

ORIGINAL

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

PRINTED: 09/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY HOWARD			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST HAZEL AVENUE HOWARD, SD 57349	
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F 000	<p><i>*Addendums noted with an asterisk per 10/11/16 per telephone with facility administrator. SB/SDO/HJL</i></p> <p>Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/12/16 through 9/14/16. Good Samaritan Society Howard was found not in compliance with the following requirements: F329, F441, and F514.</p> <p>F 329 SS=D 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 000	<p>1.) For resident #6 and all other potential residents will have a monthly assessment for anti-psychotic medication use x 3 months. Then a quarterly review with consult Pharmacist and also newly established Behavioral/ Anti-psychotic Committee which will review the following: Target behaviors, appropriate diagnoses, gradual dose reduction, along with behavioral interventions in an effort to discontinue these types of drugs.</p> <p>2.) Resident #6 was D/C of anti-psychotic on 10/03/16 by Psychiatrist.</p>	<i>*11/3/16 SB/SDO/HJL</i>

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

Della Hunkler

TITLE

Administrator

(X6) DATE

10/03/16

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 329	Continued From page 1 by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of seven sampled residents (6) on antipsychotic medication had appropriate documentation to support the ongoing use of it. Findings include: 1. Review of resident 6's 7/6/16 Minimum Data Set (MDS) assessment revealed he: *Scored a 3 on a Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. -He had both long and short term memory loss and impaired decision making. *Was easily distracted or had difficulty following what was occurring. *Had no hallucinations or delusions. *Had exhibited physical behaviors. -The behaviors had not put the resident or other residents at risk for physical injury. -They did not interfere with the resident's care. *Had not rejected care or wandered. Review of resident 6's physician's orders revealed he received the following psychotropic medications: *Namenda XR 28 milligrams (mg) in the evening for Alzheimer's disease unspecified; dementia in other diseases classified elsewhere with behavioral disturbance. It was started on 8/19/14. *Aricept tablet 10 mg daily for Alzheimer's disease unspecified; dementia in other diseases classified elsewhere with behavioral disturbance. It was started on 12/2/13. *Seroquel tablet 25 mg daily for unspecified mood disorder. It was started on 3/13/15. Review of resident 6's nursing mood/behavior	F 329	2.) For all other potential residents- the facility must ensure each resident has accurate documentation and assessment to support the need for use of an anti-psychotic medication. The facility will assess the resident's medical diagnosis, physician orders and documentation of moods and behaviors to determine the need for anti-psychotic medication. The facility will have review the need for anti-psychotic medication usage during [redacted] with mood/behavior review, Life pharmacy consultant review and through the MDS process. The care plan will be updated with mood and behavior focus/goal and interventions. 3.) <u>IN-SERVICE</u> : Education will be provided for all nursing staff by the DNS/ Social worker. Education will include GSS policy and procedure on Anti-psychotic medication usage and gradual dose reduction. Documentation and care planning of mood/behaviors of each resident.	*QUALITY OF Life WEEKLY SB [signature]	

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F 329	<p>Continued From page 2</p> <p>documentation revealed there was behavior documented four times in the past year that included:</p> <p>*2/8/16; He had pushed another resident in wheelchair to get him out of the way and swore at him.</p> <p>*5/10/16; He had gotten up in the late evening claiming he had not eaten supper. Staff attempted to redirect him, but he repeatedly claimed he had not eaten supper. He became upset with staff, and told them to get out of his room. He did not strike out at staff.</p> <p>-There was no documentation he had been offered something to eat or if they had assessed if he was just hungry.</p> <p>*5/15/16; He was confused, and told staff he had seen his wife who was deceased. Staff attempted to redirect him by telling him repeatedly she was deceased. He went up and down hallways into residents' rooms looking for his wife.</p> <p>-There was no documentation they had tried to validate his feelings of missing his wife.</p> <p>7/5/16; He had wheeled his wheelchair backwards 'purposely' and tried to hit another resident.</p> <p>Review of resident 6's pharmacist medication regimen reviews from 7/1/15 through 9/6/16 revealed:</p> <p>*Seroquel had been reduced from 50 mg to 25 mg on 3/12/15.</p> <p>*3/10/16; "This resident has been on Namenda XR 25 mg, Aricept 10 mg daily and Seroquel 25 mg daily. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective optimal dose."</p> <p>-The physician had responded "Patient has had good response to treatment and requires this dose for condition stability. Dose reduction is</p>	F 329	<p>4.) AUDITS: The social worker/ designee will complete audits of each resident using an anti-psychotic medication and determine when the last gradual dose reduction was attempted. The audit will include the medication, diagnosis and complete and accurate documentation to support the trial dose reduction is beneficial or contraindicated. The social worker/designee will complete these audits weekly with residents scheduled to be reviewed in QOL and through the MDS process until all residents have been reviewed within the quarter. The social worker/designee will submit a monthly report to the QAPI Committee of the audit findings for further recommendations.</p>		

