

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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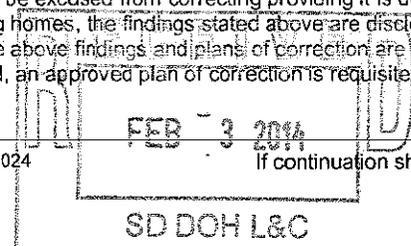
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LENNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST 6TH AVENUE LENNOX, SD 57039
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><i>Addendums noted with an asterisk per 2/20/14 telephone to facility administrator and DON, DK/5000H/JJ</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/6/14 through 1/9/14. Good Samaritan Society Lennox was found not in compliance with the following requirements: F202, F248, F281, F314, F371, and F441.</p>	F 000	<p>F tag 202</p> <p>Documentation for Transfer/Discharge of Resident</p> <p>1. For resident # 15: The provider is unable to go back to obtain a physician order for the transfer or complete the documentation of the transfer/discharge form due to resident having been discharged 6/11/13 with this as a closed medical record.</p> <p>2. For all other potential residents: The provider will obtain physician orders when a resident is planning to be transferred or discharged out of the facility. The transfer/discharge form will be fully completed by the licensed nurse. And any additional services that may be required. Documentation to be placed in the medical record.</p> <p>3. IN-SERVICE: Education of GSS policy /procedure for Physician Orders and Discharge and Transfers forms will be provided to the licensed nurses by the DNS on 2/4/14. The education provided will include instruction on completion of the discharge/ transfer form, pertinent information such as reason for transfer, significant labs, activity level, ADL needs, Date of last BM, Weights, mental and emotional status, signature of licensed nurse and medication list. Documentation will be filed in the medical record.</p>	
F 202 SS=D	<p>483.12(a)(3) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraph (a)(2)(i) through (v) of this section, the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary under paragraph (a)(2)(i) or paragraph (a)(2)(ii) of this section; and a physician when transfer or discharge is necessary under paragraph (a)(2)(iv) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Preceptor: 32331 Based on record review, interview, and policy review, the provider failed to ensure a physician's order for the transfer and completion of the resident transfer form for receiving facility had not been done for one of two transferred sampled residents (15). Findings include:</p> <p>1. Review of resident 15's closed record revealed: *There was no physician's order for the transfer to another facility.</p>	F 202		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Loche M. Anderson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-31-14</i>
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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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F 202	<p>Continued From page 1</p> <p>*The resident transfer form dated 6/11/13 at 10:29 a.m. did not have the following sections completed:</p> <ul style="list-style-type: none"> -Reason for transfer. -Significant laboratory findings. -Activity level/precautions. -Activities of daily living assistance levels. -Date of last bowel movement. -Weight. -Mental status. -Emotional status. -Signature of nurse. -Signature of physician. <p>Interview on 1/8/14 at 12:00 noon with the health information manager revealed there was no physician's order for the transfer of resident 15 to another facility.</p> <p>Interview on 1/8/14 at 2:30 p.m. with the director of nursing regarding resident 15 revealed he agreed:</p> <ul style="list-style-type: none"> *There was no physician's order for the transfer of the resident to another facility. *The transfer form was not completely filled in for the resident's transfer to another facility. <p>Review of the provider's March 2011 Discharge/Transfer policy revealed discharge or transfer from the facility required physician documentation.</p> <p>Review of the provider's August 2013 Physician's Orders policy revealed a discharge order should have been obtained and should have included:</p> <ul style="list-style-type: none"> *Where the resident was being discharged to. *Any additional services that were needed for the resident. 	F 202	<p>4. AUDITS: Audits will be completed to monitor physician orders were obtained. Audits will be completed to monitor the full completion of the Discharge / Transfer form and documentation in the medical record for each resident transferred or discharged from this facility. The DNS is responsible for the audits to be completed weekly x 1 month and monthly x 3 months and to report audit findings monthly to the QA Committee for review and further recommendations.</p>	2-17-14	

