

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

ORIGINAL

PRINTED: 04/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435117	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DEUEL COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 913 COLONEL PETE STREET CLEAR LAKE, SD 57226	
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F 000	INITIAL COMMENTS Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/14/14 through 4/16/14. Good Samaritan Society Deuel County was found not in compliance with the following requirements: F279, F281, F329, F441, and F498.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy	F 279	F 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS For resident # 2 the care plan and kardex have been updated to reflect the resident's indwelling foley catheter with measurable goals and interventions identified. The ambien was discontinued and non-pharmacological interventions to aid in sleep have been added to the care plan. For resident # 1 and resident # 5 the care plan and kardex have been updated to reflect the resident's indwelling foley catheter with measurable goals and interventions identified. For all other potential residents with physician orders for an indwelling catheter, the care plan and kardex will be updated to reflect the catheter (continued)	

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

TITLE

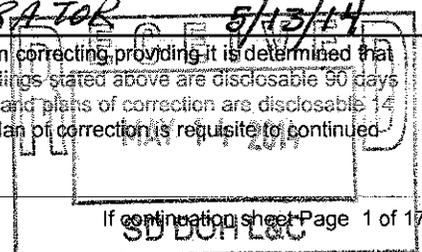
(X6) DATE

James Bloch, RHA

ADMINISTRATOR

5/13/14

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 279	<p>Continued From page 1</p> <p>review, the provider failed to revise three of nine sampled residents' (1, 2, and 5) care plans to reflect their individual needs. Findings include:</p> <p>1. Review of resident 2's 3/11/14 physician's orders revealed he: *Had an indwelling Foley catheter (tube inserted into the bladder to drain urine) for urinary retention (difficulty urinating). *Was on Ambien (medication to induce sleeping) as needed for insomnia (difficulty sleeping).</p> <p>Review of resident 2's undated care plan revealed: *No documentation regarding his indwelling Foley catheter. *Insomnia was addressed with no interventions or goals. Surveyor: 34030 Preceptor 32355</p> <p>2. Review of resident 1's 2/12/14 quarterly Minimum Data Set (MDS) assessment revealed she had an indwelling Foley catheter.</p> <p>Review of resident 1's 1/29/14 physician orders revealed she had an indwelling Foley catheter.</p> <p>Review of resident 1's care plan printed on 4/14/14 revealed the use of the Foley catheter had not been addressed.</p> <p>Surveyor: 32335</p> <p>3. Review of resident 5's 12/5/13 annual MDS assessment revealed he had an indwelling Foley catheter. The care area assessment summary revealed "urinary incontinence and indwelling catheter" should have been addressed on his care plan.</p>	F 279	<p>with measurable goals and interventions identified. For all other potential residents the care plan will be updated to reflect non-pharmacological interventions used to aid in sleep. The care plan and kardex will be reviewed and re-evaluated quarterly or with significant change with the MDS process and when resident is in review for the facility's Quality of Life meeting.</p> <p>IN-SERVICE: Education will be provided by the DNS on 5/19/2014 to the nurses for care plan updates, non-pharmacological interventions.</p> <p>AUDITS: Audits will be completed by the MDS nurse or designee to ensure the care plan and kardex reflect a resident's indwelling catheter with goals and interventions identified. Audits will be completed by the MDS nurse or designee to ensure the care plan and kardex reflect non-pharmacological interventions if need be as aid for sleep. Audits will be completed by the MDS nurse or designee weekly x one month and (continued)</p>	

