

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/19/16 through 1/21/16. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement(s): F226, F280, F314, F323, and F425.</p> <p>F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate incidents of abuse and neglect for four of four residents (5, 17, 20, and 21). Findings include:</p> <p>1a. Review of an 8/3/15 internal incident report regarding resident 5 revealed: *She had a 9 centimeter (cm) by 9 cm bruise on the back of her left hand and a 10 cm by 9 cm bruise on her right forearm. *The resident had stated it happened "when staff pulled her to [a] sitting position, names unknown." *The results of the investigation section had stated "provided re-education to CNA's [certified nursing assistants] on proper repositioning."</p>	F 000	<p>F 226 The Administrator, Social Worker and DNS completed follow-up on the incidents for Residents 5 and 21. No follow-up could be completed for Residents 17 or 20 due to the fact these 2 residents are deceased or discharged. All other residents could be affected. Due to the length of time that has lapsed, prior incidents could not be changed. Our interdisciplinary team will continue to follow our Incident Reporting Policy and Procedure. Our investigations will include more details and interviews and needed and appropriate. All staff were re-educated on 2/9/16 by the Administrator on the importance of reporting and investigating all resident incidents in accordance with our Good Samaritan Society Policy and Procedure. Proper follow-up will be conducted with family and residents. DNS or designee will audit all incident reports to verify</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maxim Tordoff</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/10/16</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 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 226	<p>Continued From page 1</p> <p>*There had been two CNAs listed as witnesses. -There was no documentation of them being interviewed about the bruising. *The questions "Is this a repeat incident?" and "Have there been previous injuries or circumstances of this type?" had question marks next to them. *There had been no other documentation regarding the coloring of the bruising, who had been working with the resident in the past few days, her cognitive functioning level, or follow-up regarding if the care plan had been implemented accordingly.</p> <p>b. Interview on 1/20/16 at 11:00 a.m. with resident 5 revealed: *She had an incident where a CNA had been transferring her with a lift from her wheelchair to another location. *The CNA had not undone the seatbelt on her wheelchair and had begun to lift her up. *She had told her to stop, but the CNA would not listen and continued to attempt to lift her out of the wheelchair. *She had been in an electric wheelchair. *She stated "It felt like my insides were being ripped out." *She could not remember the date of the incident or the name of the CNA. *She was upset the CNA would not listen to her when she told her to stop.</p> <p>Interview on 1/21/16 at 10:40 a.m. with registered nurse (RN) A and RN B regarding resident 5 and the above incident in the wheelchair revealed: *RN B remembered hearing about it through report. *She was not sure of the date it had occurred but thought it was maybe in July or August 2015.</p>	F 226	<p>that the Incident Reporting Policy had been followed for 3 months. DNS will bring audit findings to the QAPI Committee monthly x 3. QAPI Committee will review findings each month and determine ongoing interventions and monitoring.</p>	2/12/16	

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F 226	<p>Continued From page 2</p> <p>*She was not sure who had been the director of nursing (DON) at the time, since they had a few changes since then.</p> <p>*She was not sure if it had been investigated and could not remember the name of the CNA involved.</p> <p>*RN A could not recall but thought the situation sounded familiar.</p> <p>2. Review of an 11/5/15 incident report sent to the South Dakota Department of Health (SD DOH) regarding resident 20 revealed:</p> <p>*He had been found on the floor next to his wife's bed and was unconscious.</p> <p>*He regained consciousness within one minute.</p> <p>*He complained of pain on the back right side of his head.</p> <p>*His pupils were unequal, and he was sent to the emergency room.</p> <p>*He was admitted to the hospital.</p> <p>*The conclusionary summary stated: -[Resident's name] overall condition had been declining for some time - d/t [due to] ESRD [end stage renal disease]. -Likely he fell d/t increasing weakness and poor judgment. -Findings at the hospital were sepsis and c-diff. -Family did make the decision during his hospital stay to transition [resident's name] to hospice and stop dialysis. -He returned to the center on Nov. 9 and now is on hospice."</p> <p>Review of the 11/5/15 internal incident report regarding resident 20 revealed:</p> <p>*He had been found by two staff members.</p> <p>-There was no documentation they had been interviewed regarding the situation.</p> <p>*The question "Is this a repeat incident?" was</p>	F 226			

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F 226	<p>Continued From page 3</p> <p>checked yes.</p> <p>-There was no other documentation regarding that answer.</p> <p>*The question "Have there been previous injuries or circumstances of this type?" was checked yes.</p> <p>-If yes, in the last 30 days?" was checked along with "31 to 180 days?" and "Over 180 days?"</p> <p>-There was no other documentation explaining those check marks.</p> <p>*His wife reported he got up to put the call light on and fell.</p> <p>-There was no documentation regarding where the call light had been located, and why he would have had to get up to use it.</p> <p>*There was no other documentation regarding what had happened prior to the fall, who had been working with the resident in the past few days, his cognitive functioning level, or follow-up regarding if the care plan had been implemented accordingly.</p> <p>3. Review of a 1/12/16 incident report sent to the SD DOH regarding resident 21 revealed:</p> <p>*She had reported:</p> <p>-"The CNA who had got her up this morning yanked her legs to sit her up, which she said hurt her spine."</p> <p>-"This staff member also hit her in the face with a wet washcloth."</p> <p>-"Also said the nursing assistant was verbally abusive."</p> <p>*The conclusionary summary indicated they had spoken to the CNA involved, and the CNA team coordinator who had no concerns.</p> <p>*The resident had told the social worker "I don't want any black people touching me."</p> <p>**Following the investigation, Administrator and DON feel [resident's name] accusation is false and unfounded."</p>	F 226			

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F 226	<p>Continued From page 4</p> <p>*There was no other documentation regarding what other staff had been working with the accused CNA, if the resident had regular behaviors, or if the care plan had been followed prior to the incident.</p> <p>4. Interview on 1/21/16 at 11:00 a.m. with the administrator, DON, and the director of social services revealed: *There had been no investigation into the incident in finding 1b. -The CNA had not reported the incident to the charge nurse to have the resident assessed. *There was no other documentation regarding the investigations for any of the above incidents.</p> <p>Surveyor: 33265</p> <p>5. Review of resident 17's closed medical record revealed she: *Had been admitted on 11/20/13. *Had diagnoses of a tobacco use disorder, a subdural hemorrhage (bleeding into the brain), depressive disorder, and wandering. *Had a relative that lived close to the facility. *Had an order dated 12/5/13 to have a Secure Care devise (devise that would alarm if she left the building) attached at her left ankle. *She had been able to remove the Secure Care devise where ever it was placed. *Had two instances of starting items on fire while smoking in the last year. Those were on: -2/23/15 when she reported her hair got singed when she lit her cigarette. -3/7/15 when she dropped her lit cigarette into the bag attached to her walker and started papers in the bag on fire. *Had stolen cigarettes from other residents twice within the last year on 5/15/15 and 6/29/15. *Had eloped (left the building without permission</p>	F 226			