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F 248 F 248 SS=D	Continued From page 2 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure an individualized activity program for one of four (9) sampled dependent residents was developed. Findings include: 1. Observation of resident 9 on the following dates revealed: *1/6/14 at 4:10 p.m. she was in her room, sitting in a wheelchair in the dark listening to music. The call light was laying on the floor across the room beside the bed. *1/7/14 at 7:55 a.m. she was sitting at the dining room table. *1/7/14 from 9:30 a.m. through 11:15 a.m. she sat in her wheelchair in the activity area with a bedside table positioned in front of her with a magazine. There was no observed staff interaction with her during that time. *1/7/14 at 12:05 p.m. she was sitting at the dining room table. *1/7/14 from 1:30 p.m. through 4:15 p.m. she was positioned on her left side in bed facing the door. There was no observed staff interaction with her during that time frame.	F 248 F 248	F tag 248 Activities meet Interest/Needs of each Resident 1. For resident # 9: The provider developed an individualized activity program and updated the care plan to reflect that if the resident does not attend group activities, daily devotions and other activities listed on the weekly calendar then the staff will do structured 1:1 visits with the resident. The activity staff will document in the medical record participation and attendance of the structured 1:1 visits and the weekly activities the resident attended. 2. For all other potential residents: Residents identified with limited activity participation or socialization an individualized activity program will be developed. The activity program will include structured 1: 1 visits and small group or large group activities. The activity staff will document response, attendance and participation in the medical record and update the care plan to reflect the preferred activities and visits.		

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F 248	Continued From page 3 Review of resident 9's medical record revealed: *She had a diagnosis of Alzheimer's disease. *The 11/27/13 care plan revealed: -"Social participation in activity is limited. Will be assisted to/from activities 1-2 (one to two times) week. Will have one to one's 1-2 week. Family will visit often. Invite and assist to activities of interest such as devotions and music programs, read, visit, play music, touch." *The activity participation report from 10/7/13 through 1/6/14 revealed: -She had received one-to-ones six times. -There were no activities documented for fifty-seven out of ninety-four days. -Television was documented nine times as the only activity offered for those days. Interview on 1/8/14 at 8:45 a.m. with the activities director regarding resident 9 revealed she attended devotions and small groups, music programs, and one-to-ones two to three times each week. Interview and activities participation log review on 1/8/14 at 10:30 a.m. with the activities director regarding resident 9 revealed she had not provided enough activities for the resident. Review of the provider's revised June 2010 One-to-One (1-1) Activity Intervention revealed a one-to-one was a "structured program for individual residents, which focuses on needs, abilities, strengths, and interests during a staff to resident one-to-one situation."	F 248	3. IN-SERVICE: Education of GSS policy/procedure for Activity programs, 1:1 structured visits and Care planning will be provided to the Activity staff by the Activity Coordinator on 2/4/14 All staff will be reminded to ensure the call light is always within reach of the resident. 4. AUDITS: Audits will be completed to monitor individualized activity programs have been developed for residents who have limited activity participation, or unable to attend activities for health or cognitive reasons. Audits will include that the care plan reflects activity participation and need for 1:1 structured activities with supportive documentation. The Activity Coordinator is responsible for the audits to be completed weekly x 1 month and monthly x 3 months and report the audit findings monthly to the QA Committee for review and further recommendations.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		2-17-14

on four residents per week. DK/sooh bj

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F 281	<p>Continued From page 4 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Three of three observed unlicensed assistive personnel (UAP) (A, B, and C) had followed professional standards of practice for medication (med) administration for four randomly observed residents. *Medications had been given at the appropriate time for one of forty resident's (18) medication observations. *The pharmacy had been notified of a change in a physician's order for one resident's (18) medication change. *Nursing documentation had been completed for ten of thirteen sampled residents (1, 2, 3, 4, 5, 7, 8, 11, 12, and 13). Findings include:</p> <p>1a. Observation on 1/6/14 from 5:15 p.m. through 5:25 p.m. of UAP A revealed: *At 5:15 p.m. he placed resident 16's meds into a med cup. He then: -Placed the med cup down in front of the resident. -Returned to the med cart, and he signed off the medication administration record (MAR) before resident 16 had taken the meds. *At 5:20 p.m. he placed resident 4's meds into a med cup. He then: -Placed the med cup down in front of the resident. -Returned to the med cart, and he signed off the MAR before resident 4 had taken the meds.</p> <p>b. Observation on 1/7/14 at 7:55 a.m. of UAP B</p>	F 281	<p>F tag 281 Services provided meet Professional Standards</p> <p>1. For resident # 16, # 17 and # 18. The UAP and/or licensed nurses were directed by the DNS 1/8/14 to administer medications to the residents per GSS policy / procedure and in accordance to the SD Board of Nursing standard for safe administration of medications to include the practice of documenting medications following administration to the patient. The licensed nurse and/or UAP will observe the residents to have consumed the medication before initialing the MAR. For resident #18: The DNS directed the UAP'S and licensed nurses on 1/8/14 to follow physician orders for this resident to have Omeprazole administered twice daily before meals. Resident #18 also receives Vitamin B-12 1000mcg PO every day. The pharmacy was notified of physician order changes from SL to oral on 1/28/14. For resident # 2, # 3, # 5, # 8, # 11, # 1, # 4,# 7, # 12, # 13: The physician orders read weekly B/P, Pulse and Weights. The provider is unable to go</p>	

