

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1022 NORTH DAKOTA AVENUE CANTON, SD 57013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>Addendums noted with an asterisk per agency telephone to facility DON. C/S/D/S/H/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/19/14 through 8/20/14. Good Samaritan Society Canton was found not in compliance with the following requirements: F280, F309, and F425.</p>	F 000	<p>Good Samaritan Society – Canton</p> <p>Provider #435101</p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <p>Alternatively, due to the requirements of Federal law and without prejudice as to the facility's disagreement with this deficiency, the facility submits the following plan of correction.</p>	
F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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 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: 26180 Based on record review, observation, interview, and policy review, the provider failed to ensure 2</p>	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *June Marko* TITLE: *Administrator* (X6) DATE: *9/9/14*

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 280	<p>Continued From page 1</p> <p>of 12 sampled residents (3 and 7) care plans had been revised when changes in needs had occurred. Findings include:</p> <p>1. Review of resident 3's 5/20/14 Minimum Data Set (MDS) assessment revealed she: *Required the assistance of one person to provide extensive assistance with the following activities of daily living (ADL): -Bed mobility. -Transfers. -Walking in her room and the corridor. -Moving from one location to the other in her wheelchair. -Toileting. -Personal hygiene. *Was independent with eating. *Had a current weight of 118 pounds. -She had a weight loss and was not on a physician prescribed weight loss regimen.</p> <p>Random observations on 8/19/14 and 8/20/14 of resident 3 revealed: *At mealtimes she ate without assistance after her tray was set-up. *On 8/20/14 after she ate breakfast she returned in her wheelchair to her room without any assistance from staff. -She then took herself to the bathroom, and transferred herself on and off the toilet. -CNA G then entered her room and asked the resident if she needed to go to the bathroom. The resident verified she had already gone by herself.</p> <p>Review of resident 3's physician's orders revealed a nutritional house supplement had been ordered on 8/14/14.</p> <p>Review of resident 3's weight record revealed she</p>	F 280	<p>F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE C.P.</p> <p>Resident #3 has been re-evaluated with careplan team and therapist to confirm assessment accuracy for safe mobility and hygiene assistance.</p> <p>Resident #3 careplan now reflects therapy involvement and all restorative information has been individualized on ambulation assistance as required.</p> <p>Resident #3 care plan now addresses weight loss and supplements that have been ordered.</p> <p>Resident #3 care plan reflects most recent therapy assessment and recommendations for safe transfers and assistance.</p>	<p>10/01/14 CS/SBDOH/MF</p>

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F 280	<p>Continued From page 2</p> <p>had a gradual weight loss since February 2014. Her weight six months ago on 2/21/14 was 126 pounds. Her weight on 8/15/14 was 114 pounds.</p> <p>Review of resident 3's 4/23/14 care plan revealed:</p> <p>*She required extensive assistance with:</p> <ul style="list-style-type: none"> -Moving from one location to another in her wheelchair. -Bed mobility. -Dressing and grooming. -Eating. -Personal hygiene, toileting and transferring. <p>*Focus area: "Had a need for restorative intervention due to ADL self-care performance deficit/limited physical mobility/communication problem related to confusion, dementia (memory impairment) and weakness. That had been updated on 7/28/14.</p> <p>-The intervention for this problem was "Nursing rehab #1: Walking with (SPECIFY as appropriate: X person assist; assistive device, verbal cues, etc. X distance/tolerance to increase endurance; X times/day; X days/week)"</p> <p>*Focus area: "The resident has a potential nutritional problem related to dementia, poor vision, and anxiety evidenced by fluctuating intakes."</p> <p>*The intervention included:</p> <ul style="list-style-type: none"> -Monitoring and recording food intake at each meal. -Adaptive equipment needed for eating. Uses a red divided plate at all meals. <p>Interview on 8/20/14 at 3:00 p.m. with the MDS coordinator regarding resident 3 revealed:</p> <p>*The resident had been seen by the occupational therapist (OT) for the past three weeks.</p> <p>-They were working on the resident's ability to</p>	F 280			