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F 329	<p>Continued From page 3</p> <p>contraindicated because benefits outweigh risks for this patient and a reduction is likely to impair the residents function and or cause psychiatric instability."</p> <p>-On 6/8/16 the pharmacist stated "Resident has a diagnosis that supports use of Seroquel--Mood disorder per MD [physician]. *No other gradual dose reductions had been recommended.</p> <p>Interview on 9/13/16 at 10:45 a.m. with registered nurse (RN) D regarding resident 6 revealed: *She did not work a lot of hours at the facility. *She was not aware of any significant behaviors the resident had exhibited.</p> <p>Review of resident 6's 2016 psychological services progress notes revealed: *He had been seen two times per month for the past year. *He received psychotherapy during those visits. *From January through August the risk factors addressed with their occurrence were: -Sexual Acting Out; none. -Aggressive Behavior; none. -Substance Abuse; none. -Suicidal/Self Injury; none. -Homicidal; none.</p> <p>Review of resident 6's psychiatric medication management review for the following dates revealed: *5/12/16 - [Resident's name] has had a couple of incidents where he is a little confused and combative. He is now kind of wandering aimlessly into other people's rooms, but I don't think he is causing any harm doing that; it is just happening." *8/18/16 - "[Resident's name] is very much status quo. He is sleeping well. He's pretty much the "</p>	F 329		

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F 329	<p>Continued From page 4</p> <p>don't know" interview when we talk to him. We had attempted to lower his Seroquel a while back and when he got off of that medicine just a little bit it resulted in decompensation. Therefore there is no reason we would discontinue that. He offers up no other complaints. He gets along with his roommate well enough probably because he has known him through the years; a local guy."</p> <p>Interview on 9/14/16 at 9:00 a.m. with the social services director and director of nursing (DON) regarding resident 6 revealed:</p> <ul style="list-style-type: none"> *They were unaware of how or when the resident received the diagnosis of unspecified mood disorder. -Neither of them were employed at the facility at that time. *They were unable to find documentation for that diagnosis. *The surveyor offered to speak to the physician if the DON called him, but that was not done. *The DON confirmed the resident might have been started on the medication, and the diagnosis came afterwards. -She was unsure. *The DON was unfamiliar with the regulatory guidelines regarding antipsychotic medications. *They confirmed the resident might not exhibit the behaviors to support the medication. -Their behavior documentation would not have supported the use of that medication. *They were unable to find documentation to support when the resident's behavior had decompensated in the past as had been stated above. <p>Review of the provider's March 2015 psychopharmacological medications and sedative/hypnotics policy revealed:</p>	F 329		

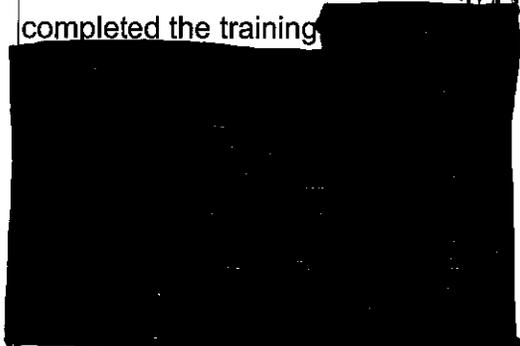
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F 329	Continued From page 5 *Antipsychotic medications should only have been used for a list of conditions/diagnosis. **For a resident who is receiving an antipsychotic medication to treat behavioral symptoms related to dementia, the gradual dose reduction (GDR) may be clinically contraindicated if: -a.) The resident's target symptoms returned or worsened after the most recent attempt at a GDR. -b.) The physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior." *For a resident receiving an antipsychotic medication to treat a psychiatric disorder, the GDR may be considered contraindicated if: a.) The continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reductions would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder."	F 329			
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;	F 441			