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F 279	Continued From page 2 Review of resident 5's April 2014 treatment record revealed he still had the indwelling catheter. Review of resident 5's care plan printed on 4/14/14 revealed the indwelling catheter had not been addressed on the care plan. Interview on 4/16/14 at 8:30 a.m. with the director of nursing and the staff development coordinator revealed they had not addressed the indwelling catheter on his care plan. The kardex the certified nursing assistants used for quick reference had not included the indwelling catheter either. They were aware it had been a care area addressed on the MDS. 4. Review of the provider's September 2012 care plan policy revealed: **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 279	monthly x 4 months to ensure the care plans and kardex reflect changes with the resident's status, and measurable goals and interventions are identified. The MDS nurse or designee will submit a monthly report of the audit findings and outcomes to the monthly QA committee for further recommendations.	6/5/14	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure the following for one of	F 281	F281 483.20(k)(3)(i) SERVICES MEET PROFESSIONAL STANDARDS DNS met with Resident #2 on 5/09/14 to provide education on pharmacy recommendation of administration of sertraline at bedtime to help with sleep. Resident agreeable to this, physician updated (continued)		

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F 281	<p>Continued From page 3 one sampled resident (2): *Pharmacy recommendations were followed for hypnotic (medication to induce sleep). *Non-pharmacological approaches were documented to induce sleep prior to the administration of a hypnotic. *The effectiveness of a hypnotic medication administered was documented. *Physician orders were transcribed completely. Findings include:</p> <p>1. Review of resident 2's 10/31/13 physician's orders revealed sertraline (antidepressant medication) 50 milligrams one and one-half tablet by mouth daily.</p> <p>Review of the resident's October 2013 through April 2014 medication administration record (MAR) revealed the sertraline had been administered at 8:00 a.m. daily.</p> <p>Review of resident 2's 12/5/13 and 3/16/14 pharmacy recommendations revealed: *"Please consider moving sertraline to bedtime to aid with sleep." *There was documentation by the 12/5/13 recommendation "Not changed as on Ambien (hypnotic medication to induce sleep) started on 12/3/13.</p> <p>Review of resident 2's 3/25/14 physician's orders revealed "Discontinue hydrocodone (narcotic pain medication) and Ambien."</p> <p>Review of resident 2's 12/5/13 through 4/15/14 as needed (PRN) documentation notes revealed: *Ambien was documented as administered eleven times for sleep. *There was no documentation regarding any</p>	F 281	<p>on this information, and order to give sertraline at HS obtained on 5/12/14. Resident #2 and night staff were educated on use of non-pharmacological interventions to aid in sleep. Non-pharmacological interventions will be offered to Resident #2 or any other potentially affected residents prior to offering medications for sleep. Hydrocodone and Ambien removed from Resident #2's MAR on 5/09/14. To ensure services provided by this facility meet professional standards, education will be provided by DNS at 5/19/14 Nurses' Meeting reviewing the GSS Policy and Procedure on sleep assessments, use of non-pharmacological interventions, and follow-up documentation on effectiveness of the interventions and / or medications. DNS or designee to audit pharmacy review monthly x 4 to ensure that all recommendations are addressed with physician. DNS or designee to audit charts of 5 residents with diagnosis of insomnia (continued)</p>	

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F 281	<p>Continued From page 4</p> <p>non-pharmacological interventions to induce sleep prior to the administration of the Ambien. *There was no documentation for seven of the doses of Ambien administered if it had been effective to promote sleep.</p> <p>Review of resident 2's April 2014 MAR revealed both the hydrocodone and Ambien remained as current medications.</p> <p>Interview on 4/15/14 at 3:00 p.m. with the director of nursing regarding resident 2 revealed: *His sertraline had been reviewed in quality of life related to the pharmacist's recommendations to change the time from morning to bedtime. *He preferred to continue taking the sertraline in the morning. *She was not sure if he had been educated that the rational of changing the time of the sertraline to bedtime was to help him sleep as that had not been documented. *All the PRN doses of administered Ambien should have had follow-up documentation of the effectiveness on his sleep. *Non-pharmacological interventions should have been tried prior to the administration of the Ambien and should have been documented. *The hydrocodone and Ambien should not have been left on the current MAR.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th ED., St. Louis, MO, pp. 958-959, revealed: **"Consider alternative approaches to promote sleep." **"When a patient has a sleep problem, conduct a complete sleep history. Diagnosing sleep problems depends on identifying factors that impair sleep."</p>	F 281	<p>for use of non-pharmacological interventions, use of sleep medications, review of orders, and follow up documentation. Audits will be conducted weekly x 4, then monthly x 4 or as directed by QA committee. The DNS or designee will report the results of the audits to the monthly QA committee for further recommendations based upon audit findings and determine the need for continued review or monitoring.</p>	6/5/14	

