

ORIGINAL

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CORSICA	STREET ADDRESS, CITY, STATE, ZIP CODE 455 NORTH DAKOTA CORSICA, SD 57328
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F 000 INITIAL COMMENTS

Surveyor: 12218
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/7/14 through 1/9/14. Good Samaritan Society Corsica was found not in compliance with the following requirements: F156, F280, F281, and F309.

F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
SS=B

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.

F 000

Addendums noted with an asterisk per 2/13/14 telephone to facility DON.

MJH/SDDOH/JJ

F 156

- F 156
1. Unable to change the notification of benefits for residents 5 and 12.
 2. All residents receiving Medicare benefits will receive timely notifications when services are ending.
 3. The administrator will provide education to the Medicare team regarding the notification of benefits process on 2/4/2014.
 4. The administrator or designee will audit Medicare non-coverage notices to assure all were done timely. These audits will be done weekly X4 and then monthly X4. The administrator or designee will report audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed.

2/5/14

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

Felix Nelson

TITLE

Administrator

(X6) DATE

2/4/14

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.

FEB 6 2014

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F 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	F 156			

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F 156	<p>Continued From page 2</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to ensure two of three sampled residents (5 and 12) had been notified in a timely manner that services would be ending. Findings include:</p> <ol style="list-style-type: none"> 1. Review of resident 5's notice of medicare non-coverage form revealed her skilled nursing services had ended on 12/18/13. Her power of attorney had signed the form on 12/17/13. 2. Review of resident 12's notice of medicare non-coverage form revealed his skilled nursing services had ended on 12/4/13. His power of attorney had signed the form on 12/5/13. <p>Review of the certified mail receipt revealed the notice had been delivered to resident 12's power of attorney on 12/5/13.</p> <ol style="list-style-type: none"> 3. Interview on 1/9/14 at 9:00 a.m. with registered nurse A revealed notices should have been 	F 156		
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F 156	Continued From page 3 delivered to power of attorneys at least two days prior to the services ending.	F 156			
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 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans were updated and revised for two of ten sampled residents (1 and 6). Findings include: 1. Review of resident 1's medical record revealed:	F 280	F 280 1. Resident 1's care plan has been updated to reflect the ability to self-administer nebulizer treatments. Resident 6's care plan has been updated to reflect the use of supportive shoes and braces. The bilateral ankle replacement diagnosis has been added to the cumulative diagnosis list. 2. All residents will have their care plan reflect any unique characteristics, issues, conditions, strengths and weaknesses. 3. The DNS will provide education to the care team and nursing staff regarding the importance of updating the care plan with changes, keeping the care plan individualized for each resident and specific strengths and weaknesses on 1/28/2014. 4. The DNS or designee will review care plans to assure they are being updated timely, have resident specific issues, concerns, and interventions to assist in providing	2/6/14	

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F 280	<p>Continued From page 4</p> <p>*A physician's order dated 12/2/13 for DuoNeb (for shortness of breath) nebulizer solution.</p> <p>*A physician's order dated 11/12/13 stating he could self-administer the nebulizer treatment after set-up by the nurse.</p> <p>*An 11/11/13 self-administration of medication assessment indicating he was capable of self-administering medications.</p> <p>*Neither the revised 12/12/13 care plan nor the previous care plan indicated he was to self-administer the nebulizer.</p> <p>Interview on 1/9/14 at 8:50 a.m. with the director of nursing (DON) revealed resident 1's self-administration of medication should have been addressed on the care plan.</p> <p>Review of the provider's revised January 2011 Resident Self-Administration of Medication policy revealed the care plan should have indicated which medications the resident was to self-administer, where they were kept, who would document the medication, and the location of the administration, if applicable.</p> <p>Surveyor: 12218</p> <p>2. Review of resident 6's medical record revealed:</p> <p>*She was admitted on 7/20/09.</p> <p>*She had a clinic referral on 9/3/13 to check her feet.</p> <p>*The clinic referral had orders for:</p> <p>- "New ankle braces."</p> <p>- "Physical therapy to help with lower extremity (legs/feet) strengthening and gait training. Resident hopes and wants to try to walk more."</p> <p>*A 9/3/13 physician's order on an orthotic and prosthetic specialties company form stated "supportive shoes with upright braces."</p>	F 280	<p>cares. This audit will be done weekly X4 and then monthly X4, the DNS or designee will report audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed.</p>		