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F 441	Continued From page 6 (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 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: 37545 A. Based on observation, interview, manufacturer's instructions review, and policy and procedure review, the provider failed to follow manufacturer's instructions for disinfecting one of two whirlpool tubs (100 wing) during one of one observed whirlpool cleaning by certified nursing assistant (CNA) A. Findings include: 1. Observation on 9/13/16 at 9:30 a.m. with CNA A during disinfecting of the whirlpool tub down the	F 441	1.) Education to be provided to designated nursing staff/by the DNS and infection control nurse by Oct. 12th regarding the whirlpool manufacture directions for disinfecting the whirlpool and the "Classic" whirlpool cleaner's instructions which are in attached documentation. The education has started and we have been following this procedure since survey on Sept. 14th. 4 out of 5 Bath Aides have completed the training  Audit: To ensure compliance following the directions from the manufacture and also the "Classic" whirlpool disinfectant to disinfect the whirlpool. The audit will include the staff showing knowledge and compliance with the stated directions and that all surfaces will be wet with disinfectant for 10 minutes and	*including CNA-A SB/SDOHH/EL *11/3/16 SB/SDOHH/EL *SB/SDOHH/EL SB/SDOHH/EL *completed by the DNS or designee	

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F 441	<p>Continued From page 7</p> <p>100 wing revealed: *She had: -Added approximately one gallon of pre-mixed disinfectant solution to the foot well of the whirlpool tub. -Added water in the foot well until it covered the water intake. -Turned the air jets on. -Sprayed the interior surfaces of the tub with pre-mixed disinfectant solution. -Scrubbed the interior surfaces of the tub with a brush for less than one minute. *The chair and some of the interior surfaces of the tub had dried at 9:35 a.m., five minutes after being sprayed. *She confirmed those areas were dry.</p> <p>Interview on 9/13/16 at 9:50 a.m. with CNA A revealed she: *Agreed the disinfecting directions on the container of the CLASSIC Whirlpool Disinfectant Cleaner revealed to "Wet the surface thoroughly. Allow to remain wet for 10 minutes and then let air dry." *Stated she would not have monitored the whirlpool or chair surfaces to ensure they had remained wet for a ten minute contact time.</p> <p>Interview on 9/14/16 at 2:32 p.m. with the infection control supervisor confirmed: *Their Whirlpool Tub Disinfection policy and procedure did not follow the disinfectant manufacturer's instructions. *CNA A did not follow the correct procedure to disinfect the whirlpool tub according to the disinfectant manufacturer's instructions.</p> <p>Review of the provider's nondated Whirlpool Tub Disinfection policy and procedure revealed to "Let</p>	F 441	<p>disinfectant for 10 minutes and brushed frequently to keep it wet during those 10 minutes. This will be completed daily x 2 weeks, and weekly x 1 month, and then monthly x 3 months with a monthly report of audit findings presented to QAPI committee for further recommendations.</p> <p><i>*by the DON / designee.</i> <i>SB/DOO/HEL</i></p>		

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F 441	Continued From page 8 disinfectant stay on surfaces for 10 minutes. (Or, as recommended by the instructions on the disinfectant concentrate container.)"	F 441	<p><i>*All resident records including residents 1, 3, 4, 5, 6, 7 and 8 were reviewed by the dietary manager/designee to ensure past dietitian visit documentation was recorded and up to date.</i></p> <p><i>SB/SPDOH/EL</i></p> <p>1.) For residents # 1, 3, 4, 5, 6, 7, and 8 and for all other potential residents- The facility must ensure the resident medical record is complete and accurate. The facility must ensure the registered dietitian completes assessments and documentation in the progress notes in a timely manner. The administrator conducted a phone conference on 9/29/16 with the registered dietitian in accordance to the 2567 F-Tag 514. The administrator reviewed the deficiency cited and the expectations that the registered dietitian will enter documentation into the resident medical record the day of the visit or within 5 calendar days of the visit.</p>		
F 514 SS=F	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 37545 Based on record review, interview, job description, and policy review, the provider failed to ensure seven of eight sampled residents (1, 3, 4, 5, 6, 7, and 8) had timely documentation entered into their medical records by the consulting registered dietitian (RD). Findings include:</p> <p>1. Review of resident 3's medical record revealed</p>	F 514			