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F 280	<p>Continued From page 3</p> <p>have been more independent in the bathroom. -The OT had discontinued working with the resident on 8/19/14, because the resident was not capable of doing any more than she already was doing. *The resident should not have gone to the bathroom alone. -She could stand up alone if she used the grab bar in the bathroom. -She also needed assistance with hygiene after she went to the bathroom. *The care plan had not been updated when OT was working with the resident. *The nursing rehab intervention listed above had not been individualized. -What was listed on the nursing rehab care plan came directly off of the computer program. The care plan team should have individualized it by replacing the X with a specific number or frequency. *They had not updated the care plan to address her actual weight loss and the supplements that had been ordered by the physician. *The care plan was not accurate regarding the resident needing extensive assistance with her level of dependence with getting around in her wheelchair.</p> <p>2. Review of resident 7's weight record revealed her weights were: *2/17/14 - 89 pounds. *4/24/14 - 84 pounds. *6/16/14 - 86 pounds. *8/18/14 - 80 pounds.</p> <p>Review of resident 7's physician's orders revealed she received: *A nutritional house supplement three times a day Strawberry only.</p>	F 280	<p>F 280 Continued:</p> <p>Resident #7 care plan was updated to address the nutritional intervention related to the resident weight loss. Care plan specifically addresses the use of Remeron and the scheduled supplements.</p> <p>A report will be prepared which lists all nutritional supplement orders, all resident listed will have their care plan reviewed and updated to reflect individualized and accurate plan for nutritional supplements.</p> <p>A report will be prepared which lists all restorative therapy orders. All residents listed will have their care plan reviewed and updated to reflect individualized and accurate plan for restorative therapy as ordered by physician.</p> <p>Careplans will be reviewed ongoing through weekly clinical issues meetings and quarterly care-plan review meetings. Policy and Procedure for updating careplans will be presented at the September Licensed Nurses meeting.</p> <p>Audits of care plans being individualized, will be completed monthly x 3 then quarterly x2. Audit findings will be submitted to monthly QAPI meeting for review and recommendations.</p> <p>Compliance to be monitored by Director of Nursing or designee. <i>*by the Staff Development Coordinator or designee CSKDDCH/MF</i></p>	<p><i>CSKDDCH/MF</i></p> <p><i>CSKDDCH/MF</i></p>	

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

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F 280	Continued From page 4 *Remeron (a medication to stimulate appetite). Observation of resident 7 on 8/19/14 at the noon and supper meals revealed she: *Fed herself. *Had an adaptive spoon, and she ate very small bites of food. Review of resident 7's 3/31/14 care plan revealed: *Focus: The resident has a potential nutritional problem related to dehydration, edema (fluid retention), pain, esophageal stricture (narrowing of the tube between mouth and stomach), and history of poor appetite evidenced by weight loss and fluctuating intakes. *The interventions had not addressed the supplement or the medication given for weight loss. Interview on 8/20/14 at 3:00 p.m. with the MDS coordinator confirmed resident 7's care plan had not been updated with the nutritional interventions related to the resident's weight loss. Review of the provider's September 2012 care plan policy revealed "A qualified team of persons will review care plans at least quarterly. Care plans will be reviewed, evaluated and updated when there is a significant change in the resident's condition and /or in accordance with state guidelines. This plan of care will be modified to reflect the care currently required/provided for the resident.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	<p>Continued From page 5</p> <p>provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (9 and 10) receiving hospice services had those services included in their care plans. Findings include:</p> <p>1. Review of resident 9's 5/30/14 physician's order revealed there was an order for hospice services.</p> <p>Review of resident 9's 6/28/14 Minimum Data Set (MDS) assessment revealed she was receiving hospice services.</p> <p>Review of resident 9's 6/23/14 care plan revealed: *A focus: Resident had a terminal prognosis related to congestive heart failure evidenced by health decline. -An intervention was to consult with a health care provider and social services to have hospice care for resident in the facility. *There was no other mention of the hospice services that had been part of this resident's care at this time.</p> <p>2. Review of resident 10's physician's orders revealed hospice services had been ordered to</p>	F 309	<p>F309 Provide Care/Services for Highest Well Being</p> <p>The hospice plan of care for Resident #9 was scanned into Resident #9 medical record. The hospice cares and plans were then integrated within the facility care plan with identification which cares are being provided by which provider.</p> <p>Resident #10 passed away on 9/01/14.</p> <p>All current residents receiving hospice services will have their care plan reviewed to reflect a coordinated comprehensive plan of care jointly developed by the center and hospice. The resident care plans will be updated as needed.</p> <p>Audits will be completed on careplans of residents receiving hospice services. These audits will be completed monthly x2 then quarterly x2. Audit findings will be presented to the monthly QAPI committee meeting for review and recommendations.</p> <p>Compliance to be monitored by Social Worker or designee. *by the Staff Development Coordinator or designee. CS/SDDH/ME</p>	<p>CS/SDDH/ME</p> <p>10/1/14</p>