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F 226	<p>Continued From page 5</p> <p>and without notifying anyone) three times within the last year. Those were on:</p> <ul style="list-style-type: none"> -6/1/15 was found to be at relatives house after she was noticed missing. -6/3/15 was seen by staff walking down Spring Street, a side street next to the facility building. -6/29/15 was seen by staff walking across the street. <p>*Had been transferred to another facility on 7/13/15.</p> <p>Review of the incident/investigation report forms and nursing progress notes regarding resident 17 during the last year revealed:</p> <ul style="list-style-type: none"> *The incident/investigation report form completed for the 2/23/15 singed hair incident had: <ul style="list-style-type: none"> -Not identified the date of the investigation. -Not answered if there had been previous incidents like it. -Not identified who would do the identified corrective actions. *There was no incident/investigation report form completed for the fire started in the bag attached to the walker on 3/7/15. Review of nursing progress notes revealed a nurse had put out the fire in the bag. <ul style="list-style-type: none"> -There had been no tobacco assessment completed after she had dropped the lit cigarette into the bag. *There was no incident/investigation report form completed for the 5/16/15 stealing of cigarettes from another resident. <ul style="list-style-type: none"> *Nursing progress notes documented: <ul style="list-style-type: none"> -Who the cigarettes were stolen from. -Police were called in to investigate theft. *There was no incident/investigation report form completed for the 6/1/15 elopement. Review of the nursing progress notes revealed the relative had been called. The relative informed the facility 	F 226			

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F 226	<p>Continued From page 6 the resident was there. *The investigation of the 6/3/15 elopement had: -Identified the resident was not wearing the Secure Care device. -Identified the occurrence as the first elopement, then identified a past elopement within the last thirty days. -Not identified any witnesses. -Not identified the name of the staff members who saw her walking down the street or who went outside to get her. -Not identified how far she had gotten or how she had returned to the facility, walking or in vehicle -Not identified any corrective actions under the section for corrective actions. -Not identified which entrance the resident left from. -Not identified if an alarm had sounded or not. -Not identified any predisposing (pre-existing) situational factors: "Personal alarm system in use" had been listed as one of the factors in the list. *There were two incident/ investigation forms filled out on 6/29/15. The first was for stealing cigarettes from another resident and had occurred at 12:30 p.m. The writer had: -Identified the incident as a repeat, and that another incident like it had occurred within thirty days. -Stated under "Results of Investigation" that was an "ongoing issue." -Listed a witness, then later identified there were no witnesses found. -Not been reviewed by the investigation team (social worker, administrator, and the DON) within one working day following the incident. *The second incident investigation form on 6/29/15 had been for an elopement at 1:00 p.m. The writer had:</p>	F 226		
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F 226	<p>Continued From page 7</p> <ul style="list-style-type: none"> -Identified the resident was not wearing the Secure Care device. -Not identified the date of the investigation. -Not identified the name of witness. -Not identified how far from the facility the resident had gotten. -Not identified the name of the staff member who brought her back into the facility. -Not identified which entrance the resident left from. -Not identified if an alarm had sounded or not. -Listed under "Results of Investigation" the resident "often goes out the front door to sit on bench out front-needs to be accompanied by staff." -Not been reviewed by the investigation team (social worker, administrator, and the DON) within one working day following the incident. <p>Interview on 1/21/16 at 3:00 p.m. with the DON regarding resident 17 revealed she agreed the:</p> <ul style="list-style-type: none"> *Incident/investigation forms had not been filled out for each incident. *Incident/investigation forms that had been filled out were not detailed or complete. *Incident/investigation form had not all been signed as reviewed by the investigation team within one working day of following the incident. <p>Surveyor: 32335</p> <p>6. Review of the provider's September 2013 II.A.1 Abuse and Neglect policy revealed "The Center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress."</p> <p>Review of the provider's August 2015 II.A.1a Abuse and Neglect policy revealed:</p>	F 226		

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F 226	Continued From page 8 *Purpose was to ensure a complete review of existing incident was documented. *If a staff member received an allegation of abuse they would then report the allegation to a supervisor. *The charge nurse would be notified immediately, assess the situation, and complete an initial investigation. *If it was an allegation of staff-to-resident abuse, the staff person would be removed from providing direct care to all residents. *Additionally that staff member should have been placed on suspension pending the results of the internal investigation. *The investigation could include interviewing staff, residents, or other witnesses to the incident. *The investigation team (social worker, administrator, and the DON) were to have reviewed "all incidents no later than the next working day following the incident."	F 226			
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	F 280	The care plans for Resident 6 and 11 have been revised and are now current. No follow-up could be completed for Residents 10, 17 or 18 due to the fact these residents are deceased or discharged. All other residents could be affected. All care plans will be reviewed quarterly during the MDS review. The MDS Coordinators will be re-educated on our Care Planning Policy and Procedure by 2/12/16 from the DNS. The MDS Coordinator will audit five care plans bi-monthly x 2 and then monthly x 2. The MDS		

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F 280	<p>Continued From page 9</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to review, revise, and follow, 5 of 19 sampled residents' (6, 10, 11, 17, and 18) care plans to reflect their current status and conditions. Findings include:</p> <p>1. Observation on 1/19/16 at 11:30 a.m. of resident 11 revealed: *Outside his room there was a plastic storage cart with gowns, gloves, and masks in the drawers. *He was sitting in a wheelchair in his room. *There was an intravenous (IV) pole in his room.</p> <p>Interview on 1/19/16 at 12:15 p.m. with registered nurse (RN) A regarding resident 11 revealed: *She was unsure why there was a cart outside his room with supplies for staff to use. -Those supplies were used when a resident was on specific precautions for an infection. *He was currently on IV antibiotics (medication) for a urinary tract infection (UTI, infection in bladder).</p> <p>Interview on 1/19/16 with resident 11 in his room revealed he: *Was started IV antibiotics for a UTI on 1/18/16. *Knew the infection needed a specific antibiotic,</p>	F 280	Coordinator will bring audit findings to the QAPI Committee monthly x 4. QAPI Committee will review findings each month and determine ongoing interventions and monitoring.	2/12/16	

