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

ORIGINAL

PRINTED: 05/17/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435123		05/04/2016

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

(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 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/3/16 through 5/4/16. Good Samaritan Society Selby was found not in compliance with the following requirements: F241, F281, F371, F425, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/3/16 through 5/4/16. Areas surveyed included quality of care and infection control. Good Samaritan Society Selby was found in compliance.	F 000	*Addendums noted with an asterisk per 6/8/16 per telephone with facility administrator. MP/SDDOH/EL	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and Resident's Bill of Rights review, the provider failed to ensure privacy was maintained for one of two observed residents (4) during transfers and personal care by two of two certified nurse aides (CNA) (A and B). Findings include: 1. Observation on 5/3/16 at 5:05 p.m. of resident 4's transfer, dressing change, and repositioning in her room revealed: *CNA B left resident 4's room and brought in the Hoyer lift.	F 241	F-241 1. Certified nursing assistants (CNAs) A and B and Nurse C were reminded to pull the privacy curtains in addition to closing the doors to the resident room when providing personal care to residents. All residents will be provided dignity and respect while maintaining privacy during all personal cares. 2. All nursing staff will be educated on providing privacy for residents during personal care. This education will be provided by the administrator and interim director of nursing services (DNS) on June 1, 2016. All staff will be informed that privacy will be provided by closing the privacy curtain and the door to the resident room. In addition, staff will be informed to use a covering, such as a blanket or article of clothing, to provide as much dignity and respect to the resident as possible.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy E Willia — TITLE: Administrator — (X6) DATE: 5-27-16

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 241	Continued From page 1 *She pulled back the privacy curtain to position the lift correctly to transfer resident 4 from the bath chair to her bed. *The privacy curtain had been left open during the transfer. *The door had been shut during the transfer and dressing change. *Nurse C entered and left the room several times during the transfer. *A randomly observed CNA entered and left the room during that time. *The privacy curtain had been left open while nurse C performed a dressing change to resident 4's bottom. *The privacy curtain and the door had been left open while CNA's A and B repositioned the resident. -This surveyor had been observing from the hallway while she had been repositioned. *The resident had been in full view in a nightgown during the repositioning. *Resident 4's roommate had been in the room during the above observed. Interview on 5/4/16 at 2:15 p.m. with the director of nursing revealed she expected staff to close privacy curtains and doors while performing care and transfers with residents. Review of the January 2007 revision of the Resident's Bill of Rights for Skilled Nursing Facilities revealed: *The resident had the right to personal privacy. *Personal privacy included accommodations, medical treatment, and personal care.	F 241	3. The interim DNS, Staff Development Coordinator (SDC), or designee will audit resident cares weekly for 4 weeks and then monthly for 3 month, including but not limited to dressing, personal hygiene, peri-care, and skin treatments. These audit findings will be reported to the facility Quality Assurance and Performance Improvement (QAPI) committee monthly by the interim DNS. The committee will determine if further auditing is needed. 4. Date certain June 17, 2016. *These audits will include resident 4. MP/SDDOH/EL	6-17-16
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	Continued From page 2 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, care plan review, and policy review, the provider failed to ensure: *Staff had obtained a physician's order to crush medication for one of one sampled resident (13). *Staff were providing care according to resident's individualized care plan for one of seven sampled residents (10). *Certified medical assistants (CMA) (I) were practicing within their scope of practice. Findings include: 1. Observation on 5/3/16 at 5:20 p.m. observed CMA I crushing medication for resident 13. She was unable to find a physician's order to crush his medications. Interview on 5/3/16 at 5:30 p.m. with registered nurse (RN) C revealed she was unable to find a physician's order to crush resident 13's medication. Review of the provider's May 2016 Crushing Medications policy revealed staff needed to notify the medical provider crushed medications needed and obtained an order for crushing the medication. 2. Observation on 5/4/16 at 3:35 p.m. revealed CNA G and H had just changed resident 10's adult incontinence brief instead of assisting him to the restroom.	F 281	F-281 1. Certified Medication Assistants (CMAs) E and I were reminded of the policies regarding crushing medications and the medication administration process. All residents will be assured that a physician order will be obtained prior to crushing medications.*A CMAs will give the resident the medication they prepared and will stay with the resident until the medication is taken or refused by the resident. Other staff will not be given not be responsibility for assisting residents to take their medications. physicians order was obtained to crush medications for residents 13. MP/SDROH/EL CNA H was educated about following the residents' kardex care plans. Reference to CNA G in finding 2 is an inaccurate; it is unknown which CNA was working with CNA H at that time. All residents will be assured that staff will follow the residents' kardex care plans when providing personal cares.	