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F 280	<p>Continued From page 5</p> <p>-Diagnosis: History of bilateral ankle replacement with instability. -Prognosis: good.</p> <p>Review of resident 6's current 12/23/13 care plan revealed: *No mention of the resident's need for supportive shoes and braces. *The list of diagnoses had not mentioned a history of bilateral ankle replacement</p> <p>Interview on 1/8/14 at 1:30 p.m. with the Minimum Data Set (MDS) coordinator regarding resident 6 revealed: *She was unaware of the physician's 9/3/13 order for supportive shoes and braces. *There was no mention on the care plan in regards to the supportive shoes and braces. *Resident 6's previous care plan dated 10/23/13 had not mentioned the resident wore supportive shoes and braces.</p> <p>Interview on 1/8/14 at 4:30 p.m. with the DON revealed she was aware of resident 6's new supportive shoes and braces. She knew the resident had worn supportive shoes and braces for a long time. Because the shoes were wearing out they had referred her to the clinic for new ones.</p> <p>Review of the provider's September 2012 Care Plan policy revealed: *"The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths, and needs." *"The focus includes the identified problem or strength." *"The goals can be short-term or long-term and usually ...will be reached by a certain date."</p>	F 280		

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F 280	Continued From page 6 **"Interventions are what the staff do to help residents reach their goals..."	F 280			
F 281 SS=E	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: 32332 Based on observation, interview, record review, and policy review, the provider failed to ensure professional nursing standards were followed for: *Two of two randomly observed residents (8 and 13) receiving insulin injections. *Clarification of a physician's order for one of one sampled resident (8) who received insulin. *One of one sampled resident (4) who exhibited changes in behaviors. Findings include: 1. Observation on 1/7/14 during a medication pass with registered nurse (RN) B using a NovaLog FlexPen (a disposable dial-a-dose insulin pen) revealed: *At 5:10 p.m. she approached resident 13 and cleansed her hands. She then dialed the correct dose of 18 units and injected it. After the push-button had been fully depressed she allowed the insulin needle to remain in the skin for less than two seconds. *At 5:15 p.m. she approached resident 8 and cleansed her hands. She then dialed the correct dose of 9 units and injected it. After the push-button had been fully depressed she allowed the insulin needle to remain in the skin	F 281	F 281 1. Residents 8 and 13 will receive insulin per physician order following the manufacturer's guidelines when using insulin pens. 2. All residents taking insulin will have physician orders followed. If an insulin pen is used to deliver insulin the manufacturer's guidelines will be followed. 3. The DNS will provide in-service education on 1/28/2014 reviewing the need for physician orders regarding the delivery on insulin and how to follow the manufacturer's guidelines when using an insulin pen. 1. Resident 4's physician was notified of her increased behaviors and weight changes on 1/24/2014. 2. All residents will be observed for changes in condition, if seen the staff will inform the charge nurse and the charge nurse will inform the physician and family. 3. The DNS will provide in-service education to all staff on 1/28/2014 regarding the need to report changes in resident's condition to the charge nurse who will then inform the physician and family.	2/6/14	