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F 281	Continued From page 5 **"Routine monitoring of patient response to sleeping medication is important."	F 281		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Preceptor: 32355 Based on interview, record review, and policy review, the provider failed to ensure duplicate	F 329	F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Concerns regarding Resident #1's drug regimen were addressed with the physician on 4/18/14. Ambien and Zoloft were discontinued on 4/18/14. Resident's use of Lexapro (cited as Celexa) and Trazadone as well as other medications will continue to be monitored at resident's quarterly Quality of Life meetings, upon completion of MDS, and with Significant change. Review of all residents' medication regimens to be conducted by Quality of Life committee at individually scheduled meetings, upon completion of MDS, and with significant change. Education to be provided by DNS at 5/19/14 mandatory Nurses' Meeting (with make-up no later than 5/26/14) on GSS Medication Policy and Procedure, (continued)	

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F 329	<p>Continued From page 6</p> <p>medications for depression and for sleep were not ordered and administered for one of five sampled residents (1). Findings include:</p> <p>1. Review of resident 1's April 2014 medication administration record (MAR) revealed she had received:</p> <ul style="list-style-type: none"> *Ambien on an as needed basis and Trazodone once daily at night for sleep. From 4/1/14 to 4/15/14, eight doses of Ambien were given in addition to the once nightly Trazodone. *Both Celexa and Zoloft were given once daily from 4/1/14 to 4/15/14 for depression. <p>Review of the 1/25/14, 2/28/14, and 3/27/14 consulting pharmacist's reports revealed no duplicate medications had been noted by the pharmacist or reported to the physician.</p> <p>Interview, MAR review, and policy review on 4/16/14 at 2:45 p.m. with the director of nursing regarding resident 1's above noted duplicate medications revealed:</p> <ul style="list-style-type: none"> *Physician notification of the above noted duplicate therapy had not been completed by the pharmacist and nursing staff. *She agreed the pharmacist had not noted the duplicate medication therapy. *Nursing staff had not found the duplicate medication therapy noted above. *The provider's September 2012 unnecessary medications policy and procedure stated "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." *She confirmed they had not followed their September 2012 Unnecessary Medication policy. 	F 329	<p>the need to recognize duplicate medications and provide physician notification of any findings. DNS to review GSS Policy and Procedure on Unnecessary Drugs with nurses at 5/19/14 meeting and at meeting with pharmacist on 5/14/14.</p> <p>To ensure that residents' drug regimens are free of unnecessary drugs, DNS or designee will audit 3 - 5 charts to compare medications with diagnoses – reviewing for duplicate medications – weekly x four weeks and then monthly x 4 months.</p> <p>The DNS or designee will report the results of the audits to the monthly QA committee for further recommendations based upon audit findings and determine the need for continued review or monitoring.</p>	6/5/14	

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F 441 F 441 SS=E	Continued From page 7 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a 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.	F 441 F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The procedures for Catheter Drainage Bag Emptying, Standard Precautions (including glove use), and Cleaning of Blood/Body Fluid Spills were reviewed with CNA B and direct observation of proper catheter bag emptying was completed by the Infection Prevention Nurse on 5/8/2014. Review of the same procedures with facility CNAs will be conducted 5/21/2014 at the CNA Meeting by the Infection Prevention Nurse. Auditing for proper Catheter Bag Emptying, Glove Use and Cleaning of Blood/Body Spills when applicable will be completed 3 times weekly for 2 weeks, 1 time weekly for 4 weeks by the Infection Prevention Nurse or designee and will be reported to the monthly QA/CQI Committee Meeting by the Infection Prevention Nurse or designee for further recommendations of the committee. (continued)	