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F 281	Continued From page 3 Interview on 5/4/16 at 4:10 p.m. with CNA G revealed temporary staff did not usually follow the toileting instructions on the care plan for resident 10. Review of his care plan revealed that staff should have used the lift to set him on the toilet and let him go to the bathroom. Interview on 5/4/16 at 4:20 p.m. with CNA H revealed she was unaware of the careplan instructions for toileting resident 10. Review of current care plan resident 10 revealed resident should have been taken to the restroom every two hours. 3. Observation on 5/3/16 at 5:25 p.m. during supper medication pass revealed CMA E handed certified nursing assistant A (CNA) tomato juice, that had Miralax (laxative) in it to give to the unidentified resident. *Staff did not wait to observe the medication had been taken or to document how much of juice the resident had drank. Observation on 5/4/16 at 8:50 a.m. revealed Miralax mixed with orange juice was sitting on table. CNA F who was assisting resident 11 with breakfast was not aware of any medication mixed in juice. *CMA I confirmed she had mixed the Miralax into the orange juice. *Staff did not observe how much of the juice mixture was consumed. That was not documented in the chart. Interview on 5/4/16 at 11:30 a.m. with the director of nursing (DON) revealed her expectation would have been for the medication aide to administer the Miralax mixed in tomato juice and she should	F 281	2. The interim DNS and the staff development coordinator will provide education to all nursing staff on the importance of proper medication administration, reminding CNA staff that they are not allowed to give medications in food or drink to residents. CMAs and nurses will be educated on the importance of giving the medications they have prepared to the residents and not allowing other staff to give the medications. All staff will be shown how to access the resident kardex to assist them in providing the proper personal cares to residents. New staff or agency staff will be given a demonstration on how to access the kardex. This education will occur on June 1, 2016, and as new or agency staff arrives in the center. 3. The interim DNS, staff development coordinator (SDC), or designee will audit medication administration weekly for 4 weeks and then monthly for 3 months observing CMAs and nurses on the	

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F 281	Continued From page 4 not have handed it to a CNA to administer. Interview on 5/4/16 at 11:35 a.m. with the Minimum Data Set (MDS) coordinator revealed she would have expected all medications to be given by certified staff. A CNA would not have been one of those staff. Review of the provider's June 2016 Medication Administration policy revealed: *Administer only those medications that you prepare. Do not ask anyone else to administer medications that you prepared. *Do not leave medications at the table and stay with the resident until you observe all medication was taken.	F 281	proper way to administer medications including staying with the resident as they consume the medication and not allowing other staff to provide the medication to the resident. The SDC or designee will audit resident cares to assure staff are following the resident's plan of care and checking the kardex. The SDC will [redacted] ask new and/or agency staff to demonstrate how they would access the kardex. *at the same time. MP/SDOH/EL *Weekly times 4 weeks then monthly for 3 months. MP/SDOH/EL	
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: Based on observation, interview, testing, and policy review, the provider failed to ensure: *One diet card that had been dropped on the floor was cleaned by one of one cook (G) observed during one of two meals. *The kitchen floor had been maintained in a	F 371	The interim DNS or SDC will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed. MP/SDOH/EL 4. Date certain June 17, 2016. F-371 1. Cook G was an agency staff member and is no longer working in the facility. The soiled areas of the kitchen have been cleaned. All residents will be assured that staff	6-17-16