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F 514	<p>Continued From page 9</p> <p>a revised RD assessment had been completed on 8/25/16. That had been entered into the medical record on 9/13/16. Surveyor: 35625</p> <p>2. Review of resident 4's medical record revealed an initial RD assessment had been completed on 10/2/15. No other RD assessments were found in the medical record.</p> <p>3. Review of resident 5's medical record revealed: *RD assessments had been completed on: -4/20/16; That was entered into the medical record on 9/13/16. -5/19/16; That was entered into the medical record on 9/13/16. -6/15/16; That was entered into the medical record on 9/13/16. -7/13/16; That was entered into the medical record on 9/13/16. -8/25/16; That was entered into the medical record on 9/13/16. Surveyor: 32332</p> <p>4. Review of resident 1's medical record revealed RD assessments had been completed on: *6/15/16. The assessment had been entered into the medical record on 9/13/16. *7/13/16. The assessment had been entered into the medical record on 9/13/16. *8/25/16. The assessment had been entered into the medical record on 9/12/16.</p> <p>5. Review of resident 8's medical record revealed RD assessments had been completed on: *4/20/16. The assessment had been entered into the medical record on 9/13/16. *5/19/16. The assessment had been entered into the medical record on 9/13/16.</p>	F 514	<p>The registered dietitian will report to the dietary manager or Director of nursing any pertinent information the day of the visit.</p> <p>2.)EDUCATION: was provided to the registered dietitian and dietary manager by the administrator on 9/30/2016 per phone conference. This education included GSS policy and procedure, and timeliness of documentation and center expectations for documentation.</p> <p>3.)AUDITS: The dietary manager, <i>SD/SDDOJ/EL</i> designee will complete <i>*15% off</i> audits weekly x 1 month and monthly <i>all residents</i> x 4 months to ensure the registered dietitian has completed and entered all required documentation into the resident medical record, <i>*within five days</i> of her visit. The dietary manager will update the care plan to reflect the information or changes. The dietary manager <i>SD/SDDOJ/EL</i> will submit a monthly report to the QAPI Committee of all audit findings for further recommendations.</p>	

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F 514	<p>Continued From page 10</p> <p>*6/15/16. The assessment had been entered into the medical record on 9/13/16.</p> <p>*7/13/16. The assessment had been entered into the medical record on 9/13/16.</p> <p>Surveyor: 26180</p> <p>6. Review of resident 6's medical record revealed an RD assessment had been completed on 4/20/16. That assessment had not been entered into the medical record until 9/13/16.</p> <p>7. Review of resident 7's medical record revealed: *RD assessments had been completed on: -4/20/16; That was entered into the medical record on 9/13/16. -6/16/16; That was entered into the medical record on 6/24/16. -7/13/16; That was entered into the medical record on 9/12/16. -8/25/16; That was entered into the medical record on 9/13/16.</p> <p>8. Interview on 9/14/16 at 10:30 a.m. with the administrator revealed: *He had recently reduced the number of hours the RD was consulting. -He wondered if that had contributed to her not getting her documentation done more timely. *He was unaware the RD documentation was not available in the medical record in a timely manner. *It was his expectation the RD assessments would be put into the medical record when the assessments were completed.</p> <p>Surveyor: 32332 Interview on 9/14/16 at 1:15 p.m. with the RD regarding the late entries of nutritional assessments revealed:</p>	F 514			

