

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

ORIGINAL

PRINTED: 12/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DE SMET			STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVENUE NW DE SMET, SD 57231	
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F 000	INITIAL COMMENTS Surveyor: 30170 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/9/13 through 12/11/13. Good Samaritan Society DeSmet was found not in compliance with the following requirements: F241, F280, F323, and F441.	F 000	Addendums noted with an asterisk per 01/10/14 telephone to facility administrator. SC/SDDOH/ME	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, and policy review, the provider failed to ensure those randomly observed residents (12, 13, and 14) were assisted in a dignified manner during two of two observed meal services. Findings include: 1. Observation on 12/10/13 from 8:07 a.m. through 8:55 a.m. in the dining room during the morning meal service revealed: *Certified nursing assistant (CNA) A was sitting at a table and was assisting residents 12 and 13 with their breakfast meal. *She would give resident 12 a spoonful of breakfast cereal. She then wiped the excess food off her face with the spoon and did that for the duration of the meal. *She would give resident 13 a spoonful of food.	F 241	All CNAs will be re-educated on proper feeding assistance by using a napkin to wipe excess food from a resident's mouth, instead of using the spoon. The Staff Development Coordinator will randomly audit meal times weekly x 4 weeks and then monthly x 6 months to ensure napkins are being used to remove excess food. Staff Development Coordinator will report audit findings to the Quality Assurance Committee that meets monthly* for six months. *The video "Creating a Fine Dining Experience" was viewed by all CNAs by 01/10/14. SC/SDDOH/ME	1/10/14 SC/SDDOH/ME

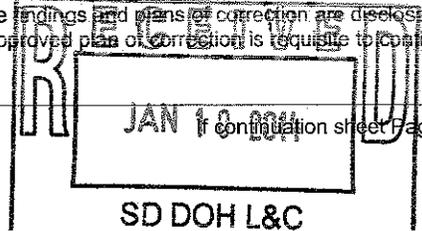
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Maria Tordoff

Administrator

1/9/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 241	Continued From page 1 She would then wipe the excess food off his face with the spoon and did that for the duration of the meal. 2. Observation on 12/10/13 from 11:55 a.m. through 12:15 p.m. in the dining room during the noon meal service revealed: *CNA B was sitting at a table and was assisting residents 12 and 13. *She would give resident 12 a spoonful of food. Then she wiped the food off her face with the spoon. *She would give resident 13 a spoonful of food. Then she wiped the excess food off her face with the spoon. 3. Interview on 12/10/13 at 5:00 p.m. with the director of nursing regarding the above observations revealed she confirmed CNAs A and B should not have been wiping the excess food off residents 12 and 13's mouths with a spoon. Review of the provider's November 2013 Nutritionally Dependent Resident policy revealed the purpose of the policy was to provide dignity for a resident who had required total assistance with meals.	F 241			
F 280 SS=D	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	F 280	* Communication with the hospice agency was completed on 12/12/13 by the DON. The DON reviewed integrating hospice and the facility responsibilities with the MDS coordinator on 12/12/13. SCS/DON/MF The care plans for Resident's 9 & 10 have been updated to reflect the specific responsibilities for the hospice agency staff and the facility staff. All care plans for other residents receiving hospice services have also been reviewed to ensure		

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F 280	<p>Continued From page 2</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170</p> <p>Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (9 and 10) that had been receiving hospice services had complete information on their care plans. Findings include:</p> <p>1. Review of resident 10's complete medical record revealed: *She had been admitted on 9/17/10. *She had been admitted to hospice on 8/23/13. *Her diagnosis was dementia with behaviors. *The 11/27/13 complete care plan revealed "hospice services." *There was no specific information in the care plan to ensure what hospice was responsible for and what the provider had been responsible for.</p> <p>Interview on 12/10/13 at 4:30 p.m. with the director of nursing (DON) regarding the care plan for resident 10 revealed there should have been a specific plan and instructions for the staff to have</p>	F 280	<p>these additions have been made and included in their plan of care. MDS Coordinator will audit the hospice resident care plans each month x 12 months to ensure the care plans specifically address the responsibilities between the hospice staff and the facility staff. The MDS Coordinator will bring the audit findings to our Quality Assurance Committee that meets each month <i>* for a period of one year.</i></p> <p><i>SC/SDDON/MF</i></p>	1/10/14