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F 371	Continued From page 5 sanitary manner. Findings include: 1. Observation on 5/3/16 from 11:50 a.m. through 12:20 p.m. of cook G while she served the midday meal revealed she dropped a diet card on the floor. She reached down, picked up the diet card, and laid it on the clean counter. She laid it directly beside a clean plate of food she had just dished up. A staff member then picked up the soiled diet card that had been on the floor and the clean plate of food. The dirty diet card was put in the container with the other diet cards. The clean plate of food was served to a resident. Neither the cook or staff member washed their hands after picking up the soiled diet card. 2. Observations on 5/3/16 from 7:30 a.m. through 6:00 p.m. and on 5/4/16 from 7:30 a.m. through 11:00 a.m. of the kitchen revealed the floor: *Behind the plate holder by the baseboard area was soiled with several unidentified tan and white colored particles. *Under the three compartment sink and to the left of the sink had a black, sticky grease-like substance build-up. *The heat register on the wall beside the sink had dust particles and tan, brown, and yellow colored unidentified particles on it. The top of the register was greasy-like and sticky to touch. *Behind the convection oven it was dusty, and had a brown, yellow, and tan unidentified particle build-up. *On both sides of the reach-in refrigerator was a black sticky substance build-up. There were yellow, brown, black, and white colored unidentified particles on top of that greasy build-up. The build-up was sticky and greasy like to touch.	F 371	are using proper sanitary procedures and that food coming from this kitchen has been prepared in a sanitary area. 2. All dietary staff will be educated on proper sanitary procedures related to anything that could potentially cross-contaminate the food. All staff will be educated on proper sanitation procedures when handling plates of food, including hand hygiene. The staff development coordinator (SDC) will provide education to all staff on sanitary procedures on June 1, 2016. A new cleaning schedule will be implemented and the certified dietary manager (CDM) will provide education to the dietary staff on the cleaning schedule on June 2, 2016. The education will include a review of the policies and procedures for Food Preparation, Cleaning-Sanitation of Non-food Contact Surfaces, Equipment Sanitation, and Cleaning Schedules. The CDM will also give the dietary staff deep cleaning assignments on June 2, 2016.	

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F 371	Continued From page 6 *Behind the stove had an unidentified particle build-up of white, brown, and yellow colored substances. Interview on 5/4/16 at 11:00 a.m. with the certified dietary manager confirmed: *The diet card was dirty after it had been on the floor. It should have been cleaned before it was put on the counter. The cook should have washed her hands after contact with that dirty diet card. *The above floor areas had been dirty. She stated there was a cleaning schedule for them. Review of the provider's February 2013 Sanitation Cleaning Schedules policy revealed: *It had been the responsibility of the director of dietary services or designee to post the cleaning schedules in the dietary area. *The director of dietary services was responsible to monitor staff to ensure the cleaning duties had been completed satisfactorily. *A PM Dietary Aide cleaning schedule was attached to the above policy. There had been no mention of cleaning the kitchen floor.	F 371	3. The CDM or designee will conduct an audit to observe staff for proper sanitary practices including situations of potential cross-contamination such as placing soiled items next to food or clean items. The CDM will also audit the kitchen for cleanliness and sanitation, including a review of the cleaning schedule to assure this has been implemented and is being followed. These audits will occur weekly for 4 weeks and then monthly for 3 months. The findings from these audits will be reported to the QAPI committee by the CDM monthly and the committee will determine if further auditing is needed. 4. Date certain June 17, 2016.	6-17-16
F 425 SS=D	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	F 425		

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F 425	Continued From page 7 acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the provider failed to ensure all narcotics were accounted for and verified according to provider's policy for two of two observations. 1. Observation and interview on 5/4/16 at 10:50 a.m. with certified medication aide (CMA) E while counting selected narcotics during medication cart inspection revealed: *When counting narcotics they include the Ativan (anxiety medication) in the refrigerator and count the Ativan. *Staff only count it if it had been used, according to the narcotic count. *She copied the number of the count on the narcotic sheet without verifying it was correct. *Staff signed it had been counted. Interview on 5/4/16 at 11:00 a.m. with registered nurse (RN) C revealed she did not count Ativan in the refrigerator when counting narcotics. Interview on 5/4/16 at 11:30 a.m. with the director of nursing (DON) revealed she would have expected the refrigerated narcotics to have been	F 425	F- 425 1. Certified medication assistant (CMA) E and nurse C were educated on including the count of Ativan when medication staff counted controlled medications. All residents will be assured that controlled medications will be counted whenever the medication staff shifts change and keys are given to the on-coming CMA or nurse. 2. The interim DNS or designee will provide education to all nurses and CMAs on June 1, 2016 related to the correct procedure for accounting for controlled medications. The policy and procedure for Controlled Medications will be reviewed during this education. 3. The interim DNS or designee will audit the controlled substance count sheets to assure all controlled medications have been counted at the time of a shift change or a change in nurse and CMA. This audit will include	