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F 280	<p>Continued From page 10 because it was hard to treat. *Had a problem with recurrent UTIs. *Thought he had been treated with antibiotics three times since he had come to the facility on 12/15/15. *Had a history of a kidney transplant several years ago.</p> <p>Review of resident 11's medical record revealed: *He was admitted on 12/15/15. *His diagnoses included: acute kidney failure, urinary incontinence (unable to control urine), UTI, diabetes (affects blood sugar levels), sleep apnea (breathing problems during sleep), morbid obesity (severely overweight), high blood pressure, chronic kidney disease with history of a kidney transplant, pain, and neuralgia (nerve pain). *On admission he: -Had a UTI infection with ESBL (drug resistant infection) that required IV antibiotics. -Was incontinent of urine with dribbling. -Was working with physical and occupational therapy for strengthening.</p> <p>Review of resident 11's 1/19/16 printed care plan revealed there was no mention of his: *History of a kidney transplant. *History of UTI's and current UTI or treatments for those. *Working with physical and occupational therapy (PT and OT). *Pain and what was being done for that. *Sleep apnea.</p> <p>2. Observation and interview on 1/19/16 at 11:45 a.m. with resident 10 in her room revealed she: *Was in a wheelchair. *Had a brace/walking boot to her lower right leg</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>and foot and a special shoe to her left foot. *She stated she admitted three months prior after she had gotten run over by a car in a parking lot. *She was going to be done wearing the boot and special shoe soon since she could now bear weight to her right leg.</p> <p>Review of resident 10's medical record revealed: *She was admitted on 10/28/15. *Her diagnoses included a broken right lower leg and broken bones in her left foot. *She had physician's orders to: -Be no weight bearing to her right leg and only heel weight bearing on her left foot. -Work with PT and OT for strengthening. *On 1/6/16 there was a faxed physician's order to be weight bearing as tolerated, use the right boot and left shoe, and she could transition to shoes in two weeks.</p> <p>Review of resident 10's 1/19/15 printed care plan revealed: *She was no weight bearing to her right lower leg and heel touch weight bearing to her left. -It had not been updated to reflect the 1/6/16 physician's order.</p> <p>Surveyor: 33265 3. Review of resident 17's complete closed medical record revealed she: *Had been admitted on 11/20/13. *Had diagnoses of a tobacco use disorder, a subdural hemorrhage (bleeding into the brain), depressive disorder, and wandering. *Had a relative that lived close to the facility. *Had an order dated 12/5/13 to have a Secure Care devise (devise that would alarm if she left the building) attached at her left ankle. *She had been able to remove the Secure Care</p>	F 280		
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F 280	<p>Continued From page 12</p> <p>devise where ever it was placed.</p> <p>*Had two instances of starting items on fire while smoking in the last year. Those were on:</p> <p>-2/23/15 when she reported her hair got singed when she lit her cigarette.</p> <p>-3/7/15 when she dropped her lit cigarette into the bag attached to her walker and started papers in the bag on fire.</p> <p>*Had stolen cigarettes from other residents twice within the last year on 5/15/15 and 6/29/15.</p> <p>*Had eloped (left the building without permission and without notifying anyone) three times within the last year. Those were on:</p> <p>-6/1/15 was found to be at relatives house after she was noticed missing.</p> <p>-6/3/15 was seen by staff walking down Spring Street, a side street next to the facility building.</p> <p>-6/29/15 was seen by staff walking across the street.</p> <p>*Had been transferred to another facility on 7/13/15.</p> <p>Review of resident 17's undated care plan regarding safety while smoking revealed:</p> <p>*The concern had been identified on 9/5/14.</p> <p>*The she had singed her hair on 2/24/15</p> <p>-The incident/investigation form identified the incident as happening on 2/23/15 not on 2/24/15.</p> <p>-She was to have her hair tied back and wear an apron when smoking.</p> <p>-Staff were to light her cigarettes for her.</p> <p>-There was no update on the two incidents where the resident had stolen cigarettes from other residents on 5/16/15 and 6/29/15.</p> <p>Review of the resident's undated care plan regarding elopement revealed:</p> <p>*Her potential for elopement was identified on 11/27/13.</p>	F 280		

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F 280	<p>Continued From page 13</p> <ul style="list-style-type: none"> -The time identified during which she attempted to elope was during the night. -All three elopements documented during the last year occurred during the day. *The personal alarm, Secure Care was to be used to alert staff to resident's movement if approaching exits dated 11/27/13. -The personal alarm was revised on 5/27/15 with resident "refusing to wear." -The attempt on 6/6/15 to put the Secure Care devise within the lining of the bag on the walker was not identified in the care plan nor were the results of the attempt. *An intervention to minimize elopement was to have family be involved. That was dated 11/27/13. *A second intervention involving the family was identified on 6/29/15 where the family was to call if resident showed up at their house. -The resident had left the facility and been found at the relative's house on 6/1/15. *No other interventions were listed on the care plan other than possible transfer to another facility. <p>Interview on 1/21/16 at 3:00 p.m. with the director of nursing regarding resident 17's incidents and care plan revealed she agreed the care plan had not included updated information on smoking safety and elopements.</p> <p>4. Review of resident 18's complete closed medical record revealed he:</p> <ul style="list-style-type: none"> *Was admitted on 12/5/14. *Had dementia without behavioral disturbances, chronic obstructive pulmonary disease, chronic kidney disease, major depressive disorder, and a pressure ulcer (area of skin breakdown). *Had been discharged on 1/15/16. 	F 280			

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F 280	<p>Continued From page 14</p> <p>Review of the resident's 1/18/16 discharge summary revealed he "could physically and verbally be aggressive during cares, and transfers from bed to wc" [wheelchair].</p> <p>Review of the resident's undated care plan had no documentation concerning the resident being physically or verbally aggressive during care and transfers.</p> <p>Interview on 1/21/16 at 3:00 p.m. with the director of nursing regarding resident 18's care plan agreed there was nothing on the resident being physically and verbally aggressive during care or transfers in the care plan.</p> <p>Surveyor: 32335 5. Observation on 1/19/16 from 4:50 p.m. through 6:10 p.m. and again on 1/20/16 from 11:45 a.m. through 12:40 p.m. of resident 6 revealed she had not received any assistance from staff to eat her meals.</p> <p>Review of resident 6's 6/13/15 and 12/6/15 MDS assessments revealed she was to receive extensive assistance from one staff person to eat.</p> <p>Review of resident 6's 12/8/15 care plan revealed she required assistance to eat.</p> <p>Interview on 1/20/16 at 10:00 a.m. with the DON regarding resident 6 revealed: *She was not sure why staff were not assisting her at meals. *She agreed she required staff assistance to eat.</p> <p>Surveyor: 35237 6. Interview on 1/20/16 at 10:00 a.m. with RN B</p>	F 280			