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F 309	<p>Continued From page 6 start on 8/5/14.</p> <p>Review of resident 10's undated care plan revealed: *A focus: Resident had an activity of daily living, self care performance deficit related to congestive health failure, weakness, fatigue (tired), arthritis, and end of life condition. That had been revised on 8/13/14. -There were no interventions related to hospice services. *A focus: Resident had a terminal prognosis related to bowel obstruction evidenced by health decline. -The intervention was to consult with health care provider and social services to have hospice care for the resident in the facility. *There was no other mention of the hospice services that had been part of the resident's care at this time.</p> <p>3. Interview on 8/20/14 at 4:00 p.m. with the Minimum Data Set (MDS) assessment coordinator and the director of nursing regarding residents 9 and 10 revealed: *They were unaware the hospice services were to have been included in their care plans. *They agreed their care plans had not addressed the specifics of hospice services.</p> <p>Review of the provider's September 2010 hospice services provided in a skilled nursing facility policy revealed: **A coordinated comprehensive plan of care shall be jointly developed by the center and hospice. Hospice participation in the care plan conference and input from the hospice representative is required. *The hospice care plan should be filed under the</p>	F 309			

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F 309	Continued From page 7 Care Plan tab to facilitate an integrated care plan."	F 309		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, observation, interview, and policy review, the provider failed to: *Date ten of twenty seven multi-dose medication containers when opened in one of one medication cart. *Document the disposition (what happened to them) of medications after one of one sampled resident was discharged and transferred to	F 425	F425 PHARMACEUTICAL SVC – ACCURATE PROCEDURES All medications of the south wing medication cart are now marked on each container with date opened for use. The north wing medication cart and the north and south medication rooms had all medication containers reviewed for appropriate labeling on the container of date open for use. The policy and procedure for proper labeling of medication containers when opened for use will be addressed and reviewed at the September 2014 licensed nurses meeting. Audits will be conducted of the north and south medication carts and north and south medication rooms to verify proper labeling of medication containers opened for use. Audits will be completed bi-weekly x2, then monthly x2, then quarterly x1. Audit findings will be presented to the monthly QAPI committee meeting for review and recommendations. Compliance will be monitored by Director of Nursing or designee. <i>*by the Staff Development Coordinator or designee</i>	 CS/DSD/HMF 10/1/14  CS/DSD/HMF

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F 425	Continued From page 8 another provider (13). Findings include: 1. Observation on 8/20/14 at 1:15 p.m. of the south wing medication cart revealed ten of twenty-seven multi-dose medication containers in the second drawer had not had the date the containers were opened for use documented on the container. Interview on 8/20/14 at 5:25 p.m. with the director of nursing (DON) revealed she agreed that all medication containers should have had an opened date documented on the container. Review of the provider's September 2012 Bulk -Over-the-Counter Medications policy revealed bulk medication containers were to have been dated when opened. Review of the provider's December 2012 Medications with Special Expiration Date Requirements guidelines revealed the date of opening should have been noted on the medication container/vial. 2. Review of resident 13's complete medical record revealed there was no documentation concerning the disposition (what happened to them) of medications when the resident was discharged and transferred to another provider for care. Interview on 8/20/14 at 5:25 p.m. with the DON revealed she agreed there was no documentation concerning the disposition of medications when resident 13 had been discharged and transferred out of the facility.	F 425	F 425 Pharmaceutical SVC – Accurate Procedures, RPH. Continued: Resident #13 was discharged from facility. The policy and procedure for proper documentation concerning disposition of medications when residents are discharged or transferred out of facility will be reviewed at the September 2014 licensed nurses meeting. Audits will be conducted on discharged/transferred resident charts monthly x3 then quarterly x1 with audit findings presented to monthly QAPI committee meetings for review and recommendations. Compliance will be monitored by Health Information Manager or designee. <i>* by the Staff Development Coordinator or designee</i> <i>CSDDDH/ME</i>	CSDDDH/ME	