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F 425	Continued From page 8 counted at every change of shift. They also should have been counted whenever other narcotics would have been counted. Review of the April and May 2016 narcotic count records revealed staff had signed they had counted the Ativan at each change of shift. Review of provider's May 2016 Controlled Substances policy revealed every time the keys that secured mediations changed from one nurse to another the nurses were to count all controlled substances.	F 425	random counts by the DNS to assure all counts are correct. These audits will be done weekly for 4 weeks and then monthly for 3 months. The interim DNS will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed. 4. Date certain June 17, 2016	6-17-16
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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	F 441	F- 441 1. Certified nursing assistants (CNAs) A and B were educated regarding infection control practices related to hand hygiene and glove use. CNA A was educated on using gloves during tub cleaning. CNA D is an inaccurate identifier as that CNA was not assigned to give baths; she is no longer working in this facility. All residents will be assured that staff use proper infection control practices for hand hygiene and cleanliness of equipment.	

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F 441	Continued From page 9 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor 32573. Based on observation, interview, and policy and procedure review, the provider failed to ensure: *Staff sanitized hands before and after glove use for three of three observed certified nurse aides (CNA) (A, B, and D) during resident transfers or care. *Three of three certified nurse aides (CNA) (A, B, and D) sanitized hands before and after glove use during and after one of one resident's (4) transfer and care. *Staff followed a glove use policy for tub cleaning for two of two CNAs (A and D) during two of two observed tub cleanings. *CNAs A and D had been trained on how to properly clean and sanitize bathing rooms. *Four randomly observed computer kiosks had been cleaned as stated by their policy. Findings include: 1a. Observation on 5/3/16 at 5:05 p.m. of resident 4's transfer and personal care revealed:	F 441	2. The staff development coordinator (SDC) will provide infection control education to nursing staff on June 1, 2016 including proper hand hygiene when entering a resident room, leaving a resident room, between resident cares, between glove use, and when sanitizing/cleaning the tub and tub room. Staff will be instructed to wipe the kiosks every shift prior to leaving. The procedures from the Infection Control manual- Hand Hygiene and Hand-washing and the procedure for Computer (kiosk) Cleaning will be reviewed. The manufacturer's guidelines outlining the correct procedure for cleaning and sanitizing the tub will be reviewed. The tub room will be thoroughly cleaned by June 3, 2016, and bottles of shampoo and conditioner will be placed in a cupboard in the tub room. Hand written notes on the walls and on bottles will be removed. A laminated instruction card outlining the proper procedure for cleaning the tub room and disinfecting the tub will be placed in the tub room.	