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F 280	<p>Continued From page 15 regarding care plans revealed:</p> <ul style="list-style-type: none"> *Resident 10's care plan had not been updated to reflect her change in weight bearing status. *Resident 11's care plan was not current or updated to reflect all his needs. -His history of kidney transplant, UTIs, pain, sleep apnea, and working with PT and OT. *Charge nurses or the Minimum Data Set (MDS) assessment nurses should have updated resident's care plans. *She confirmed resident care plans should reflect their current cares and needs. <p>Interview on 1/20/16 at 10:30 a.m. with MDS assessment nurse C regarding care plans revealed:</p> <ul style="list-style-type: none"> *The MDS nurses did the updates to resident care plans. *She would have expected changes to have been done in a day or two. *Charge nurses could have done the updates but typically did not. *She confirmed: <ul style="list-style-type: none"> -Resident 10's had not been updated to reflect her change in weight bearing status. -Resident 11's had not addressed all his needs and had not been updated. <p>Interview on 1/21/16 at 2:25 p.m. with the director of nursing confirmed resident 10 and 11's care plans had not been revised to reflect their current status and should have been.</p> <p>Surveyor: 32355 Review of the provider's September 2012 Care Plan policy revealed:</p> <ul style="list-style-type: none"> *Care plans should have been reviewed, evaluated, and updated when there was a significant change in the resident's condition. 	F 280		
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F 280	Continued From page 16 *The plan of care should have been modified to reflect the current care required or provided for the resident.	F 280		
F 314 SS=E	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to assess and implement interventions to prevent two of six sampled residents (19 and 22) from acquiring a pressure ulcer (an area of skin breakdown, when something keeps rubbing or pressing against the skin) after admission to the facility. Findings include:</p> <p>1. Interview on 1/20/16 at 3:15 p.m. with wound nurse/registered nurse (RN) A regarding pressure ulcers revealed she: *Had been the wound nurse for two years and had worked in the facility as a charge nurse for about thirteen years. *Completed wound training that had included webinars, online videos, an off-site course, and had worked with the previous wound care nurse.</p>	F 314	Resident 22's care plan was reviewed and updated. The pressure ulcers have healed. Resident 19 is deceased. All other residents could be affected. No other pressure ulcers were in the facility. Our center will follow our Pressure Ulcer Policy and Procedure. Our center will designate specific hours per week for wound care assessing and monitoring. At least annually, our wound nurse will be provided with continuing education in wound care. Our Medical Director will continue to support as needed. Our center care plans referencing toileting and repositioning will be updated. All nurses will be re-educated on wound measurement, assessment and staging on 2/17/16 by a Clinical Specialist with Gordian Medical, Inc. DNS and wound nurse will review wound assessments weekly x 4 and then monthly x 2. DNS will bring audit findings to the QAPI Committee monthly x 3. QAPI Committee will review findings each month and determine ongoing interventions and monitoring.	2/18/16

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F 314	<p>Continued From page 17</p> <ul style="list-style-type: none"> *Collaborated with the outside wound consultant. -The wound consultant used to come to the facility monthly to assess residents' pressure ulcers. -Lately she had just faxed or emailed them her assessments. *Measured all residents pressure ulcers weekly on Wednesdays. *Could not find of copy of the resources she used to help identify stages of pressure ulcers. *Kept a handwritten copy of her weekly assessments and monthly pressure ulcer reports. *Entered her weekly assessments into the resident's electronic medical record as well. *Had documented on the 1/13/16 report that resident 22 had a facility acquired, stage 3 (full thickness of skin tissue loss) ulcer from moisture not pressure to her left gluteal fold. *Did not feel resident 22's area was a pressure ulcer. -She felt it was due to moisture and incontinence (inability to control urine) and had updated her care plan to have a toileting schedule every two hours. *Stated resident 22's skin appeared macerated (skin breakdown from moisture) versus a pressure ulcer. *Confirmed the left gluteal fold was an area that a pressure ulcer could have developed when a resident was at risk for pressure ulcers. *During the discussion she stated the gluteal fold area was the area between someone's buttocks. *Stated resident 22 was at risk for pressure ulcers. She: <ul style="list-style-type: none"> -Was alert and oriented. -Used a wheelchair as her primary way of moving around. -Took herself to the bathroom at times. -Should have had staff assistance with toileting. 	F 314		

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F 314	<p>Continued From page 18</p> <p>-Did spend a lot of time in her wheelchair during the day.</p> <p>Review of RN A's pressure ulcer reports with her at the above time revealed:</p> <p>*There were currently five residents with pressure ulcers.</p> <p>- Four of those residents had facility acquired pressure ulcers.</p> <p>*On the 1/13/16 report resident 22 was listed as "other skin issues:"</p> <p>-The initial date was 1/8/16.</p> <p>-It was facility acquired.</p> <p>-Left gluteal fold was the site.</p> <p>-Measurements were 0.6 centimeters (cm) by 0.6 cm.</p> <p>-It was a stage 3 ulcer.</p> <p>-It was documented as moisture not pressure related.</p> <p>-The treatment was to have been a silicone bordered dressing every three days and as needed.</p> <p>-The consultant wound nurse was faxed, and a physician's order was obtained on 1/11/16.</p> <p>-Her care plan was updated for staff to toilet every two hours.</p> <p>Review of resident 22's medical record revealed:</p> <p>*She had been admitted on 5/10/13.</p> <p>*Her diagnoses included: unspecified open wound of unspecified buttock, anxiety (nervousness) disorder, major depressive (sadness) disorder, history of left hip replacement, and dementia with behaviors.</p> <p>Review of resident 22's January 2016 treatment administration record (TAR) revealed:</p> <p>*An as needed Repicare (type of dressing) could have been applied to coccyx area with an start</p>	F 314			