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F 280	<p>Continued From page 3 followed with regards to hospice services.</p> <p>Review of the provider's January 2009 Care Plan policy revealed: *Care plans would have been reviewed, evaluated, and updated when there was a significant change in the resident's condition and /or in accordance with state guidelines. The plan of care would have been modified to reflect the care currently required or provided for the resident.</p> <p>Surveyor: 32572 2. Review of resident 9's medical record revealed: *He had been admitted on 9/19/13. *He had been admitted to hospice services on 12/6/13. *Review of the 10/9/13 care plan revealed an entry under the interventions column dated 12/6/13 "Hospice services as ordered." -There had been no specific plans and instructions for the staff to follow for hospice services. *There had been a sheet placed in the front section of the chart labeled Compassionate Care Hospice. -A column labeled Hospice responsibilities stated: -"Hospice staff shall coordinate the palliative (no cure) services provided to each patient by reviewing the plan of care and treatment with the facility staff, family, and patient." -"Hospice shall provide a copy of the patient's plan of care to the facility staff." -"Hospice shall communicate effectively with the facility staff." -"Hospice shall document in the patient's record." -"Hospice retains responsibility for all cares related to the terminal illness."</p>	F 280		

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F 280	Continued From page 4 -"Hospice shall provide copies of the following: hospice election statement, hospice plan of care, certification and re-certification information, and interdisciplinary (all disciplines, such as dietary, social services, and activities) comprehensive (detailed), and progress notes." *The 12/6/13 signed physician's orders revealed the following care plan problems that were not addressed on the provider's interdisciplinary care plan: -"Initial patient plan of care." -"Alteration (change) in physical comfort/pain." -"Altered nutrition." -"Durable medical equipment (such as air mattress and oxygen equipment) and supplies." -"Personal care assignment home (nursing assistant duties to perform)." -"Resuscitation-DNR (do not resuscitate)." -"Self care deficit (lack of)." -"Treatment schedule (how often and which specific hospice staff will visit)." -"Visit schedule (what days hospice staff will visit)." Interview on 12/11/13 at 8:30 a.m. with the DON confirmed she would have expected the hospice provider to have documented on the care plan the designated services that would have been provided. The written communication would have provided better continuity (continuousness) of care.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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	F 323	The tobacco smoking assessment has been completed for Resident 4. No other residents currently smoke that reside in our facility. For those	

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F 323	<p>Continued From page 5 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (4) who smoked independently had been assessed to ensure his safety. Findings include:</p> <p>1. Observation on 12/9/13 at 6:30 p.m. near the nursing station by the 300 wing revealed resident 4 was going outside in his wheelchair to smoke.</p> <p>Review of resident 4's complete medical record revealed: *He had used tobacco products. *He was alert and orientated to person, place, and time. *His diagnoses had included: -A history of alcoholism. -A cerebral vascular accident with left hemiplegia (stroke with left sided paralysis). -Anxiety. *The December 2013 medication administration record revealed the nursing staff were monitoring his ability to smoke outside independently to ensure resident safety. *There was no smoking assessment completed.</p> <p>Interview on 12/10/13 at 11:30 a.m. with the Minimum Data Set (MDS) coordinator regarding resident 4's smoking assessment revealed: *No formal smoking assessment had been completed.</p>	F 323	<p>residents in which it applies, the tobacco smoking assessment will be completed upon admission to the facility, quarterly and following a significant change in condition to ensure the resident's safety. This will be completed by the Social Worker. The Social Worker will audit quarterly x 4 to ensure the tobacco smoking assessments are being completed and filed for those residents that choose to smoke. The Social Worker will bring the audit findings to the Quality Assurance Committee that meets monthly <i>* for a period of one year. SJSDDOH/ME</i></p>	1/10/14	