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F 441	Continued From page 10 *CNAs A and B had gloves on while transferring the resident into her bed. *They had put an incontinence brief on the resident after they had gotten her into bed. *CNA B had removed her gloves and had not washed her hands or used hand sanitizer. -She got a clean sheet out of the clean linen closet. -She returned to the room to position the resident. -She put the lift used for the transfer in the hallway and went into another resident's room. -She touched a blanket in that resident's room. *CNA A had removed her gloves and brought soiled linens to the soiled linen bin. -She returned to the room and repositioned the resident without washing her hands or using hand sanitizer. Surveyor 29162. b. Observation on 5/4/16 at 7:45 a.m. of CNA D revealed she entered resident 5's room and put on gloves. She assisted the resident out of bed using a Stand-Aid. She did not wash her hands when she entered the resident's room before she put on the gloves. Surveyor 32573. Interview on 5/4/16 at 2:15 p.m. with the director of nursing revealed staff should have washed hands: *Before and after glove use. *In-between having contact with each resident. Review of the provider's March 2016 Hand Hygiene and Handwashing procedure revealed: *Alcohol-based hand rub should have been used: -"After having direct contact with another person's skin. -After having contact with body fluids, wounds, or	F 441	3. The SDC or designee will audit hand-washing and hand hygiene during resident cares, including bathing, weekly for 4 weeks and then monthly for 3 months to assure proper infection control practices are followed by staff. The SDC or designee will audit proper cleaning of the tub following the manufacturer's guidelines weekly for 4 weeks and them monthly for 3 months. This audit will include observing where shampoo and other products are stored and if hand written notes are on products or walls. The SDC or designee will audit the cleanliness of the kiosks to assure they are being sanitized every shift, weekly for 4 weeks and then monthly for 3 months. These audit findings will be reported to the QAPI committee by the SDC monthly and the committee will determine if further auditing is needed. 4. Date certain June 17, 2016	6-17-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435123		05/04/2016

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

(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 11 broken skin. -After touching equipment or furniture near the resident. -After removing gloves." 2. Observation on 5/3/16 at 5:20 p.m. of the tub cleaning revealed CNA A had not put on gloves prior to cleaning the tub. Observation on 5/4/16 at 10:46 a.m. of the tub cleaning revealed CNA D had not put on gloves prior to cleaning the tub. Review of the provider's May 2016 bathing procedure revealed the procedure for cleaning the tub and shower stall had been "1. Wearing gloves, use cleaning brush and spray bottle of approved cleaner/disinfectant solution." 3. Observation on 5/3/16 at 11:55 a.m. of the bathing room revealed: *A computer kiosk had finger prints and dried drops of a liquid on the screen. *Cobwebs in the corners near the floor by resident shampoo and conditioner bottles. *A paper label taped to a shampoo bottle that had gotten wet and dried multiple times. -That shampoo bottle had six resident's initials written on that soiled paper label for use. -That paper label had been dried and "crunchy" to the touch. Interview on 5/4/16 at 10:50 a.m. with CNA D revealed: *Bath aides had been responsible for cleaning the entire tub room. *They used the computer kiosk in the bathing room for charting.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435123		05/04/2016

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

(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 12 Interview on 5/4/16 at 2:30 p.m. with nurse C revealed: *She performed training for CNAs and bath aides. *Bath aides had not been formally trained on correct procedures for cleaning the tub room. 4. Observation throughout the survey from 5/3/16 through 5/4/16 revealed: *5/3/16 at 12:35 p.m., a computer kiosk in the dining room had been soiled with finger prints and smudges. *5/3/16 after the noon meal, two computer kiosks in the 100 hallways had been soiled with finger prints and smudges. *Refer to finding 3 for initial observation of computer kiosk in the bathing room. *5/4/16 at 11:05 a.m. the above computer kiosks had still been soiled with finger prints and smudges. Interview on 5/4/16 at 2:30 p.m. with nurse C revealed: *CNAs had been responsible for cleaning the computer kiosks. *Each shift should have cleaned the kiosk with designated wipes. Review of the provider's March 2016 Computer Cleaning procedure revealed computer kiosks should have been cleaned on a daily basis.	F 441		

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

ORIGINAL

PRINTED: 05/17/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	435123		**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SELBY	**4861 LINCOLN AVENUE** **SELBY, SD 57472**

(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: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/03/16. 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 K019, K062, and K144 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: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with National Fire Protection Association (NFPA) 25 (quarterly flow testing and repairs to the system). Findings include: 1. Document review at 2:00 p.m. on 5/03/16 of the fire sprinkler inspection reports prepared by Western States Fire Protection revealed a gap in quarterly flow testing report dates between 4/29/15 (previous survey) and 5/03/16. *A 5 year inspection report and quarterly fire sprinkler inspection report had been documented	K 062	K 062 1. Unable to complete the missed quarterly flow testing for the automatic sprinkler system. All residents will be assured that the automatic sprinkler system will function properly with future quarterly flow testing as required. 2. Western States Fire Protection, the contractor that supports the automatic sprinkler system for this facility, has added quarterly flow testing to their schedule. Contact was made and documentation requested to verify that improvements as recommended in the 7/8/2015 report were completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy E Williams
TITLE: Administrator
(X6) DATE: 5-27-16