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F 314	<p>Continued From page 19 date of 9/16/13.</p> <ul style="list-style-type: none"> -That had been initialed as administered only on 1/10/16. *An as needed Zinc Oxide Cream (to prevent and treat a skin rash) to be applied to her buttocks for reddened skin with a start date of 10/14/15. -That had been administered on 1/10/16. -On 1/11/16 an as needed silicone border dressing could have been applied for a stage 3 left gluteal ulcer when loosened until healed. -There were no initials that it had been administered. -That treatment was discontinued on 1/20/16. *On 1/12/16 a silicone border dressing was added and was to be applied once every three days for a stage 3 left gluteal ulcer. -That was initialed as administered on 1/12/16, 1/15/16, and 1/18/16. -That treatment was discontinued on 1/20/16. The reason it was discontinued was not stated. <p>Review of resident 22's 1/20/16 printed care plan revealed:</p> <ul style="list-style-type: none"> *A 1/13/16 initiated focus area for bowel and bladder incontinence, and she was unable to tell when she needed to use the toilet. Interventions for that area included: <ul style="list-style-type: none"> - "Check resident frequently and assist with toileting as needed." - "Brief use. Resident uses incontinence products XL [extra large] briefs Toilet frequently and change as needed." *She required extensive assistance of one staff member for ADLs. *For toilet use "resident requires 1 staff participation to use toilet upon rising, before and after meals hs [bedtime] and prn [as needed]." *For bed mobility "resident uses 1 staff with encouragement to reposition and turn in bed. No 	F 314		
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F 314	<p>Continued From page 20</p> <p>air overlay on mattress. Uses grab bar for mobility."</p> <p>-There was no mention of how often to reposition and turn in bed.</p> <p>*A 1/20/16 initiated focus area for "stage 3 PU [pressure ulcer] (Hx [history] of ulcers." Interventions for that focus area were initiated on 1/20/16 and included:</p> <p>-"Educate resident/family as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning."</p> <p>-"Assist to turn and reposition at least every 2 hours. Pressure reduction mattress to bed."</p> <p>-"Provide pressure reducing device both bed and w/c."</p> <p>*The above focus areas and interventions had been initiated after the resident's ulcer was discovered on 1/8/16.</p> <p>Review of resident 22's 12/31/15 quarterly Minimum Data Set (MDS) assessment revealed:</p> <p>*She required extensive assistance of one staff with activities of daily living (ADLs; dressing, hygiene, toileting, bathing, and moving around).</p> <p>*She had a Brief Interview for Mental Status (BIMS) assessment score of 14 indicating she was alert and able to make her own decisions.</p> <p>*No behaviors were noted in the look back period, but she had rejected care one time.</p> <p>*She was frequently incontinent of bowel and bladder and was not on a toileting program.</p> <p>*She was identified as at risk for pressure ulcers and did not have moisture associated skin damage.</p> <p>*Treatments for her skin and ulcers included:</p> <p>-Pressure reducing device for chair.</p> <p>-Turning and repositioning program.</p>	F 314		
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F 314	<p>Continued From page 21</p> <p>*Areas for skin and ulcers that were not checked and could have been included: -Pressure reducing device for bed. -Nutrition or hydration intervention to manage skin problems. -Pressure ulcer care. -Application of nonsurgical dressing with or without topical medications other than to feet. -Application of ointments/medications other than to feet.</p> <p>Review of resident 22's Care Area Assessment (CAA) worksheets from her 4/15/15 MDS revealed she had triggered for pressure ulcer and urinary incontinence. The CAA notes revealed: *For incontinence "Staff to assist with bathrooming." *For pressure ulcer "skin is intact at this time with pressure reduction device in w/c [wheelchair] and staff repositions q2hr [every two hours] at night." *There was no mention of how often: -Staff assisted her with bathrooming. -She was repositioned during the day or other interventions related to pressure ulcers.</p> <p>Review of resident 22's Braden Scale (assessment for predicting pressure ulcer risk) scores revealed: *On 1/3/16 she scored an 18. *On 10/1/15 she scored a 16. *On 7/8/15 she scored a 14. *On 4/11/15 she scored a 17. *A score of 15 to 18 indicated mild risk. An intervention guide for that score recommended: -"Frequent turning (e.g. [for instance] q [every] 2 hours." -"Maximal remobilization (movement)." -"Pressure-reduction support surfaces if bed- or chair-bound."</p>	F 314			

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F 314	<p>Continued From page 22</p> <ul style="list-style-type: none"> - "Manage Moisture." - "Manage Nutrition." - "Manage friction and shear." <p>*A score of 13 to 14 indicated moderate risk. An intervention guide for that score recommended the same interventions as above and:</p> <ul style="list-style-type: none"> - "Frequent turning with a planned schedule." - "Use foam wedges for 30 degree lateral positioning." - "Pressure Reduction Support Surface." <p>*Both categories indicated if there were other major risk factors present to advance to the next level of risk.</p> <p>Observations of resident 22 on 1/21/16 revealed:</p> <ul style="list-style-type: none"> *At 8:00 a.m. she was eating breakfast in the dining room in her wheelchair. *At 9:00 a.m. she was not in her room. *At 10:50 a.m. and 11:30 a.m. she was in the activity room in her wheelchair. <p>Interview on 1/21/16 at 8:10 a.m. with wound nurse/RN A regarding resident 22 revealed:</p> <ul style="list-style-type: none"> *She had not looked at her skin yesterday, since she did not consider it a pressure ulcer. *Her care plan should have indicated which interventions were in place for her. *Charge nurses and MDS nurses made changes on the care plans. *She had updated her care plan on 1/13/16 related to her incontinence to include the toileting schedule. *She confirmed the care plan stating "check resident frequently" and "assist with toileting as needed" were not specific and were not really a toileting plan. *Resident 22 was busy with activities and visiting her husband frequently and spent a lot of time in her wheelchair which created a higher risk for 	F 314		

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F 314	<p>Continued From page 23</p> <p>pressure ulcers. *She was not aware of resident 22 refusing care.</p> <p>Interview on 1/20/15 at 5:10 p.m. and again on 1/21/16 at 8:15 a.m. and 2:25 p.m. with the director of nursing (DON) regarding pressure ulcers revealed: *RN A was the facility's wound nurse and had four hours designated to wound care every week. *She was aware they currently had four facility acquired pressure ulcers according to the wound nurse. *They discussed pressure ulcers at quality assurance meetings monthly. *She confirmed resident 22 was at risk for pressure ulcers. -It would have been difficult to designate her left gluteal fold area as just moisture associated breakdown and not pressure because of her risk. *Resident 22's care plan did not specify a specific toileting schedule. -Her care plan said "frequently" and "as needed" for toileting. *She felt resident 22 typically took her self to the bathroom, but staff should have helped her. *She confirmed the pressure ulcer area of her care plan had an initiated date of 1/20/16, and the area had been documented as open since 1/8/16. *She confirmed residents at higher risk for pressure ulcers required more interventions than someone designated at low risk. *Her expectation would have been that they followed the interventions that were recommended based on the resident's Braden scores.</p> <p>Interview on 1/21/16 at 9:30 a.m. with CNA D regarding resident 22 revealed she: *Was not on a toileting schedule they just</p>	F 314			