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F 323	Continued From page 6 *The nursing staff would monitor the appropriate exiting and re-exiting the building. *Laundry had been notified to inform the nursing staff when they noted any burn holes in his clothes. Interview on 12/10/13 at 11:45 a.m. with the director of nursing regarding resident 4's independent smoking revealed: *There had been no formal smoking assessment completed. *She had felt his cognition (mental status) was good, and he had been safe smoking independently. *There had been no incidents of burn holes or injuries to the resident. *The staff had not inspected his clothing each time he had returned from smoking. Review of the provider's March 2013 Smoke-Free Centers policy revealed: *All residents who smoked or used tobacco products would be assessed. *Upon admission, all residents who smoked or used tobacco products would be assessed using the Tobacco Use Assessment. Review of the undated Smoke-Free Facilities Addendum policy revealed: Smoking by residents classified by the facility as not responsible or independent is prohibited, except under direct supervision of a staff person or relative/friend of the resident to ensure the resident's safety."	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	* Education on hand hygiene was provided by written communication by the administrator on 11/14. JCSDDO/HMF All CNAs will be re-educated on proper assistance with feeding by sanitizing their hands between residents. A The	

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F 441	<p>Continued From page 7</p> <p>safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, and policy</p>	F 441	<p>Staff Development Coordinator will randomly audit mealtimes weekly x 4 weeks and then monthly x 6 months to ensure CNA's are properly sanitizing their hands between residents during feeding assistance. The Staff Development Coordinator will report the audit findings to the Quality Assurance Committee that meets monthly. All gait belts will be returned to the center and washed here at the facility. Then, the gait belts will be re-distributed and issued to one resident only. The CNA will only use that resident gait belt and it will be washed if soiled and/or resident is no longer residing in the facility. At that time, the gait belt will be washed and sanitized before being issued to a new resident. All CNA staff will be educated on this change. The Staff Development Coordinator will randomly audit monthly x 6 to ensure each resident's gait belt remains in their room when not in use and is clean.</p>	<p><i>* for six months schedule</i></p> <p><i>* see page 9 schedule</i></p>
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F 441	<p>Continued From page 8</p> <p>review, the provider failed to ensure:</p> <p>*Appropriate hand hygiene had been used by two of two randomly observed certified nursing assistants (A and B) during two of two observed meal services.</p> <p>*Gait belts were used in a sanitary manner during one of one randomly observation of CNA B.</p> <p>*Sanitary handling of soiled neck aprons by dietary aide C for one of two observed meals.</p> <p>Findings include:</p> <p>1. Observation on 12/11/13 from 8:07 a.m. through 8:55 a.m. of the morning meal service revealed:</p> <p>*CNA A was assisting residents 12, 13, and 14 in the dining room.</p> <p>*She would:</p> <p>-Assist resident 13, then would wipe his mouth with a paper napkin using her bare hands, and never washed or sanitized her hands.</p> <p>-Touch the back of resident 13's wheelchair and then would assist resident 14, and she had not washed or sanitized her hands.</p> <p>-Touch the back of the residents 12 and 13's wheelchairs and the back of the residents shirts, then returned to assisting those residents, and had not washed or sanitized her hands.</p> <p>*She then returned and had sat between residents 12 and 13 and had resumed assisting those residents with the meal.</p> <p>-She had wiped the mouth of resident 12 and 13 with a paper napkin and she had never washed or sanitized her hands throughout the observation period.</p> <p>2. Observation on 12/11/13 from 11:55 a.m. through 12:15 p.m. in the dining room during the noon meal revealed:</p> <p>*CNA B was assisting resident 12 with the noon</p>	F 441	<p>The Staff Development Coordinator will report the audit findings to the Quality Assurance Committee that meets monthly. All staff will be re-educated on the proper handling of soiled linens in the dining room. The Dietary Manager will randomly audit mealtimes service weekly x 4 and then monthly x 6 months to ensure facility staff are properly handling the soiled napkins away from their body. The Dietary Manager will report the audit findings to the Quality Assurance Committee that meets each month.</p> <p><i>* for six months 8/30/13/14</i></p> <p><i>*The administrator provided communication with the staff regarding the gait belts on 1/10/14 8/30/13/14</i></p> <p><i>* by the administrator on 1/10/14 8/30/13/14</i></p>	1/10/14
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F 441	<p>Continued From page 9 meal.</p> <p>*She had wiped the mouth of the resident with a paper napkin using her bare hands. She then would return assisting the resident without sanitizing her hands.</p> <p>*She had touched the back of the resident's wheelchair several times.</p> <p>*She had not performed any hand hygiene throughout the observation period.</p> <p>Interview on 12/11/13 at 4:30 p.m. with the director of nursing regarding the above observations revealed the CNAs should have used proper hand hygiene when assisting residents 12, 13, and 14 during the meal services.</p> <p>Review of the provider's November 2011 Hand Hygiene and Handwashing policy revealed: *When hands were not visibly soiled or contaminated with blood or body fluids. Alcohol-based hand rub would routinely have been used to cleanse the hands. *Sanitize hands: -Prior to having had direct contact with residents. -After having had direct contact with a resident's skin. -After equipment or furniture near the resident had been touched.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005, p. 789, revealed "The most important and most basic technique in preventing and controlling transmission of infections is hand hygiene. Hand hygiene includes using an instant alcohol hand antiseptic before and after client care."</p>	F 441			