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 31 2016
SD DOH L&C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435123		05/03/2016

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

(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 1 for 7/08/15. *An annual fire sprinkler inspection report had been documented for 12/17/15. *Quarterly flow testing should have occurred between those two reports and after the annual report. *Noted improvements needed to the sprinkler system by Western States Fire Protection Co. on the 7/08/15 report included replacement of the #1 check in BFP (back flow preventer); replace the wet system two inch angle globe valve (main drain); relocate the FDC (fire department connection) ball drip to the lowest point on the FDC piping - replace the four inch check on the FDC line; and replace one 21.5 inch Chrome 401 Horizontal dry sidewall. There was no documentation indicating work was performed for the above missing reports or the noted repair items. Interview with the director of environmental services at 3:00 p.m. on 5/03/16 revealed he was not aware of the above flow testing requirement. He indicated he believed Western States Fire Protection Inc. was conducting all the required testing. He stated he was a new employee since the 4/29/15 survey inspection. This deficiency has the potential to affect 100% of the building occupants.	K 062	3. The Administrator and the Director of Environmental Services will review the TELS Work Schedule together for any tasks that are past due every month for three months. The Administrator will then review the Work Schedule quarterly to identify any areas past due and will follow-up with the Director of Environmental Services to identify support that may be needed. The Administrator will report the results of the reviews to the QAPI committee monthly for the first three months and the committee will determine if further reviews are needed. 4. Date certain June 23, 2016	6-23-16

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

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435123	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	DATE SURVEY COMPLETE: 5/3/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 4861 LINCOLN AVENUE SELBY, SD		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 019	NFPA 101 LIFE SAFETY CODE STANDARD Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.2 and the opening is installed in bottom half of the wall (80 in.2 in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain corridor separation from use areas at two randomly observed rooms (100 wing and 200 wing nurse charting rooms) in two of seven smoke compartments. Findings include: 1. Observation beginning at 1:30 p.m. on 5/03/16 revealed the 100 wing charting room had a sliding window installed (approximately 30 inches tall and 24 inches wide) to the corridor. The room was not equipped with a smoke detector (that would have needed to have been tied into the fire alarm system). Further observation revealed the 200 wing charting room also had a similar sliding window to the corridor installed. the nurse charting rooms were not manned continuously. Interview with the director of environmental services at the time of the observations confirmed those findings. He stated that he was a new employee within the past year and had been told the windows had been in place for many years. The deficiency affected two smoke compartment locations required to maintain corridor separation from use areas.
K 144	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 generators. Findings include: 1. Observation at 1:00 p.m. on 5/03/16 revealed there was not an emergency stop button installed for the generator. Interview with the director of environmental services 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

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

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435123	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **5/3/2016**
NAME OF PROVIDER OR SUPPLIER **GOOD SAMARITAN SOCIETY SELBY**	STREET ADDRESS, CITY, STATE, ZIP CODE **4861 LINCOLN AVENUE SELBY, SD**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 144	Continued From Page 1 mover is located outside the building (National Fire Protection Association 110, Chapter 3-5.5.6, 1999 Edition). The deficiency affected one of several requirements for emergency generator installations.

ORIGINAL

PRINTED: 05/17/2016
FORM APPROVED

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	10676		05/04/2016

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY SELBY

STREET ADDRESS, CITY, STATE, ZIP CODE: 4861 LINCOLN AVE, SELBY, SD 57472

(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: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 5/03/16 through 5/04/16. Good Samaritan Society Selby was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 29162 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 5/3/16 through 5/4/16. Good Samaritan Society Selby was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Peggy Williams

TITLE: Administrator

(X6) DATE: 5-27-16

STATE FORM 6899 EUA511 If continuation sheet 1 of 1

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