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F 314	<p>Continued From page 24</p> <p>checked on her.</p> <p>*Did not like to put her call light on and liked to take herself to the bathroom.</p> <p>*Let staff help her if they offered.</p> <p>*Spent a lot of time in her wheelchair for activities and meals.</p> <p>*Was mostly continent of urine but sometimes incontinent.</p> <p>*Did have an open area to her buttocks that the nurses were treating.</p> <p>*Would have reported skin problems to the nurse.</p> <p>Interview on 1/21/16 at 10:40 a.m. with MDS assessment nurse C regarding resident 22 revealed:</p> <p>*She was at risk for pressure ulcers because of multiple risk factors including incontinence, her need for the wheelchair, sitting so often, possible friction and shear, and need for staff assistance with ADLs.</p> <p>*She took herself to the bathroom, and staff helped her at times when she told staff she needed help.</p> <p>*It was hard to prove the resident was repositioned every two hours and how often she was taken to the bathroom. The certified nursing assistants (CNA) charting was done usually once a shift and not after each occurrence.</p> <p>*In the past they had listed every two hours on the care plan and the kiosk (computer system for the CNA) for the CNAs to know how often those things needed to be done, but a previous DON had told them not to list that specifically.</p> <p>*She felt they had more facility acquired pressure ulcers, since they had taken off the specific two hour schedules for some residents.</p> <p>*She confirmed they should have followed their Braden score guidelines for appropriate interventions to prevent pressure ulcers.</p>	F 314			

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F 314	Continued From page 25 Observation and interview with wound nurse/RN A and resident 22 in her room on 1/21/16 at 12:55 p.m. revealed: *Resident 22 was laying in her bed and stated: - "I sit all the time. I don't walk." - She sat in her wheelchair a lot. - Would have called the staff when she needed to use the bathroom. *The wound nurse thought they had discontinued the silicone dressing to her left gluteal fold area last evening, and now they were using PRN Zinc oxide ointment instead. *The resident was incontinent of bowel movement, and the nurse stated "she can't tell" when she has to use the bathroom. *She cleansed the area and changed the resident's disposable brief. *The resident's buttocks appeared purplish in color on both sides but not macerated (breakdown caused by moisture). *The purplish area blanched (turned white when pressure was applied) when the wound nurse was assessing the area, and she stated it was improved from last week. *Upon further assessment there were three open areas noted between the resident's buttocks in the coccyx area. - The top one measured 0.5 cm by 0.2 cm. - The middle one measured 1.3 cm by 0.1 cm. - The bottom one measured 1.2 cm by 0.2 cm. *The wound nurse stated those were new, and the previous area had been more to the left of those areas and appeared to have been gone now. *She was unsure when those new open areas had started. *When asking about what location she would classify them as she stated she thought the area	F 314			

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F 314	<p>Continued From page 26</p> <p>between the buttocks was the gluteal fold and that was why the first one was listed as left gluteal fold.</p> <p>*She agreed on their wound assessments from the electronic medical record the left gluteal fold location was listed as being under the buttocks where the buttocks met the thigh.</p> <p>*The area where the above opened areas were would have been listed as coccyx on their wound assessments.</p> <p>*She stated she would have classified the new areas as stage 3 pressure ulcers because of the top layer of skin missing and the depth.</p> <p>-She had not measured the depth during the observation.</p> <p>*She applied the Zinc oxide ointment to the areas and surrounding skin.</p> <p>*She agreed resident 22 was at high risk for pressure ulcers, and repositioning and toileting schedules were important interventions to reduce that risk.</p> <p>Interview on 1/21/16 at 1:50 p.m. with the medical director regarding pressure ulcers confirmed:</p> <p>*Resident 22 was at risk for pressure ulcer development due to multiple risk factors including sitting a lot in her wheelchair, moisture concerns related to incontinence, and need for staff assistance with her ADLs.</p> <p>-He had not been aware of her current open areas.</p> <p>*He reviewed the wound nurse's documentation and attended quality assurance meetings where they discussed pressure ulcers.</p> <p>Review of the provider's September 2012 Pressure Ulcers policy revealed:</p> <p>*"Based on the resident's comprehensive assessment, the center will use prevention and</p>	F 314			

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F 314	<p>Continued From page 27</p> <p>assessment interventions to ensure that a resident entering the center without pressure ulcers does not develop a pressure ulcer unless the clinical condition demonstrates that this was unavoidable."</p> <p>*"A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing."</p> <p>Review of the provider's revised 12/2015 Pressure Ulcer Practice Guidelines policy revealed:</p> <p>*"Risk factors are factors that increase a resident's susceptibility to develop or impact healing times of pressure ulcers. They include, but are not limited to:"</p> <p>-"Impaired/decreased mobility and decreased functional ability."</p> <p>-"Co-morbid conditions..."</p> <p>-"Resident refusal of or level of compliance with plan of care and treatment."</p> <p>-"Cognitive impairments."</p> <p>-"Exposure of skin to urinary and fecal incontinence."</p> <p>-"History of a previous ulcer..."</p> <p>*"...Prevention strategies are ongoing and will be individualized based on the areas or level of risk determined. Include these prevention strategies on the resident's care plan. Inform caregivers of prevention strategies. Ensure competence of caregiver implementation of care plan."</p> <p>*"Staff should perform toileting actions that include checking for incontinence and/or offering to assist with bathroom needs."</p> <p>*"Staff should implement resident-specific turning and positioning programs based upon an individualized assessment."</p>	F 314			