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F 281	<p>Continued From page 5 revealed: *At 7:55 a.m. she placed resident 17's meds into a med cup. She then: -Placed the med cup down in front of the resident. -Returned to the med cart, and she signed off the MAR before resident 17 had taken the meds.</p> <p>c. Observation and interview on 1/7/14 at 8:12 a.m. of UAP C revealed: *At 8:12 a.m. she placed resident 18's meds into a med cup. She then: -Placed the med cup down in front of the resident. -Returned to the med cart, and she signed off the MAR before resident 18 had taken the meds. -Confirmed she had initialed the MAR before resident 18 had taken the meds.</p> <p>d. Interview on 1/8/14 at 8:20 a.m. with the director of nursing (DON) revealed his expectations were for the person who had administered the meds to a resident would to sign off the meds after administration.</p> <p>Review of the provider's revised November 2013 Administration of Medication policy revealed "As soon as possible after administration, document that the medication was given."</p> <p>Review of the South Dakota Board of Nursing statement dated 10/17/06 revealed "It is the position of the South Dakota Board of Nursing that the standard for safe administration of medication includes the practice of documenting medication following administration to the patient."</p> <p>2. Observation, interview, and record review on 1/7/14 from 8:10 a.m. through 8:30 a.m. with UAP C regarding resident 18 revealed:</p>	F 281	<p>back to capture past B/P, Pulses and Weights. The provider will ensure residents with physician orders for weekly B/P, Pulse and Weights have been obtained and documented in the medical record from this date forward. For all other potential residents: The provider will ensure the physician orders are entered into Electronic medical record as physician orders for weekly B/P, Pulse and Weight in which the UAP or licensed nurse will see a reminder to obtain the weekly B/P, Pulse and Weight. .</p> <p>2. IN-SERVICE: Education of GSS policy/procedure for weekly B/P, Pulse and weights to be recorded by the nursing department in the Hands on application and medical record. GSS policy /procedure of the Medication administration. Notification of physician orders and medication changes communicated to the pharmacy providers timely. Education provided by the DNS to the nursing department on 2/4/14.</p> <p>3. AUDITS: The DNS is responsible to ensure audits are completed to monitor the weekly B/P, pulses and weights. Audits will include monitoring the Medication administration/med pass and pharmacy notification with physician orders and medication changes.</p>		

*on four residents per week
K/SADON/IT*

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F 281	<p>Continued From page 6</p> <p>*At 8:10 a.m. the resident had been eating his breakfast.</p> <p>*At 8:12 a.m. UAP C placed the med cup down in front of him.</p> <p>*The UAP confirmed resident 18 usually waited until he was done eating before taking his medications.</p> <p>*The 12/16/13 physician's order revealed an order for omeprazole (for treatment of stomach problems) to have been given twice daily before meals.</p> <p>Interview on 1/8/14 at 8:20 a.m. with the DON confirmed the above med should have been given before the meal.</p> <p>Review of the provider's revised January 2007 Medication policy revealed the purpose was to ensure "Accurate and accountable medication administration."</p> <p>Review of the provider's revised August 2013 Physician's Orders policy revealed the purpose was "To provide a procedure that facilitates the timely and accurate processing of physician's orders."</p> <p>3. Observation, interview, and record review on 1/7/14 from 8:12 a.m. through 8:30 a.m. with UAP C regarding resident 18 revealed:</p> <p>*At 8:12 a.m. the UAP removed one Vitamin B-12 tablet from the medication card and placed the med into a cup. She then placed the med cup in front of resident 18.</p> <p>*At 8:15 a.m. the resident placed the med cup up to his mouth and swallowed all the meds.</p> <p>*The UAP confirmed resident 18 had swallowed all his meds.</p> <p>*Review of the Vitamin B-12 medication card</p>	F 281	<p>Audits will be completed by the DNS and/or designee weekly x 1 month and monthly x 3 months. The DNS is responsible for reporting the audit findings monthly to the QA Committee for review and further recommendations.</p>	2-17-14	