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F 441	<p>Continued From page 10</p> <p>Surveyor: 28057</p> <p>3. Observation on 12/10/13 at 9:55 a.m. revealed CNA B removed a gait belt from under her smock top and around her waist. She had then placed that gait belt around resident 3's waist. She assisted the resident to the bathroom. CNA B put a clean pair of gloves on her hands. When the resident had finished using the toilet she had cleaned the resident's bottom with toilet paper. While wearing those same gloves she had adjusted the tightness of the gait belt several times while it had still been around the resident's waist. CNA F entered the room and offered to take the resident to the tub room for her bath. CNA B told CNA F to bring the gait belt back when she had finished using it with resident 3.</p> <p>Interview on 12/10/13 at the above time with CNAs B and F confirmed: *CNA B took her gait belt home to wash. *She had washed it about once a week. *She had used that belt for other residents, and not just resident 3. *CNA F had washed hers at home and at other times at the facility if time allowed.</p> <p>Interview on 12/11/13 at 9:20 a.m. with the director of nursing confirmed CNA B should have removed her gloves and washed her hands before touching the gait belt. She further confirmed a gait belt should have been on the resident's bathroom door to be used for her rather than sharing one between residents. She had agreed each resident should have their own gait belt instead of the CNAs sharing them with multiple residents.</p> <p>Review of the provider's revised August 2013 Gait</p>	F 441			

