assistant training has been scheduled for all staff meeting in June. PE/SDDO/H/EL</p>	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DE SMET	STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVE NW DE SMET, SD 57231
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S 000	Continued From page 2	S 000		
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/26/16 through 1/28/16. Good Samaritan Society DeSmet was found in compliance.</p>	S 000		