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F 281	<p>Continued From page 7</p> <p>revealed "Dissolve one tablet under tongue daily at 8:00 a.m."</p> <p>*Review of the 11/30/12 physician's order revealed "B12 1000 mcg (microgram) SL (sublingual) (under tongue) daily.</p> <p>*Review of the 1/30/13 physician's order revealed "B12 1000 mcg po (mouth) every day."</p> <p>*Review of the 11/30/13 pharmacy consultation sheet revealed "B12 daily SL."</p> <p>Interview on 1/8/14 at 8:20 a.m. with the DON confirmed the 1/30/13 physician's order should have been communicated with the pharmacy.</p> <p>Interview on 1/8/14 at 9:45 a.m. with the pharmacist revealed:</p> <p>*The pharmacy had received orders for resident 18 to receive Vitamin B12 SL.</p> <p>*They had not received any further physician's orders for change in the above medication.</p> <p>*If the pharmacy had not received any communication from the facility, the pharmacy continued to fill the medication as ordered.</p> <p>Review of the provider's revised January 2012 Acquisition, Receiving, Dispensing, and Storage of Medications policy revealed "The pharmacy needs to be kept up to date on any order changes."</p> <p>Surveyor: 33265 Preceptor: 32331</p> <p>4. Review of resident 2's complete medical record revealed:</p> <p>*A physician's order for blood pressure and pulse readings to have been done weekly and started on 10/25/13.</p> <p>-Both the blood pressure and pulse were not</p>	F 281		
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F 281	<p>Continued From page 8</p> <p>recorded for two weeks of a nine week period.</p> <p>-One week a blood pressure was listed without a pulse.</p> <p>*An order on the care plan for weekly weights started on 11/27/13 and was approved by the physician.</p> <p>-Weights were recorded on 11/27/13, 12/4/13, 12/11/13, and 12/30/12 for four of those six weeks.</p> <p>-No weights were completed during the two and a half weeks between 12/11/13 and 12/30/13.</p> <p>5. Record review of resident 3's complete medical record revealed:</p> <p>*A physician's order for blood pressure and pulse readings to have been done weekly and started on 6/28/12.</p> <p>-The Vital Signs Record listed two blood pressure and pulse readings recorded between 11/1/12 and 7/31/13 with thirty-four of thirty-six weeks left blank.</p> <p>-The Vital Signs Records had no blood pressure or pulse readings recorded between 8/1/13 and 1/2/14.</p> <p>-The MAR for 8/1/13 to 1/2/14 recorded at least one blood pressure and pulse readings for eight weeks with twelve of twenty weeks left blank.</p> <p>*An order on the care plan for weekly weights dated 11/14/13 had been approved by the physician.</p> <p>-Between 11/14/13 and 1/4/14 three of eight weeks had no weight recorded.</p> <p>Surveyor: 32331</p> <p>6. Review of resident 5's complete medical record revealed:</p> <p>*He had been admitted on 5/6/10.</p> <p>*His diagnoses had included:</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>-Congestive heart failure and coronary artery disease (heart disease). -Hyperlipidemia (high fats in the blood). *He had an 8/20/13 physician's order for a weekly blood pressure check.</p> <p>Review of resident 5's revised 12/12/13 care plan revealed he was to have had a weekly blood pressure and pulse check.</p> <p>Review of resident 5's Vital Signs Record from 6/6/13 through 1/7/14 revealed: *Two of the weeks had a weekly blood pressure and pulse documented. *The rest of the weeks did not have a weekly blood pressure and pulse documented.</p> <p>7. Review of resident 8's complete medical record revealed: *He had been admitted on 9/8/11. *His diagnoses had included: -Hypertension (high blood pressure). -Generalized pain/elevated temperatures. *He had a 9/8/11 physician's order for a weekly blood pressure and pulse check.</p> <p>Review of resident 8's revised 12/24/13 care plan revealed he was to have had a weekly blood pressure and pulse check.</p> <p>Review of resident 8's Vital Signs Record from 6/20/13 through 1/7/14 revealed: *Three of the weeks had a weekly blood pressure and pulse documented. *The rest of the weeks did not have a weekly blood pressure and pulse documented.</p> <p>8. Review of resident 11's complete medical record revealed:</p>	F 281		