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F 314	<p>Continued From page 28</p> <p>Review of the provider's revised 12/2015 Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements policy revealed "Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is recommended based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time."</p> <p>Review of the provider's February 2008 Best Practice Guidelines for stage 3 pressure ulcers revealed clinical strategies included: *"Decrease or eliminate external pressures." *"Employ pressure reduction devices..." *"Reposition Q [every] 1- 2 hrs [hours]." *"Reduce moisture from incontinence and other sources." *"Increase mobility in bed-bound or chair-bound residents."</p> <p>Surveyor: 33265 2. Review of resident 19's complete closed medical record revealed: *She was admitted on 6/9/15. *She was on hospice (end of life care). *She had no pressure ulcer documented on admission. *She had developed a pressure ulcer on the coccyx (tailbone) that was first documented on 8/6/15. *She was discharged on 8/25/15.</p> <p>Review of resident 19's documentation concerning the pressure ulcer on Wound Data Collection form and the Wound RN Assessment form regarding the coccyx revealed:</p>	F 314			

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F 314	<p>Continued From page 29</p> <ul style="list-style-type: none"> *On 8/6/15 the pressure ulcer was noted as being a stage 2 (part of top skin layer was gone and there was an open area). -A special mattress for pressure reduction was requested from hospice. -No baseline measurement of the size of the open area had been documented. *On 8/9/15, 8/10/15, and 8/14/15 a Wound Data Collection form was completed. -No measurements of the open area size were documented. -The dressing being utilized was documented. *On 8/15/15 a Wound Data Collection form was completed. -Measurements of the open area size were documented for the first time. -The depth of the wound was documented as zero or having no depth. *On 8/15/15 a Wound RN Assessment form was completed. -The pressure ulcer was now graded as a stage 3 (all of the skin layer was gone and fat was visible). -There had been a change in the depth of the wound, but the depth was not measured. -A special air mattress was noted as being on the resident's bed. *On 8/16/15 and on 8/18/15 a Wound Data Collection form was completed. -No measurements of the open area size were documented. *On 8/19/15 a Wound Data Collection form was completed. -Measurements were done and included a depth of 0.3 cm (centimeters). -Black tissue was documented under comments. -100% eschar (dead tissue often black in color) was documented to describe the wound. *On 8/19/15 a Wound RN Assessment form was 	F 314		
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F 314	Continued From page 30 completed. -The pressure ulcer was now graded back to a stage 2, but comments under the same section said "would reclassify to stage IV [4]" [open wound down to muscle and bone], "100% black tissue". *On 8/21/15, 8/22/15, 8/23/15, and 8/24/15 a Wound Data Collection form was completed. -No measurements of the open area size were documented. *On 8/25/15 a Wound Data Collection form was completed. -Measurements of the open area size were documented with the depth being 0.5 cm. -Description included "black tissue, odersome, stage III [3]." *On 8/25/15 a Wound RN Assessment form was completed. -The pressure ulcer was now a stage 3 with 100% necrotic (dead) tissue and an odor. Interview on 1/21/16 at 3:00 p.m. with the director of nursing regarding the assessments of the residents' pressure ulcers revealed she agreed the assessments of the wound were not consistent with nursing standards. 3. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO, 2013, p. 1179, revealed, "Pressure ulcer staging describes the pressure ulcer depth at the point of assessment. Thus, once you have staged the pressure ulcer, this stage endures even as it heals. Pressure ulcers do not progress from a stage III to a stage I, rather, a stage III ulcer demonstrating signs of healing is described as a healing stage III pressure ulcer."	F 314			
F 323	483.25(h) FREE OF ACCIDENT	F 323			

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F 323 SS=D	<p>Continued From page 31 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: 16385 Based on observation, interview, policy review, and record review, the provider failed to maintain the electrically activated audible alarm at one of one front entrance door resulting in the elopement of one of one resident (17). Findings include:</p> <p>1. Observation on 1/19/16 at 11:00 a.m. revealed the front entrance door was equipped with an audible alarm. The alarm was not activated at the time of the observation and only activated during the evening hours from 8:00 p.m. to 5:00 a.m. The main entrance was within sight distance of the reception office with the aid of a reflective mirror. The exit door would classify as being monitored during general office hours from 8:00 a.m. to 5:00 p.m. During the times when reception staff left at about 5:00 p.m. the door would no longer be considered monitored.</p> <p>The main entrance door was observed not activated and not monitored on: *1/19/16 at 6:30 p.m. *1/20/16 at 7:30 a.m. *1/20/16 at 5:30 p.m.</p>	F 323	<p>Resident 17 is no longer a resident at our facility. Our receptionist will monitor the front door Monday-Friday 8:00am-4:30pm. When she is on break, another staff member will take her place. From 4:30pm-8:00am Monday-Friday, the front door will lock and alarm and also Friday at 4:30pm to Monday morning at 8:00am. Our plan of action is to call Automatic Building Controls and/or our electrician tomorrow (3/4/16) to have them install a key pad on the front door as soon as possible. The receptionist has been re-educated to alert nursing staff whenever she notices a resident outside that she does not recognize, even if the resident is not attempting to leave the premises. All staff were provided education regarding this change on 3/3/16 by the Administrator.</p>	3/11/16	

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F 323	<p>Continued From page 32 *1/21/16 at 7:25 a.m.</p> <p>Observation of the door alarm panel on 1/21/16 at 10:00 a.m. revealed the front entrance button (#18) was in the off position. Instructions posted on the panel had read "on at 8:00 p.m." and "off at 5:00 a.m."</p> <p>Interview on 1/21/16 at 9:30 a.m. with the administrator confirmed the would lock automatically at 8:00 p.m. and unlock at 5:00 a.m.</p> <p>Interview on 1/21/16 at 10:30 a.m. with registered nurse (RN) B revealed the night shift turned the alarm on at 8:00 p.m. and off at 5:00 a.m.</p> <p>Review of the provider's November 2013 Center/Campus Security policy revealed "The front entrance door, staff break room door and west employee entrance door will remain alarmed, but unlocked until 8pm. At that time, these 2 doors will automatically lock until 5am. To gain access when locked, staff and visitors use intercom system to call nurse."</p> <p>Surveyor: 33265 2. Review of resident 17's complete closed medical record revealed she: *Had been admitted on 11/20/13. *Had diagnoses of a tobacco use disorder, a subdural hemorrhage (bleeding into the brain), depressive disorder, and wandering. *Had a relative that lived close to the facility. *Had an order dated 12/5/13 to have a Secure Care devise (devise that would alarm if she left the building) attached at her left ankle. *She had been able to remove the Secure Care devise where ever it was placed. *Had eloped (left the building without permission</p>	F 323		