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F 441	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained: *To ensure one of one sampled resident's (1) Foley drainage bag (collects urine) was emptied in a sanitary manner. *For proper storage of treatment medications in one of two observed medication rooms (north wing). *For proper glove use by one of two staff members licensed practical nurse (LPN) C for one of two residents (2) observed blood sugar checks. *To ensure electric razors had been cleaned and were free from compacted hair and dried skin debris for three of four observed resident's razors (5, 11, and 12). *To ensure three of five observed residents' (1, 13, and 14) oxygen concentrator filters had been cleaned and were free from lint. *For one of one observed microwaves in the therapy room was dirty inside with tan/brown debris. Findings include: 1. Observation on 4/15/14 at 5:20 p.m. of certified nursing assistant (CNA) B during the emptying of a Foley drainage bag for resident 1 revealed: *She had washed her hands and put on a pair of gloves. *With those gloves she had: -Removed the resident's Foley drainage bag cloth cover. She had laid the cover directly on the floor. -Placed a graduate (plastic measuring container)	F 441	Direct observation of correct glove use during Blood Glucose Monitoring by LPN C was completed on 5/8/2014 by the Infection Control Nurse. The Procedure for Blood Glucose Monitoring will be reviewed with the nurses at the Professional Nurse's Meeting 5/19/2014. Auditing for proper glove use during Blood Glucose Monitoring will be completed by the Infection Prevention Nurse or designee weekly for 4 weeks and then monthly for 4 months and will be reported to the monthly QA/CQI Committee Meeting by the Infection Prevention Nurse for further recommendations of the committee. Oxygen concentrator filters for residents 1, 13, and 14 were cleaned and documented on the MAR/TAR on 4/27/2014. All oxygen concentrator filters, in use by residents on 5/8/2014 were clean and lint free and had been documented on the MAR/TAR. Auditing of 3 to 5 oxygen concentrator filters for cleanliness / lint free and documentation (continued)		