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F 514	<p>Continued From page 11</p> <p>*She agreed the residents' assessments had not been completed and entered in the medical record at the time the residents had been assessed.</p> <p>*She had been consulting at the facility twice monthly until the current administrator had been hired. Since then her time at the facility had been cut to once monthly.</p> <p>*She spent all her time at the facility in meetings or seeing the residents.</p> <p>*There was not enough time to enter her assessments into the medical record while she was in the facility.</p> <p>*The assessments had been entered into the computer from home.</p> <p>*Her expectation was the assessments should have been entered into the medical record when they were done.</p> <p>Interview on 9/15/16 at 2:30 p.m. with the dietary manager regarding the late entries of RD nutritional assessments revealed:</p> <p>*She was aware the RD nutritional assessments had not been entered into the medical record at the time the residents had been assessed.</p> <p>*The RD had left notes of meetings and some recommendations during her visits.</p> <p>*Her expectation was the RD nutritional assessments would have been completed at the time of the assessments.</p> <p>Surveyor: 26180 Review of the provider's February 2013 RD responsibilities policy revealed: *"According to the American Dietetic Association Standards of Practice for Registered Dietitians in Nutrition Care, the RD is accountable and responsible for his or her practice and service to the location.</p>	F 514			

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F 514	Continued From page 12 *The RD will provide written reports to the location monthly regarding visit activities and recommendations -It is recommended that the Visit Report by Consultant RD and Medical Record Reviewed by Consultant RD be used for this purpose."	F 514			

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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/14/16. Good Samaritan Society Howard 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 and the Fire Safety Evaluation System (FSES) dated 9/19/16 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column (X5) for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K038, K052, and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 10/11/16 per telephone with facility administrator. LF/SDDO/H/EL	
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on measurement and document review, the provider failed to maintain proper exit access door widths for two of two randomly observed sets of cross-corridor doors (north and east of the nurses station). Findings include: 1. Measurement at 2:00 p.m. on 9/14/16 revealed each leaf in the pair of one hour fire rated cross-corridor doors to the north of the nurses	K 028	*LF/SDDO/H/EL	F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator (X6) DATE: 10/10/16

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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K 028	Continued From page 1 station measured 30 inches in clear width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed that condition was part of the original construction. 2. Measurement at 2:15 p.m. on 9/14/16 revealed each leaf in the pair of one hour fire rated cross-corridor doors to the east of the nurses station measured 31.5 inches in width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed that condition was part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and document review, the provider failed to ensure at least two conforming exits existed from each floor of the building. The basement did not have a conforming exit. Findings include:	K 032	 *LF/SDDOH/EL	 F

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K 032	Continued From page 2 1. Observation at 1:00 p.m. on 9/14/16 revealed the basement did not have a conforming exit. The primary exit was the basement stairway that discharged onto the main level corridor system. The second exit was through a window to an area well equipped with a fixed ladder. Review of the previous survey report confirmed the condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 032	1. Signage that meets the Life Safety Code requirement for delayed egress doors has been ordered and will installed upon receipt, prior to November 3, 2016.	LF/SPDOHJEL *11/3/16 
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure exits were readily available at all times at one of nine exits (east end of the 100 wing). Findings include: 1. Observation at 11:20 a.m. on 9/14/16 revealed an exit door at the east of the 100 wing. That exit door was equipped with a delayed egress locking feature that would activate the lock upon approach of a resident provided with a wander management device. That door would then alarm when the door panic bar was pushed and unlock after fifteen seconds. That door was not provided with the proper signage indicating the means to unlock that door. That door should have been provided with code required signage indicating "push until alarm sounds, door can be opened in 15 seconds."	K 038	2. No other doors were identified with similar deficiencies. 3. A review of the facilities policy and procedure related to means of egress requirements was reviewed with the Environment Services Director on October 5, 2016. 4. Verification of installation of signage will be reported to the QAPI committee at a next scheduled meeting after installation occurs. *by maintenance director. 5. Installation of required signage will occur prior to November 3, 2016.	LF/SPDOHJEL 