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F 441	<p>Continued From page 11</p> <p>Belt procedure had not addressed the cleaning of the gait belts. It also had not addressed the use of one gait belt with multiple residents.</p> <p>Surveyor: 32572</p> <p>4. Observation on 12/10/13 from 8:20 a.m. through 9:00 a.m. of dietary aide (DA) C revealed:</p> <ul style="list-style-type: none"> *She had been collecting resident's soiled neck aprons from dining room tables. *She collected them and placed them under her arm as she went around the dining room. *Those soiled neck aprons had been touching her uniform making it contaminated. <p>Interview on 12/11/13 at 8:30 a.m. with the DON confirmed she would have expected the soiled neck aprons to not be in contact with the uniform.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO., 2013, pp. 410 and 414, revealed:</p> <ul style="list-style-type: none"> *Standard precautions are used with all residents. *Standard precautions apply to blood, blood products, all body fluids (saliva, tears) ... and mucous membranes (an example was mouth tissue). *Standard precautions protect the resident and provide protection for the health care worker. 	F 441		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/10/13. Good Samaritan Society DeSmet (Building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiencies identified at K019, K029, K038, K052, K062, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 01/21/14 telephone to facility administrator. CH/SDDOH/ME	
K 019 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Vision panels in corridor walls or doors are fixed window assemblies in approved frames. (In fully sprinklered buildings, there are no restrictions in the area and fire resistance of glass and frames.) 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the smoke tight rating of corridor wall assemblies for the main office. A fire-rated roll-up window could not be closed. Findings include:	K 019	In order to maintain the smoke tight rating of the corridor wall for the nurses station, the roll-up window will be manually closed by a charge nurse during a fire drill or actual disaster. This change/update will be made to our center's Disaster Plan as well. All Staff will be educated on this change on 1/29/14. Environmental Services Manager will audit to ensure this is being done following each fire drill monthly x 6 months. Environmental Services Manager will report audit	

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

TITLE

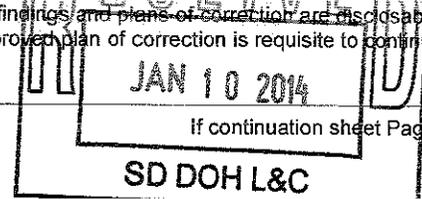
(X6) DATE

Marcia Tordoff

Administrator

1/9/14

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 019	Continued From page 1	K 019	findings to the Quality Assurance Committee. Our QA Committee meetings are held monthly.	1/29/14
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of two of two hazardous areas (boiler room wall and maintenance repair shop wall and corridor door). Findings include:</p> <p>1. Observation at 1:30 p.m. on 12/10/13 revealed the boiler room had two unsealed openings (approximately one inch in diameter) around</p>	K 029	<p>The unsealed openings in the maintenance repair room will be sealed with fire caulk to maintain the proper separation to these 2 hazardous areas. In addition, a proper closer will be installed on the maintenance repair room door.</p> <p>* The environmental services manager will report the completion of this work to the administrator who will report to the QA committee. CHJSDDH/ME</p>	1/30/14

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K 029	Continued From page 2 wiring penetrations to the maintenance repair room. The maintenance repair room corridor door was a three quarter hour fire-rated door and was not equipped with a closer. Interview with the maintenance supervisor at the time of the observations confirmed that finding.	K 029		
K 038 SS=F	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: 18087 Based on observation, document review, and interview, the provider failed to ensure eight of eight exits were readily accessible at all times (main entrance, main dining room, gazebo/south exit from the kitchen corridor, northeast exit from the 100 wing/Hoeger Boulevard, chapel exterior exit, southwest exit from the 200 wing/Jerstad Drive, west exit from the Pineview wing, and south exit from the Pineview wing). Findings include: 1. Observation beginning at 11:30 a.m. on 12/10/13 revealed the eight building exits were each equipped with a device that would magnetically lock the door when a resident with a wander management device came in close proximity to the exit. A keypad was mounted adjacent to the door that would also unlock the magnet. A code to unlock the door was posted at the main entrance on a piece of paper taped to	K 038	All exit doors in the facility (9 total doors) will be equipped with the delayed egress mechanism. Automatic Building Controls has been contacted and plans are in place for this work to be completed. <i>*The completion of the work will be reported by the administrator to the QA committee. Checking the magnetic locks will be performed by the environmental services manager monthly during the fire alarms activations who will report to the administrator. The administrator will report those findings to the QA committee. CH/SDDH/MF</i>	01/30/14 CH/SDDH/MF