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F 441	<p>Continued From page 9</p> <p>underneath of the Foley drainage bag.</p> <ul style="list-style-type: none"> -Emptied the urine from the Foley drainage bag into the graduate. She had filled the graduate with urine to the edge of the opening. -Upon picking up the graduate she spilled urine on the floor. -Gone into the bathroom and emptied the rest of the urine into the toilet and flushed the toilet. -Touched the handle on the faucet and turned the water on to rinse out the graduate. -Retrieved some paper towels and a hand towel. -Wiped up the urine on the floor with the paper towels and hand towel. -Opened the resident's top dresser drawer and retrieved a plastic garbage bag to place the soiled towel inside. -Picked up the resident's cloth Foley drainage bag off of the floor and covered the bag. -Moved the resident's wheelchair (w/c) by using the handles. -Assisted the resident into her w/c. -Removed her gloves and washed her hands. <p>Interview on 4/16/14 at 10:00 a.m. with the staff development coordinator confirmed the above process had not been a sanitary process. She had no audits to review for education regarding the emptying for the Foley drainage bags. She had been unaware that glove use and proper handwashing had been an issue with emptying Foley drainage bags.</p> <p>Review of the provider's November 2013 Catheter Drainage Bag Emptying policy and procedure revealed no process in place for changing of gloves or what should be done with the spilling of urine.</p> <p>2. Observation on 4/15/14 at 11:20 a.m. with LPN</p>	F 441	<p>of cleaning will be completed by the Infection Prevention Nurse or designee weekly for 4 weeks then monthly for 4 months and will be reported to the monthly QA/CQI Committee Meeting by the Infection Prevention Nurse or designee for further recommendations of the committee.</p> <p>The microwave oven in the Therapy Area was removed from the Therapy Area on 4/16/2014. An audit of 3 pieces of equipment for cleanliness after use in the Therapy Room will be completed weekly for 4 weeks then monthly for 4 months by the Infection Prevention Nurse or designee and reported to the montly QA/CQI Committee for further recommendation by the Infection Prevention Nurse or designee. Electric Razors for individual use for residents 5, 11, and 12 were checked for cleanliness following use on 5/1/2014. Razor for resident 11 was found to have a small amount of gray debris which was cleaned from the razor by the Infection Prevention Nurse. (continued)</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435117	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DEUEL COUNTY		STREET ADDRESS, CITY, STATE, ZIP CODE 913 COLONEL PETE STREET CLEAR LAKE, SD 57226		
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F 441	<p>Continued From page 10</p> <p>C during a blood sugar check for resident 2 revealed:</p> <ul style="list-style-type: none"> *She had sanitized her hands and put on a pair of clean gloves. *With those gloves she had: <ul style="list-style-type: none"> -Opened the medication cart and retrieved all of the supplies necessary to do a blood sugar check. -Knocked on the resident's door and pushed open the door with the palm of her hand. -Held the resident's right hand while performing the blood sugar check. *Removed her gloves and retrieved all of her supplies. *Left the room without sanitizing or washing her hands. <p>Interview on 4/15/14 at the time of the above observation with LPN C confirmed she had not maintained a sanitary process leaving the potential for cross-contamination. She stated she had been audited two weeks ago on the same process.</p> <p>Interview on 4/16/14 at 10:05 a.m. with the staff development coordinator revealed:</p> <ul style="list-style-type: none"> *She had been doing audits on the blood sugar testing. *The above LPN had just been re-educated on the proper procedure for blood sugar testing. *She confirmed the above observation had provided the potential for cross-contamination. <p>Review of the provider's November 2013 Blood Glucose Monitoring procedure revealed the staff were to have gathered the necessary supplies prior to putting on gloves.</p> <p>3. Observation on 4/16/14 at 1:30 p.m. of the</p>	F 441	<p>The Infection Prevention Nurse will review the facilities procedure for cleaning of the electric razors after individual resident use with the CNAs at the 5/21/2014 CNA Meeting. As residents provide their own electric razors and electric razors are used only by the individual resident.</p> <p>*ADDENDUM to Shaving Procedure was added 5/9/2014 [If cleaning of a resident's electric razor beyond the daily cleaning is needed the manufacture's recommendation for the individuals razor will be followed.] Audits of 3 to 5 individual resident use electric razors for cleanliness after use will be completed by the Infection Prevention Nurse or designee weekly X 4 weeks and then monthly X 4 months and reported to QA/CQI Committee by the Infection Prevention Nurse or designee for further recommendation.</p> <p>Items in the container in the North Medication Room containing multiple "comingled" resident use external medications were separated</p> <p>(continued)</p>	

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F 441	<p>Continued From page 11</p> <p>medication room on the north wing revealed: *There had been four plastic containers on top of the counter. *Those containers had contained multiple resident use treatment supplies. Those treatment supplies had been individually marked with the residents' names for individualized use. *Inside of one of the containers revealed multiple resident use treatment products co-mingled (mixed) together. *Those items had been: -One tube of arthritis cream. -Two tubes of hydrocortisone cream (steroidal medication). -Three bottles of Nyamyc (anti-fungal powder) to be applied to groins and abdominal folds. -One bottle of Freeze-it (pain relief medication). -One tube of lidocaine ointment (pain relief medication).</p> <p>Interview on 4/16/14 at the time of the observation with the director of nursing (DON) confirmed the resident treatment supplies should not have been stored together. The treatment supplies should have been stored in separate bags or containers.</p> <p>The provider had no policy for the storage of treatment medications.</p> <p>4. Random observations from 4/14/14 through 4/15/14 of three electric razors revealed: *The razors had been located in residents' 1, 13, and 14's rooms. *Inside of the razors was compacted hair and dried skin debris.</p> <p>Interview on 4/15/14 at 10:45 a.m. with the DON and staff development nurse revealed the razors</p>	F 441	<p>into closeable plastic bags for individual residents by the charge nurse on 4/17/2014. On 5/8/2014 the North and South Medication Room and Medication Carts were checked by the charge nurse and Infection Prevention Nurse and all resident external medications were stored in individual storage containers or closable bags. ADDENDUM to Acquisition, Receiving, Dispensing and Storage of Medications Procedure was added 5/12/2014 [Individual resident treatment items will be stored separately in plastic container or closable plastic bags to prevent "comingling" of residents' treatment items.] Review of facility procedure for Acquisition, Receiving, Dispensing and Storage of Medications will be reviewed with the nurses at the Professional Nurse's Meeting 5/19/2014 by the Infection Prevention Nurse. An audit of North and South Medication Rooms (continued)</p>	