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K 038	Continued From page 3 Interview with the director of maintenance at the time of the above observation confirmed that condition. He indicated he had not noticed the signage was not provided on that door. He indicated that door was new, and he must have forgotten to replace the signage. This deficiency has the potential to affect one of nine smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review and interview, the provider failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 72 National Fire Alarm Code. Access was not provided for a duct detector and was unable to be tested. Findings include: 1. Document review at 10:30 a.m. on 9/14/16 revealed a fire alarm inspection report dated 12/16/15 prepared by Automatic Building Controls Inc. That report provided a comment indicating the service technician was unable to test one duct detector located in the dining room. That duct detector was not provided with a feasible means of access for testing.	K 038		
K 052 SS=B		K 052	1.) ABC controls contacted on Oct. 5 and are in agreement to have the the duct in the dining room checked and inspected. The time ABC originally came out is was over 100 degrees and refused to access it from another route until the weather was cooler. 2.) To ensure this does not occur again, ABC will be required to give a report to the Maintenance director from each visit. 3.) The required tests will be completed by ABC in the time allotted by regulation. If the weather is not permitting due to heat, the inspection will be done as soon as the heat breaks due to health risks of the heat.	*LTD APPROVED *11/3/16 LTD APPROVED

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K 052	Continued From page 4 Interview with the director of maintenance at the time of the above document review confirmed that condition. He indicated he was unaware that duct detector was required to be tested on an annual basis.	K 052	4.) ABC controls and HOWE electric both are required to provide a report from each visit. 5.) This correction will be completed by November 3rd, 2016.	
K 062 SS=C	This deficiency has the potential to affect one of nine smoke compartments. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, document review, and interview, the provider failed to ensure the automatic fire sprinkler system was continuously maintained in reliable operating condition. There was no record of a three year full trip test on the dry system. There was improper clearance around sprinkler heads (100 wing cubical curtains). Findings include: 1. Document review at 10:30 a.m. on 9/14/16 revealed an annual fire sprinkler system inspection report dated 4/14/16 prepared by Howe Engineering Inc. That report did not provide any information on the last time a three year full trip test had been conducted on the dry fire sprinkler system. Review of previous inspection reports back to when the sprinkler was originally installed in April 2012 did not indicate a full trip test had ever been conducted. The three year full trip was approximately seventeen months overdue.	K 062	*6.) The maintenance director will provide report to the QAPI committee at the next scheduled meeting. LF/SDDOH/EL 1.) Contracted company, Howe Electric, was called Sept. 14th and the documentation for the 3 year report will be sent to the facility. The report was done, but not given to facility for proof of service. LF/SDDOH/EL 2.) The 3 and 5 year checks will be added to TELS for proper tracking. 3.) These reports will be given to the maintenance director or Administrator for proper filing and tracking. And with the TELS tracking system, any inspection or report not checked off on, will flag for verification. *4.) Verification of the required test will be reported to the QAPI committee at the next scheduled meeting by the maintenance director. LF/SDDOH/EL	11/3/16 LF/SDDOH/EL

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K 062	<p>Continued From page 5</p> <p>Interview with the director of maintenance at the time of the above record review revealed he did not know about the required three year full trip test requirement.</p> <p>2. Observation at 11:45 a.m. on 9/14/16 in resident room 111 revealed a cubicle curtain separating a dual occupancy resident room. That curtain did not provide proper clearance to allow for full development of fire sprinkler water flow discharge pattern. The top eighteen inches should have been provided with an open area or open mesh to allow for the sprinkler head discharge pattern to develop. That condition was also observed in all the residents' rooms of the 100 wing.</p> <p>Interview with the director of maintenance at the time of the above observation revealed he had not noticed those curtains did not provided the proper clearance for the sprinkler heads.</p> <p>This deficiency has the potential to affect one of nine smoke compartments.</p>	K 062	<p>1.) The curtains that do not meet fire code will be ordered Oct. 5th, 2016 and in place as soon as they are received or by Nov. 3rd, 2016.</p> <p>2.) The curtains for the resident rooms that do not have 18 inch clearance need removed. New curtains for areas of concern will be purchased by Nov. 3rd, 2016.</p> <p>3.) To ensure we no longer have curtains out of compliance, we will purchase enough curtains that there will no longer be a curtain in the building that is out of compliance.</p> <p>*4.) Verification of the required installation will be reported to the QAPI committee at the next scheduled meeting by the maintenance director.</p>	<p>*11/3/16 LFSD/DH/ECL</p>