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F 425	Continued From page 9 Review of the provider's September 2012 Disposition of Medications procedure revealed there should have been documentation on medication disposition that included the: *Resident's name. *Medication name. *Prescription number if applicable. *Quantity. *Date of disposition. *Involved staff, consultant, or other applicable individuals.	F 425			

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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 8/19/14. Good Samaritan Society Canton 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>Julie Marko</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/9/14</i>
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SEP 12 2014
If continuation sheet Page 1 of 1
SD DOH LSC

South Dakota Department of Health

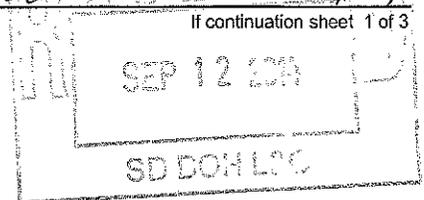
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
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S 000	Initial Comments Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/19/14 through 8/20/14. Good Samaritan Society Canton was found not in compliance with the following requirements: S210 and S236.	S 000	<p align="center">Good Samaritan Society – Canton</p> <p>Provider #10604</p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <p>Alternatively, due to the requirements of Federal law and without prejudice as to the facility's disagreement with this deficiency, the facility submits the following plan of correction.</p> <p>S 210 44:04:04:06 Employee Health Program</p> <p>Employees (A,B,C,D and E) of the survey sample have been evaluated and had appropriate form completed which states each sample employee has been evaluated by a health professional to determine they were free from a reportable communicable disease.</p>	
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable 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. 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 the physician's designee to no longer have the disease in a communicable stage. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on employee file review and interview, the provider failed to ensure five of five newly hired sampled employees (A, B, C, D, and E) were evaluated by a health professional to determine they were free from a reportable communicable	S 210		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julie Marks</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/9/14</i>
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10/1/14

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1022 N DAKOTA AVENUE CANTON, SD 57013
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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 210	Continued From page 1 disease. Findings include: 1. Review of employees A, B, C, D, and E's employee files revealed: *They had all become employed by the provider since January 2014. *They had not been evaluated by a health professional to determine they were free from a reportable communicable disease. Interview on 8/20/14 at 4:45 p.m. with the staff development coordinator revealed: *She had not been aware of this requirement. *She had not included that evaluation in any of the above employees health records. *Their policy would have been to follow the state requirements.	S 210	S 210 continued: All current employees hired since 2013 health dept survey will be evaluated and the appropriate form will be completed stating the employee has been evaluated by a health professional and is determined to be free from a reportable communicable disease. <i>*by the staff development coordinator or designee</i> Audit of new employee files will be completed monthly x2 then quarterly x2 to determine compliance with this regulation. Audit findings will be presented at monthly QAPI meeting for review and recommendations. Compliance to be monitored by Infection Control Nurse or designee.	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active	S 236	S 236 44:04:04:08:01 Tuberculin screening requirements: As of July 8, 2014, all new employees have received the TB mantoux 2 step method skin test upon hire <i>*including employees A, B, C, D and E.</i> Audit of new employee files will be completed monthly x2, then quarterly x2 to determine compliance with this regulation of 2 TB mantoux 2 step method skin test upon hire. Audit findings will be presented at monthly QAPI meeting for review and recommendations. Compliance to be monitored by Infection Control Nurse or designee.	 10/01/14 <i>CSJSD/DMF</i>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1022 N DAKOTA AVENUE CANTON, SD 57013		
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S 236	<p>Continued From page 2</p> <p>disease;</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180</p> <p>Based on employee file review, interview, and policy review, the provider failed to ensure five of five newly hired sampled employees (A, B, C, D, and E) received the two-step Tuberculin (TB) screening within two weeks of employment. Findings include:</p> <p>1. Review of employees A, B, C, D, and E's employee files revealed: *They had all become employed by the provider since January 2014. *They had not received the two-step TB screening upon being hired.</p> <p>Interview on 8/20/14 at 4:45 p.m. with the staff development coordinator revealed: *She had not been aware until recently that the two-step TB screening was a requirement. *They had not been doing that when the above employees were hired. *She expected their policy to follow the regulatory requirements.</p> <p>Review of the provider's March 2014 TB skin testing policy revealed: *"New employees will have baseline TB screening using the TST two-step method. This involves administering the initial TST [two step tuberculin] to be read in 48 hours by a nursing professional or physician. The second test is administered in one to two weeks and is read 48 to 72 hours after administration by a nursing professional or physician."</p>	S 236		