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F 441	<p>Continued From page 12</p> <p>should have been emptied after each use. Night shift was to have sanitized the razors weekly. There was no documentation to support when that had been done.</p> <p>Review of the provider's 10/6/13 CNA staff meeting revealed education had been provided for the cleaning of razors.</p> <p>Review of the provider's revised November 2012 night shift cleaning schedule revealed the disinfecting of the electric razors was not found on the list of items for cleaning.</p> <p>Review of the provider's November 2013 Shaving procedure revealed: *The razor head was to have been cleaned after each use. *There was no procedure on the disinfecting process for the electric razors.</p> <p>5. Random observations from 4/14/14 through 4/15/14 of oxygen concentrators located in residents' 1, 13, and 14's rooms revealed the filters were dirty with white/gray debri. The debri made a small clouded area when poked by this surveyor.</p> <p>Interview on 4/15/14 at 10:50 a.m. with the DON and staff development nurse revealed: *The oxygen concentrator filters were to have been cleaned by the nurses every Tuesday. *The nurses were to have charted on the treatment administration record (TAR) upon completion of cleaning the filters. *Review of resident 1's March and April 2014 TARs revealed no documentation for cleaning oxygen concentrator filters. *The DON had added an area on resident 1's</p>	F 441	<p>and medication carts for proper storage of individual resident external medications will be completed by the Infection Prevention Nurse or designee weekly for 4 weeks then monthly for 4 months and reported to the monthly QA/CQI Committee Meeting for further recommendations.</p>	6/5/14

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F 441	Continued From page 13 TAR for documentation of cleaning her oxygen concentrator filters the day of this interview. Review of the provider's January 2009 Oxygen Concentrator procedure revealed the filters should have been cleaned weekly and documented on the TAR. 6. Observation on 4/15/14 at 9:50 a.m. of the therapy room revealed: *A kitchen area with a microwave unit on the counter. *Inside the microwave unit there was brown/tan debri. *The debri was stuck to the sides, top, bottom, and plate of the microwave unit. Interview on 4/15/14 at the time of the above observation with physical therapist F confirmed the above findings. She stated all the therapists in the department were responsible for cleaning and the upkeep of the microwave. Interview on 4/16/14 at 11:10 a.m. with the DON revealed she had been unaware the therapists had been using the microwave. She stated the therapists should have been cleaning the microwave after using it.	F 441		
F 498 SS=B	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 498		

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F 498	Continued From page 14 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and manufacturer's instructions review, the provider failed to: *Train staff according to the manufacturer's instructions on how to use Broda chairs (tilt and recline positioning wheelchairs) for three of three observed residents (4, 13, and 15) using those type of chairs. *Document training provided to staff regarding Broda chairs. Findings include: 1. Observation on 4/15/14 at 11:40 a.m. in the dining room revealed: *Resident 15 was in a Broda chair. -She had been brought to the table and put into an upright position. -Staff had walked away from the table after placing her in an upright position. *Resident 4 was in a Broda chair positioned up to the table in an upright position. -She had been leaning forward reaching for items on the table. *Resident 13 had been in a Broda chair, and his feet had not been positioned in the foot rest. Observation on 4/15/14 at 5:30 p.m. of resident 13 revealed he: *Had been in a Broda chair. *Had been positioned in an upright position and was at the dining room table. *Had been reaching forward trying to get to the	F 498	F 498 483.75 (f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS Resident 13 is no longer using a Broda Seating Chair. Resident 15, 4, and all other residents using the Broda Seating Chair will be evaluated by a Skilled Therapist for proper positioning, seat tilt, comfort and safety recommendations and the residents care plan and Kardex will be updated by the Restorative Nurse to reflect the Therapist's recommendations appropriate for the individual residents. Training as recommended by the manufacturer will be provided for employees operating, performing maintenance or moving the resident's Broda Seating Chair on 5/28/2014 by the Staff Development Director. The operator's manual for the Broda Seating Chair will be available in the Restorative Nurse's office for employee reference. Employees operating, maintaining, or moving the Broda Seating Chair (continued)		