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F 281	<p>Continued From page 10</p> <p>*He had been admitted on 4/4/13. *His diagnoses had included: -Hypertension (high blood pressure). -Congestive heart failure. -Hyperlipidemia (high fats in the blood). *He had a 4/4/13 physician's order for a weekly blood pressure and pulse check.</p> <p>Review of resident 11's Vital Signs Record from 6/24/13 through 1/7/14 revealed: *Two weeks had a weekly blood pressure and pulse documented. *The rest of the weeks did not have a weekly blood pressure and pulse documented.</p> <p>Surveyor: 16385 9. Review of resident 1's medical record revealed he had been admitted on 11/7/13.</p> <p>Review of his 1/1/14 MAR revealed a 11/7/13 physician's order for weekly blood pressure (B/P) and pulse checks. The B/P and pulse check had not been recorded on 1/3/14.</p> <p>Review of the Vital Signs Record from 11/8/13 to 1/7/14 revealed one B/P and pulse check had been recorded on 1/7/14. Five weeks had no B/P or pulse checks recorded.</p> <p>10. Review of resident 4's 1/1/14 MAR revealed a 7/3/13 physician's order for weekly B/P and pulse checks. His MARs revealed: *No B/P and pulse checks had been recorded on 1/3/14. *Two recordings of B/P and pulse checks on the 12/1/13 MAR. Two weeks were not recorded. *Five recordings of B/P and pulse checks on the 11/1/13 MAR. One week was not recorded.</p>	F 281			

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F 281	<p>Continued From page 11</p> <p>*One recording of B/P and pulse checks on the 10/1/13 MAR. Three weeks were not recorded.</p> <p>*No recordings of B/P and pulse checks on the 9/1/13 MAR. Four weeks were not recorded.</p> <p>*Two recordings of B/P and pulse checks on the 8/1/13 MAR. Three weeks were not recorded.</p> <p>Review of the Vital Signs Record from 8/5/13 to 1/7/14 revealed one B/P and pulse check had been recorded on 1/7/14. Sixteen weeks had no B/P or pulse checks recorded.</p> <p>11. Review of resident 7's 1/1/14 MAR revealed a 12/2/13 physician's order for weekly B/P and pulse checks. The MAR revealed the B/P and pulse check had not been recorded on 1/5/14.</p> <p>12. Review of resident 12's 1/1/14 MAR revealed a 3/1/13 order for weekly B/P and pulse checks. His MARs revealed: *No B/P and pulse checks had been recorded on 1/5/14. *Three recordings of B/P and pulse checks on the 12/1/13 MAR. One week was not recorded. *Five recordings of B/P and pulse checks on the 11/1/13 MAR. *One recording of B/P and pulse check on the 10/1/13 MAR. Three were not recorded. *One recording of B/P and pulse check on the 9/1/13 MAR. Three were not recorded.</p> <p>Review of the Vital Signs Record from 6/5/13 to 1/7/14 revealed: *Two recordings B/P and pulse checks on 7/5/13 and 7/19/13. *One recording of B/P and pulse check on 1/7/14. *Thirty-four weeks had no B/P or pulse checks recorded.</p>	F 281		