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F 281	<p>Continued From page 7 less than two seconds.</p> <p>Interview on 1/9/14 at 8:50 a.m. with the director of nursing (DON) revealed her expectation had been the nurse should have:</p> <ul style="list-style-type: none"> *Primed the NovoLog FlexPen by giving an airshot prior to insulin administration. That would have ensured a full dose had been injected. *Allowed the needle to remain in the skin according to the manufacturer's recommendations to ensure the full dose had been given. <p>Review of the Novo Nordisk Novolog FlexPen Patient Instruction For Use revised October 2013, http://www.novologpro.com/resources/managing-mealtime.aspx revealed:</p> <p>**Giving the airshot before each injection: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing:</p> <ul style="list-style-type: none"> -Turn the dose selector to select 2 units. -Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. -Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. -A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times." <p>"After the airshot, the insulin dose was to have been drawn using the dose selector, and injected. After the injection "Keep the needle in the skin for at least six seconds, and keep the push-button pressed all the way in until the needle has been pulled from the skin. This will make sure that the</p>	F 281	<p>4. The DNS will audit medication passes to assure all insulin administration is being done according to physician orders and per manufacturer's guidelines, <i>*on each shift weekly X4 MJH/S200H/JJ</i> and then monthly X 4. The DNS will audit resident conditions and medical records to assure staff have notified the charge nurse of changes in resident conditions and that the charge nurse informed the physician and family; weekly X4 and then monthly X4. The DNS will report audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed. <i>*Each nurse will be audited to ensure for correct insulin pen administration. MJH/S200H/JJ</i></p>	

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F 281	<p>Continued From page 8 full dose has been given."</p> <p>2. Observation on 1/7/14 at 5:15 p.m. of RN B during an insulin administration to resident 8 revealed: *An order for NovoLog solution, inject 9 units once daily. *Then nurse prepared and injected 9 units of insulin from a NovoLog FlexPen.</p> <p>Interview at that time with RN B revealed: *The resident received all NovoLog using a FlexPen. *The physician had not been contacted to clarify the insulin order for use of the FlexPen.</p> <p>Interview on 1/9/14 at 8:50 a.m. with the DON revealed the physician should have been contacted for clarification of the insulin order.</p> <p>Review of Patricia A. Potter and Ann Griffin Perry, Fundamentals of Nursing, 6th Edition, Mosby, St. Louis, Mo, 2005, revealed on page 419: *The physician was responsible for directing medical treatment. Nurses were obligated to follow physicians' orders unless they believed the orders were in error or would harm clients. *If orders were in question further clarification from the physician was necessary.</p> <p>Surveyor: 33488 Preceptor: 18560</p> <p>3. Interview on 1/7/14 at 3:34 p.m. with RN B regarding resident 4 revealed: *She would get very verbally and physically abusive to staff. -She would often refuse care or the meal and supplements during those times.</p>	F 281		
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F 281	<p>Continued From page 9</p> <p>-If she had not been aggressive she would then eat and accept care from staff.</p> <p>*That had been a "usual behavior" from the resident, and the staff had "left her alone" until it resolved.</p> <p>Review of resident 4's medical record revealed:</p> <p>*She had a diagnosis of dementia with aggressive behaviors.</p> <p>*She had been taking Cymbalta (an antidepressant medication used to treat mood disorders) daily.</p> <p>*Since 9/3/13 her behaviors had been documented as increasing in frequency and severity. She had been noted to hit, bite, scratch, slap, spit, and swear at staff.</p> <p>*There had been no notification by staff to the physician regarding her worsening and continued behaviors between 9/3/13 and this survey beginning 1/7/14.</p> <p>Interview and record review on 1/8/14 at 8:15 a.m. with the DON regarding resident 4 revealed:</p> <p>*There had been no notification to the physician regarding the resident's worsening and continued aggressive behavior.</p> <p>-She had stated that should have been done, and the physician's orders should have been followed.</p> <p>*When the resident had exhibited behaviors during meal times she would refuse to eat or ate very little, including drinking her supplements.</p> <p>*She agreed the resident had a twenty pound weight loss in the last year.</p> <p>*She agreed it had been likely the resident's lack of food intake while she exhibited aggressive behaviors could have caused her weight loss.</p> <p>*That weight loss and the aggressive behaviors should have been reported by the nurse to the physician.</p>	F 281		