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F 498	<p>Continued From page 15 food placed in front of him. *Appeared agitated and continued to reach forward and was not able to reach the food.</p> <p>Interview on 4/16/14 at 10:30 a.m. with certified nursing assistant (CNA) D revealed she had been employed with the provider for three years. She had not received training on the Broda chairs with this provider.</p> <p>Interview on 4/16/14 at 8:15 a.m. and at 2:00 p.m. with the staff development coordinator regarding Broda chair training revealed: *The provider currently had two different types of Broda chairs being used. *CNAs who had been trained in other facilities had not received training on the Broda chairs. She expected them to have had previous training on using Broda chairs. *Staff who received CNA training at the facility received a hands on training. They did not read the manual. -They had no documentation those staff had received training on the Broda wheelchairs. *She had not read the manufacturer's instructions on the Broda chairs.</p> <p>Interview on 4/16/14 at 2:00 p.m. with Minimum Data Set coordinator I revealed she had provided hands-on training to new CNAs. She could not remember when she had read the manufacturer's instruction manual for the Broda chairs.</p> <p>Review of the manufacturer's instructions for the Broda chair provided by the facility revealed: **"Anyone involved with the operation or maintenance of the Broda chair, including resident's family members, must read this operating manual before using the chair."</p>	F 498	<p>employed after 5/28/2014 will receive training as recommended by the Broda Seating Chair manufacturer during General Orientation by the Staff Development Director or designee. Audits will be completed weekly for 4 weeks and then monthly for 4 months by the Staff Development Director or designee for proper operation of the Broda Seating Chair by employees and completed training and audit results will be reported to the QA/CQI Committee monthly by the Staff Development Director or designee for committee's recommendation.</p>	6/5/14	

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F 498	Continued From page 16 **The resident's primary caregiver is responsible for ensuring that anyone who is unfamiliar with, unwilling, or unable to adhere to the safety and operating instructions, is not permitted to operate or move the chair." **When a resident has been moved to their destination, the chair is placed where the resident cannot reach handrails or other objects, fixed or movable. This is to prevent the resident from pulling the chair over or pulling themselves off the seating surface and to prevent the resident from pulling movable objects onto their chair or themselves." **We recommend that the resident's feet be correctly positioned on the footrests and slightly to fully elevated to prevent the resident from sliding or falling forward off the chair."	F 498			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY DEUEL COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 913 COLONEL PETE STREET CLEAR LAKE, SD 57226
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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 4/15/14. Good Samaritan Society Deuel County 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>James Block, RHA</i>	TITLE ADMINISTRATOR	(X6) DATE 5/13/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S 000	<p>Initial Comments</p> <p>Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/14/14 through 4/16/14. Good Samaritan Society Deuel County was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

James Bloch, NHA

TITLE

ADMINISTRATOR

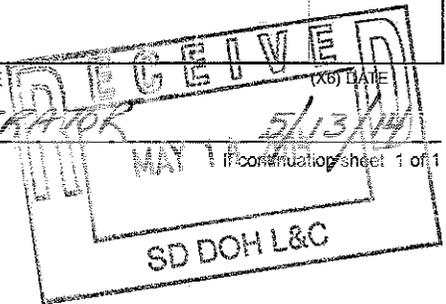
(X6) DATE

5/13/14

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If continuation sheet 1 of 1