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K 038	Continued From page 3 the wall. Interview with the maintenance supervisor at the time of the observations confirmed those findings. 2. Document review at 2:45 p.m. revealed an internal email from the provider's parent organization detailing the methods to be used for magnetically locked doors that were not delayed egress. Those instructions indicated posting a code for the locks which were access-control type locks. Access-control locks are not acceptable for use in a path of egress unless they meet the exceptions in the Life Safety Code 101, 2000 Edition, Chapter 7.2.1.6.2. Posting the code to unlock the magnet with the keypad does not meet the standard. Interview with the administrator at 4:45 p.m. revealed the magnetic door locks were not the delayed egress type. She indicated the doors were only locked when a wander management device came in close proximity to the lock. It was not determined if the magnetically locked doors would unlock when the fire alarm was activated.	K 038		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	The Environmental Services Manager will begin making a verification call to our center's monitoring agency following each fire drill. Environmental Services Manager will review and audit each fire drill record to ensure this is being completed each month x 12 months. Environmental Services Manager will	

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K 052	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to ensure the automatic fire alarm functioned as required. Verification calls from the provider after the completion of fire drills to the central monitoring agency had not been performed in eight of the previous twelve months beginning January 2013. Findings include: 1. Review of the provider's fire drill reports revealed eight of the previous twelve months beginning January 2013 (January, March, April, June, July, August, October, and November) were not noted that a signal had been sent to the central monitoring agency. The box on the back of the form was not checked to indicate a callback verification from the provider to the central monitoring agency had been performed. Interview with the maintenance supervisor at the time of the review confirmed that finding. He revealed he was not aware the callback verification was required.	K 052	report audit findings to the Quality Assurance Committee. Our QA Committee meetings are held monthly.	1/10/14
K 062 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087	K 062	In order to ensure that the 11 inch clearance is maintained to not obstruct the sprinkler, the top shelf in the linen closet will be removed and those items will be relocated to a separate storage area. All staff will be educated on this change on 1/29/14.	

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K 062	Continued From page 5 Based on observation, measurement, and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector so the water discharge was not interrupted for one randomly observed sprinkler (in the clean linen closet). Findings Include: 1. Observation and measurement at 12:45 p.m. on 12/10/13 revealed the sprinkler in the clean linen closet was obstructed by blankets stacked on the top shelf within eleven inches of the sprinkler discharge. Interview with the maintenance supervisor at the time of the observation revealed he was not aware of the obstructed sprinkler.	K 062	Environmental Services Manager will audit linen closets to ensure this clearance for the sprinkler is continuing to be met. This will be audited monthly x 3 months. Environmental Services Manager will report audit findings to the Quality Assurance Committee. Our center's QA Committee meets monthly.	1/29/14
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the generator battery per NFPA 99 guidelines. A maintenance-free battery had been installed. Specific gravity testing for the generator battery had not been done. Findings include:	K 144	Cummins Central Power has been contacted and will be installing an unsealed, approved battery for the generator. Environmental Services Manager will begin monthly gravity testing and this will also be logged monthly as well. Environmental Services Manager will audit monthly x 12 to ensure proper testing and logging is being completed. Environmental Services Manager will report audit findings to the Quality Assurance Committee that meets monthly.	1/30/14

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K 144	Continued From page 6 1. Observation at 1:45 p.m. on 12/10/13 revealed the generator battery was dated April 2013 (eight months prior to the survey date). The installed battery was a maintenance-free battery (sealed). Interview with the maintenance supervisor at the time of the observation revealed he did not know the maintenance-free (type) battery was not acceptable. He was unaware monthly specific gravity tests had to be performed and logged.	K 144		

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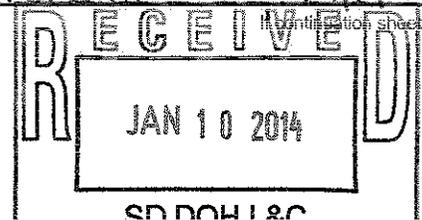
S 000	Initial Comments Surveyor: 30170 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 12/9/13 through 12/11/13. Good Samaritan Society DeSmet was found not in compliance with the following requirements: S130 and S199.	S 000	Addendums noted with an asterisk per 01/31/14 telephone to facility administrator. SC/SDDOH/MF	
S 130	44:04:02:06 FOOD SERVICE Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Rule is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the vegetable preparation sink in the kitchen was not provided with a physical air break on the drain line in accordance with ARSD 44:02:07:70. Findings include: 1. Observation at 1:15 p.m. on 12/10/13 revealed the three compartment sink in the kitchen was not provided with a one inch physical air gap	S 130	A one inch physical air break will be installed to the drain line of the 3-compartment sink in the kitchen. *The administrator will report to the QA committee when this has been completed. SC/SDDOH/MF	1/30/14