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F 323	<p>Continued From page 33</p> <p>and without notifying anyone) three times within the last year. Those were on:</p> <ul style="list-style-type: none"> -6/1/15 was found to be at relatives house after she was noticed missing. -6/3/15 was seen by staff walking down Spring Street, a side street next to the facility building. -6/29/15 was seen by staff walking across the street. <p>*Had been transferred to another facility on 7/13/15.</p> <p>Review of the incident/investigation report forms and nursing progress notes regarding resident 17's elopement during the last year revealed:</p> <ul style="list-style-type: none"> *There was no incident/investigation report form completed for the 6/1/15 elopement. Review of the nursing progress notes revealed the relative had been called. The relative informed the facility the resident was there. *The investigation of the 6/3/15 elopement had: <ul style="list-style-type: none"> -Identified she was not wearing the Secure Care device. -Identified the occurrence as the first elopement, then identified a past elopement within the last thirty days. -Not identified how far she had gotten or how she had returned to the facility, walking or in a vehicle -Not identified any corrective actions under the section for corrective actions. -Not identified which entrance the resident left from. -Not identified if an alarm had sounded or not. -Not identified any predisposing (pre-existing) situational factors: "Personal alarm system in use" had been listed as one of the factors in the list. *The incident investigation form on 6/29/15 for an elopement: <ul style="list-style-type: none"> -Identified she was not wearing the Secure Care 	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104		
(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 323	Continued From page 34 device. -Not identified how far from the facility she had gotten. -Not identified which entrance she left from. -Not identified if an alarm had sounded or not. -Listed under "Results of Investigation" the resident "often goes out the front door to sit on bench out front-needs to be accompanied by staff." -Not been reviewed by the investigation team (social worker, administrator and the director of nursing [DON]) within one working day following the incident. Review of the provider's August 2015 Abuse and Neglect procedure revealed: *Purpose was to ensure a complete review of the existing incident is documented. *The investigation team (social worker, administrator and the DON) were to have reviewed "all incidents no later than the next working day following the incident." Interview on 1/21/16 at 3:00 p.m. with the DON regarding resident 17's incidents revealed she agreed the: *Resident had been able to elope from the building three times in the last year. *Incident/investigation forms had not been filled out for each incident. *Incident/investigation forms that had been filled out were not detailed or complete. *Incident/investigation form had not all been signed as reviewed by the investigation team within one working day of following the incident.	F 323			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425	Resident 6's pharmacy recommendation was completed and order was received by the facility. All other pharmacy		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104		
(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	<p>Continued From page 35</p> <p>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.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet 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: 32335 Based on record review, interview, and policy review, the provider failed to ensure pharmacy recommendations were followed-up on for one of six sampled residents (6) on antidepressant medication. Findings include:</p> <p>1. Review of resident 6's medication administration records from 1/1/16 through 1/19/16 revealed she was taking citalopram hydrobromide (antidepressant) started on 10/4/15.</p> <p>Review of resident 6's medical record revealed: *On 12/17/15 the pharmacist note stated:</p>	F 425	<p>recommendations for the prior month will be reviewed to ensure completion. Our consultant pharmacist upon visits to the center will complete recommendations prior to leaving the facility. The Social Worker, nurses and pharmacy consultant will review and audit to ensure recommendations were accurately completed the following week for the prior week. The new process has been agreed upon by the Social Worker and pharmacy consultant. The Social Worker will audit pharmacy recommendations weekly x 4 and then monthly x 2. The Social Worker will bring audit findings to the QAPI Committee monthly x 3. QAPI Committee will review findings each month and determine ongoing interventions and monitoring.</p>	2/18/16

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104
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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 425	<p>Continued From page 36</p> <ul style="list-style-type: none"> - "Added Citalopram in October to try to help with anxiety. - Had a few good days initially, but then went back to normal. - Combative every day. - Unpredictable behaviors. - Will ask Dr. to stop Citalopram and increase Seroquel to 25 mg [milligrams] bid [two times per day]. - No pain issues looks very passive and comfortable." <p>*That recommendation had not been sent to the doctor or followed-up on as of 1/21/16.</p> <p>Interview on 1/21/16 at 2:15 p.m. with the pharmacist revealed she attended monthly meetings at the facility to review residents' medications. She was last there on 12/17/15. She had agreed to send the recommendation for resident 6's medication changes to the doctor but had forgotten. Once she sent the recommendation to the doctor she would leave a copy for the nursing department. She had still not sent the information to the doctor at the time of this interview.</p> <p>Interview on 1/21/16 at 2:30 p.m. with the administrator and the director of social services revealed:</p> <ul style="list-style-type: none"> *The director of social services was in charge of the meetings the pharmacist attended to make her recommendations. *She would follow-up on the recommendations the following month at the next meeting. *There was usually one item each month that had not been followed-up on. *The pharmacist wanted to send most of the recommendations to the physicians herself. *Nursing services did not follow-up on those 	F 425		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104		
(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 37 recommendations until they had been sent to the physician. *The administrator was unaware there was a problem with pharmacy recommendations getting to the physicians.	F 425			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104	
(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/21/16. Good Samaritan Society Sioux Falls Center (Building 01 original 1957 structure) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Melina Tardoff

Administrator

2/11/16

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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SD DOH L&C

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 - 1965 ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104	
(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/21/16. Good Samaritan Society Sioux Falls Center (Building 02 1965 addition) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Moshe Tardoff TITLE Administrator (X6) DATE 2/11/16

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BUILDING 03 - 1972 ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104
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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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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/21/16. Good Samaritan Society Sioux Falls Center (Building 03 1972 addition) 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>Melina Toddoff</i>	TITLE <i>Administrator</i> 2/11/16
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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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 04 - 2000 ADDITION B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104	
(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/21/16. Good Samaritan Society Sioux Falls Center (Building 04 2000 addition) 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Maurio Tardoff Administrator 2/11/16

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If continuation sheet Page 1 of 1
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/21/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CE	STREET ADDRESS, CITY, STATE, ZIP CODE 401 W 2ND ST SIOUX FALLS, SD 57104
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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: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/19/16 through 1/21/16. Good Samaritan Society Sioux Falls Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 32335 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 1/19/16 through 1/21/16. Good Samaritan Society Sioux Falls Center was found in compliance.	S 000		

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

Melissa Tordoff

STATE FORM

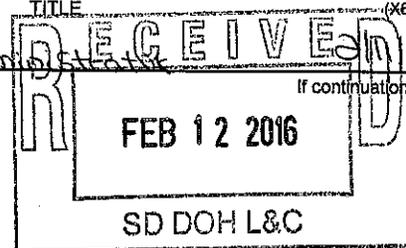
6889

QBT211

TITLE

Adrian Stratt

(X6) DATE



If continuation, sheet 1 of 1