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S 000	Compliance/Noncompliance Statement Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/12/16 through 9/14/16. Good Samaritan Society Howard was found not in compliance with the following requirements: S206 and S210.	S 000	*Addendums noted with an asterisk per 10/11/16 per telephone with facility administrator. SB/SDDOH/EL	
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	In addition to current yearly required trainings, all-staff will also be required to complete training on the "proper use of restraints" and "Dining assistance, nutritional risks and hydration needs of residents". These trainings will become apart of the yearly required trainings at the facility. The trainings will be audited yearly to ensure all-staff are completing required trainings. The trainings will also be broken down into monthly required staff development trainings to ensure accuracy of audits and allotting enough time for completion. The two topics have been posted and will be completed by the end of the year to maintain 2016 compliance. *The staff development administrator will submit audit findings monthly to the QAPI committee for further recommendations.	*SB/SDDOH/EL [REDACTED] *11/3/16 SB/SDDOH/EL *will be done by 11/3/16 and SB/SDDOH/EL *by staff development and administrator. SB/SDDOH/EL SB/SDDOH/EL SB/SDDOH/EL SB/SDDOH/EL SB/SDDOH/EL

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

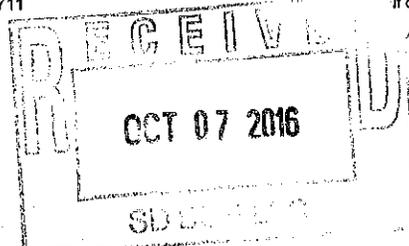
Dutton Hurd

TITLE

Administrator

(X6) DATE

10/15/16



South Dakota Department of Health

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S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and required educational listing review, the provider failed to ensure the required annual education for 2 of 11 required topics (use of restraints and nutrition and hydration) was provided to all employees. Findings include:</p> <ol style="list-style-type: none"> 1. Interview and record review on 9/14/16 at 11:05 a.m. with the director of nursing (DON) revealed she thought they had covered the use of restraints, and nutrition and hydration in the last years inservices. However no records supporting that were found before the end of the survey. 2. Interview and record review on 9/14/16 at 11:10 a.m. with the administrator revealed he agreed the use of restraints, and nutrition and hydration for more than dietary staff were not included on the required educational listing. <p>Review of the provider's November 2013 Skilled Nursing Facilities Required Annual Training Topics listing had not included: *Use of restraints. *Nutrition and hydration for more than dietary staff.</p>	S 206		
S 210	<p>44:73:04:06 Employee Health Program</p> <p>The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable</p>	S 210		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY HOWARD		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W HAZEL AVE HOWARD, SD 57349		
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S 210	<p>Continued From page 2</p> <p>communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and policy review, the provider failed to have a health evaluation completed for two of five sampled newly hired employees (dietary assistant B and nursing assistant C) within the first fourteen days after being hired. Findings include:</p> <p>1. Interview on 9/13/16 at 3:00 p.m. with the administrator and the business office/human resource manager regarding health evaluation forms completed for dietary assistant B and nursing assistant C revealed: *Both employees had been hired on 8/19/16. *Neither had a completed health evaluation form in their employee file.</p> <p>Review of the provider's March 2016 Health Questionnaire policy and procedure revealed: *The form was to have been completed before general orientation or during general orientation.</p>	S 210	<p>The employee health evaluation has been added to the General Orientation Checklist as it was not previously. Each new employee will meet with a Registered Nurse and have it reviewed and signed. In reference to employee B and C: B was completed on 09/14/16 and employee C was completed on 09/30/16. Audits: An audit will be completed by the business office with new hires weekly x 4 and then monthly x 3 months.</p> <p>*The business office manager/HR will submit a monthly report of audit findings to the QAPI committee for further recommendations.</p> <p>SBSDDOH/JEL</p>	<p>*10/3/16 SBSDDOH/JEL</p> <p>SBSDDOH/JEL *manager</p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10631	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY HOWARD		STREET ADDRESS, CITY, STATE, ZIP CODE 300 W HAZEL AVE HOWARD, SD 57349		
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S 210	Continued From page 3 *If completed during orientation it was to have been reviewed prior to the employee beginning work in his or her department and any concerns were to have been addressed.	S 210		
S 000	Compliance/Noncompliance Statement Surveyor: 32332 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 9/12/16 through 9/14/16. Good Samaritan Society Howard was found in compliance.	S 000		