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F 281	Continued From page 12 13. Review of resident 13's 1/1/14 MAR revealed a 11/5/13 physician's order for weekly B/P and pulse checks. His MAR revealed: *No B/P and pulse checks had been recorded on 1/5/14. *No recording of B/P and pulse checks on the 12/1/13 MAR. Four were not recorded. *One recording of B/P and pulse check on the 11/1/13 MAR. Four were not recorded. *No recording of B/P and pulse checks on the 10/1/13 MAR. Four were not recorded. Review of the Vital Signs Record from 6/4/13 to 1/7/14 revealed: *Two recordings B/P and pulse checks on 7/5/13 and 7/19/13. *One recording of B/P and pulse check on 1/7/14. *Ten weeks had no no B/P and pulse checks recorded. Interview on 1/8/14 at 3:00 p.m. with the director of nursing (DON) confirmed the provider had not consistently recorded B/P and pulse checks on the residents' MARs or the Vital Signs Records.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (2 and 9) did not acquire a pressure ulcer (an area of skin breakdown, when something keeps rubbing or pressing against the skin) after admission to the facility. Findings include:</p> <p>1. Review of resident 9's medical record revealed: *She had been admitted on 11/11/13 under hospice services. *An 11/13/13 physician's admission order had no documentation of a pressure ulcer. *A 12/3/13 physician's order revealed: -"DuoDerm to coccyx, change every three days and prn (when necessary) for stage 2 pressure area to coccyx." *Review of the 11/11/13 physical nursing data admission sheet revealed there were no skin issues.</p> <p>Review of the 11/11/13, 11/18/13, 11/25/13, and 12/2/13 Braden Scale (form used for predicting pressure ulcer risk) revealed she had scored 11 at each assessment. (A score of 10 to 12 indicated a high risk). An intervention guide recommended frequent turning with a planned schedule, supplement with small shifts in position, protect heels, manage moisture, manage nutrition, and manage friction and sheering.</p> <p>Review of resident 9's 11/18/13 Minimum Data Set (MDS) revealed: *She required extensive or total assistance with bed mobility, transfer, locomotion, dressing,</p>	F 314	<p>F tag 314 Treatment/Services to Prevent/Heal Pressure Sores</p> <p>1. For resident # 9: Acquired a stage II sore to the coccyx with physician orders for duo-derm on 12/3/13. Braden score of 11 determined high risk for skin breakdown. Hospice provided services to this resident also. As of this date the coccyx has resolved with no skin issues at this time. The provider is unable to go back to capture wound measurements and documentation for treatments. From this date forward the facility will ensure if the resident has an open area that the GSS 487 wound flow sheet be initiated upon discovery of the wound and weekly there after to determine measurements. The RN will complete weekly assessment to document progression of the wound. The care plan will be updated to reflect wound management and interventions. The physician will be notified immediately to begin treatment.</p> <p>1a. For resident # 2: Acquired a blister to the L) heel. The resident had scheduled whirlpools and wet to dry dressings. The physician was notified of the blister status per fax. At this time the L) heel blister is resolving</p>	

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F 314	<p>Continued From page 14</p> <p>eating, toileting, personal hygiene, and bathing. *She was frequently incontinent of bladder and occasionally incontinent of bowel movement. *She was on a mechanically altered diet. *She was at risk for developing pressure ulcers. *She had not had turning/repositioning program marked as being done. *She had received an antipsychotic medication daily.</p> <p>The Care Area Assessment (CAA) from the 11/18/13 MDS had triggered for pressure ulcer. The CAA assessment had stated "She rely's on staff to reposition her as she does not reposition independently. She is incontinent of bowel and bladder and has a Braden score of 11."</p> <p>Review of the nutrition assessment completed by the registered dietitian (RD) on 11/21/13 revealed "No skin issues noted." Review of the Mini-Nutritional Assessment-Short Form completed by the certified dietary manager (CDM) on 11/24/13 revealed a score of 7 (a score of 0-7 indicated malnutrition). There was no further documentation by the RD or CDM.</p> <p>Review of resident 9's hospice documentation revealed: *On 12/5/13 she had a 0.6 by 0.6 stage two pressure ulcer to her coccyx (tailbone). *On 12/19/13 the pressure ulcer to coccyx was 0.4 by 0.9. Area has some slough (shedding)/necrotic (death of tissue) tissue. *On 12/31/13 the pressure ulcer to the coccyx was a stage one.</p> <p>Review of the facility wound flow sheet revealed: *On 12/16/13 has a stage two pressure ulcer to</p>	F 314	<p>with the wound nurse completing weekly measurements and assessment of the wound progress. The resident's goal is to discharge the end of this month.</p> <p>For all other potential residents: The licensed nurses must ensure the residents identified with low Braden score and at high risk for skin breakdown have interventions in place to reduce the risk for pressure ulcers. The GSS 487 wound flow sheet will be initiated upon discovery of a wound. The physician notified immediately to begin treatment. The care plan updated to reflect interventions and pressure sore management to prevent further skin break down and resolve any current skin impairments.</p> <p>2. IN-SERVICE: Education of GSS policy/procedure for pressure ulcer prevention, GSS wound flow sheet, interventions to reduce risk and assist in prevention of pressure sores. THE documentation of treatment to the TAR, Wound Flow sheet for weekly measurements and RN assessment to the progression of the wound. Physician orders for treatment to be timely and the GSS Nutrition at Risk notification form for all staff to complete when finding a change in skin integrity to communicate to the nurses, dietary</p>	