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F 309	<p>Continued From page 11</p> <p>*She had been admitted to hospice services on 4/26/13 for congestive heart failure. *Her 5/10/13 significant change Minimum Data Set (MDS) was coded for being on hospice under the special treatment section.</p> <p>Review of resident 9's 11/13/13 plan of care had not revealed: *Which hospice staff members were scheduled to come. *How often the hospice staff members were scheduled to come. *What cares and services were done by the provider and which were done by hospice in order to be responsive to the unique needs of the resident.</p> <p>Surveyor: 33488 Preceptor: 18560 2. Review of resident 8's medical record revealed: *He was admitted to hospice on 4/9/13. *His hospice care plan was not combined with the provider's care plan. *His hospice care plan had been stored separately in the resident's chart.</p> <p>Surveyor 12218 3. Interview on 1/9/14 at 8:35 a.m. with the MDS coordinator and on 1/9/14 at 8:55 a.m. with the director of nursing confirmed: *The plan of care had not been coordinated with the hospice staff. *Documentation of services offered and or given to the resident by the hospice staff and how often offered and or given were not coordinated into the resident's care plan.</p> <p>4. Review of the provider's September 2010</p>	F 309	<p>3. The care team members will be educated by the DNS on 1/28/2014 regarding the integration of the Hospice care plan with the center care plan describing who will provide what cares.</p> <p>4. The DNS or designee will audit all Hospice resident care plans to assure Hospice care plans are available and that it has been integrated into the center care plan. The care plan will describe what Hospice staff will provide what cares and when. This audit will be done weekly X4 and then monthly X4 by the DNS or designee. The DNS or designee will report audit findings to the QA committee monthly and the QA committee will determine if further auditing is needed.</p>

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

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CORSICA		STREET ADDRESS, CITY, STATE, ZIP CODE 455 NORTH DAKOTA CORSICA, SD 57328		
(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 309	Continued From page 12 revised policy for Hospice Services Provided in a Skilled Nursing Facility revealed: **Definition: Hospice. The hospice provider's plan of care is integrated with the center's comprehensive care plan, thus the reference to "joint plan of care." **Procedure10: 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."	F 309		

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

ORIGINAL

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CORSICA			STREET ADDRESS, CITY, STATE, ZIP CODE 455 NORTH DAKOTA CORSICA, SD 57328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/8/14. Good Samaritan Society Corsica was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

Jacky Nelson

TITLE

Administrator

(X6) DATE

2/4/14

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.

FEB 6 2014
SD DOH L&C

ORIGINAL

PRINTED: 01/23/2014
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10609	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CORSICA	STREET ADDRESS, CITY, STATE, ZIP CODE 455 NORTH DAKOTA AVENUE CORSICA, SD 57328
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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
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S 000	Initial Comments Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/7/14 through 1/9/14. Good Samaritan Society Corsica was found not in compliance with the following requirements: S206 and S235.	S 000		
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	S 206 1. The facility will provide in-service education to all staff on 2/27/2014 covering the following; dining assistance, nutritional risks, and hydration needs including observation and awareness of resident eating requirements, assistance with encouragement, substitutions, feeding precautions to prevent choking, fluid requirements and changes in resident eating abilities. This education will be provided by the RD. 2. The facility will ensure that all required education will be provided to staff on an annual basis. The Staff Development coordinator will set up education and monitor staff participation. 3. The administrator will educate the SD coordinator and RD regarding the need for annual education on 1/13/2014.	2/27/14

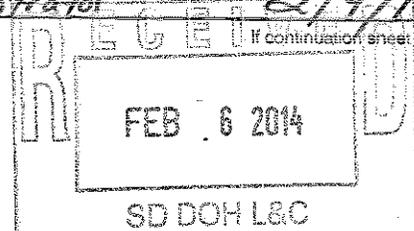
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ruby Nelson</i>	TITLE Administrator	(X6) DATE 2/4/14
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STATE FORM