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

Marcia Tordoff

Administrator

1/9/14



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S 130	Continued From Page 1 (break) in the drain line from any of the three compartments. Interview with the dietary manager at the time of the observation revealed two of the three compartments were sometimes used for vegetable preparation. She noted the garbage disposal had an air break. That was not connected to the drains from any of the compartments. Interview with the maintenance supervisor at the time of the observation revealed he was unaware the requirement for the physical air break on the drain line had not been met.	S 130	* The administrator and the DON provided the education on the General Orientation Checklist on 10/13/13 to the Staff Development Coordinator. The new checklist has been placed in all new hire employee packets. <i>SC/SD/DOH/IMF</i>	
S 199	44:04:04:04 PERSONNEL The facility must have a sufficient number of qualified personnel to provide effective and safe care. Staff members on duty must be awake at all times. Supervisors must be 18 years of age or older. Written job descriptions and personnel policies and procedures must be made available to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility must establish and follow policies regarding special duty or staff members on contract. This Rule is not met as evidenced by: Surveyor: 32572 Based on record review and interview, the provider failed to ensure job descriptions were available for four of four new employees (G, H, I, and J). Findings include: 1. Review of employee G's file revealed:	S 199		The Job Descriptions and Competencies/Training Checklists have been completed for Employees G, H, I and J. Our Staff Development Coordinator has been re-educated on the use of the facility's General Orientation Checklist which indicates the requirement of completion for these forms mentioned above. The Staff Development Coordinator will audit all newly hired employee files monthly x 12 to ensure these forms are being completed and filed in the employee's personnel file. The Staff Development Coordinator will report the audit findings to the Quality

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DE SMET		STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVE. NW DE SMET, SD 57231		
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S 199	Continued From Page 2 *She had been hired on 7/29/13 as a dietary aide (DA). *No documentation had been noted she had received a job description. *No competency skills checklist had been noted in her file. 2. Review of employee H's file revealed: *She had been hired on 9/5/13 as a certified nursing assistant (CNA). *No documentation had been noted she had received a job description. *No competency skills checklist had been noted in her file. 3. Review of employee I's file revealed: *She had been hired on 8/23/13 as a DA. *No documentation had been noted she had received a job description. *No competency skills checklist had been noted in her file. 4. Review of employee J's file revealed: She had been hired on 10/17/13 as a CNA. *No documentation had been noted she had received a job description. *No competency skills checklist had been noted in her file. 5. Interview on 12/10/13 at 3:37 p.m. with the director of nursing (DON) confirmed job descriptions were not in the employees files. She confirmed at 4:05 p.m. that same day there had been no documentation of competency skills completed for any of the above employees. Review of the provider's revised July 2007 Job Description/Performance Feedback System policy revealed: **The purpose was to provide tools for supervisors and staff members that aid in	S 199	Assurance Committee. The facility's QA Committee meets monthly. *The Staff Development Coordinator will report the audit findings to the QA committee for one year. <i>SC/SDBDH/MF</i>	1/30/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10614	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2013
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DE SMET		STREET ADDRESS, CITY, STATE, ZIP CODE 411 CALUMET AVE. NW DE SMET, SD 57231		
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S 199	Continued From Page 3 creating a quality work environment..." **"The Good Samaritan Society views the Job Description/Performance Feedback System as one of the most important process in ensuring effective employment practices that comply with regulations."	S 199		