021199

48QV11

If continuation sheet 1 of 4



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10609	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CORSICA		STREET ADDRESS, CITY, STATE, ZIP CODE 455 NORTH DAKOTA AVENUE CORSICA, SD 57328		
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S 206	<p>Continued From Page 1</p> <p>This Rule is not met as evidenced by: Surveyor: 12218</p> <p>Based on record review and interview, the provider failed to ensure all required in-service training sessions each year were offered to all the staff. Findings include:</p> <p>1. Review of the annual required in-service agendas for 2013 revealed: *Dining assistance, nutritional risks, and hydration needs of residents had not been presented. *Dining assistance included observation and awareness of resident eating requirements, assistance with encouragement, substitutions, feeding precautions to prevent choking, types of fluid requirements, and changes in eating abilities. *Nutritional risks usually included dangers of weight loss and weight gain, risks of nutrient deficiency, awareness of diet requirements such as dysphagia (difficulty in swallowing), diabetic, protein, lactose (allergy to dairy products), gluten (allergy to foods containing oats, wheat, barley and rye grains), fluid restrictions, and poor eating habits.</p> <p>In July 2013 the consultant registered dietitian (RD) had conducted an in-service with the dietary staff on dietary and kitchen preparedness for the upcoming annual survey. The RD had not been asked to present an all staff in-service on dining assistance, nutritional risks, and hydration needs of the residents.</p> <p>Interview on 1/9/14 at 8:40 a.m. with the director of nursing confirmed: *The in-service had not been included in their annual required staff in-services. *She was unaware of the above requirement.</p>	S 206	<p>4. The administrator or designee will audit the process for education of staff; will review the in-service attendance, and the learning center attendance to assure all staff receive the required training weekly X4 and then monthly X4. The administrator or designee will report findings to the QA committee monthly and the QA committee will determine if further auditing is needed.</p>	

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10609	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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S 206	Continued From Page 2 *They had a set agenda of in-services outlined by month that had been planned by the corporation, but it did not include the above requirement.	S 206		
S 235	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Each facility shall develop criteria to screen healthcare workers...or residents for Mycobacterium tuberculosis based on the guidelines issued by Centers for Disease Control and Prevention. Policies and procedures for conducting Mycobacterium tuberculosis risk assessment shall be established and should include the key components of responsibility, surveillance, containment, and education. The frequency of repeat screening shall depend upon annual risk assessments conducted by the facility. This Rule is not met as evidenced by: Surveyor: 33488 Preceptor: 18560 Based on interview, record review, and policy review, the provider failed to ensure two of five sampled new employees (C and D) completed their tuberculin (TB) screening requirement within fourteen days of being hired. Findings include: 1. Review of the provider's employee personnel files on 1/8/14 revealed: *Certified nursing assistants (CNA) C and D had begun their employment on 12/23/13.	S 235	S 235 1. Employees C and D have completed the 2-step TB screening. 2. All employees will have the 2-step TB screening done within 14 days of employment. 3. The DNS or designee will educate the nursing staff regarding the need to have new employees receive the 2-step TB testing done within 14 days of employment on 1/28/2014. 4. The DNS or designee will audit new employee files to assure all new employees have received the 2-step TB testing within 14 days of employment. This audit will be done weekly X4 and then monthly X4, the DNS or designee will report findings to the QA committee monthly and the QA committee will determine if further auditing is needed.	2/3/14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10609	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2014
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S 235	Continued From Page 3 *There had been no documentation of the required TB screening within fourteen days of employment. Interview on 1/8/14 at 4:00 p.m. with the director of nursing (DON) regarding the above mentioned employees revealed: *Neither CNA completed their TB screen within fourteen days of employment. *She agreed this had not been done according to the provider's policy or state regulation and should have been completed in the fourteen day timeframe allowed. Review of the provider's General Employee Health Information Policy revised on Novemeber 2011 revealed TB testing would have been done for all employees post-hire except where contraindicated.	S 235			