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F 314	<p>Continued From page 15 coccyx that measured 0.4 by 0.9 cm (centimeters). *On 12/24/13 has a stage two pressure ulcer to coccyx that had not included any measurements. *There was no further documentation in the medical record by the facility staff regarding the pressure ulcer.</p> <p>Review of the treatment assessment record (TAR) for January revealed a physician's order for: *DuoDerm to coccyx, change every three days initiated 11/29/13. *DuoDerm to pressure area on coccyx change prn and every three days initiated 11/29/13. *Review of the above TAR received from the facility on 1/6/14 at 6:00 p.m. revealed the treatment was supposed to have been done on 1/5/14 but had not been initiated by a staff person. *Review of the above original TAR on 1/7/14 at 10:00 a.m. revealed there had been a signature written into the 1/5/14 treatment area. The initials were circled. *Interview with registered nurse (RN) D confirmed he had signed off the above area and circled his name. Upon further interview RN D stated he had not done the treatment.</p> <p>Review of the 11/27/13 care plan revealed resident 9 had impaired skin integrity related to immobility and incontinence of bowel and bladder, was at risk for pressure ulcers, and had an open area on the buttock. Plans included to routinely reposition the resident to relieve pressure from bony prominences (a bony area that protrudes more).</p> <p>Random observations on 1/7/14 from 9:00 a.m.</p>	F 314	<p>and MDS nurse who is also the wound nurse 3. AUDITS: The DNS and Wound Nurse will be responsible that the audits be completed to monitor the weekly completion of the Wound Flow sheet and RN assessment. Interventions such as turning and repositioning occur and documented by the C.NA'S. Audits will include the Physician orders were obtained timely when notified of alteration in skin integrity and monitoring of the TAR for documentation. GSS procedure on the use of Nutrition at Risk #196 as a communication tool for the interdisciplinary team. Audits will be completed by the DNS and MDS RN weekly x 1 month and monthly x 3 months. The DNS will be responsible to report audit findings monthly to the QA Committee for review and further recommendation.</p>	2-17-14

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F 314	<p>Continued From page 16 through 11:30 a.m. and from 1:30 p.m. through 4:15 p.m. of resident 9 revealed she had not been repositioned.</p> <p>Interview on 1/7/14 at 10:00 a.m. with certified nursing assistants E and F confirmed resident 9 had received a bath that morning. She had been placed in the wheelchair by 8:00 a.m.</p> <p>Interview on 1/8/14 at 7:50 a.m. with the MDS coordinator regarding resident 9 revealed: *She had been unaware resident 9 had a pressure ulcer. *She was responsible to do the weekly skin measurements and documentation. *She felt the "ball got dropped" on resident 9. *Her expectations were to measure pressure ulcers weekly. *Hospice had done "their own measurements at the facility of pressure ulcers but her expectations were for the facility to continue with their own weekly measurements and documentation." *She agreed the care plan for repositioning was "unacceptable." *Her expectations for residents with pressure ulcers was to off load sooner than what resident 9's care plan stated. *The facility had not used turning or repositioning flow sheets to keep track of the time it had last been done.</p> <p>Interview on 1/8/14 at 8:40 a.m. with the DON revealed his expectations for resident 9 were the same as the MDS coordinator's above expectations.</p> <p>Interview on 1/8/14 at 10:00 a.m. with the RD confirmed that she had not been aware of resident 9's pressure ulcer.</p>	F 314		

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F 314	<p>Continued From page 17</p> <p>Interview on 1/8/14 at 2:00 p.m. with the CDM regarding resident 9 revealed: *She had not been notified of the residents pressure ulcer. *The usual routine was for nursing to let her know which residents had skin issues. *The information was put on the nutritional at risk flow sheet for the RD to review on the next nursing home visit. *If residents had skin issues measures were implemented that included food with extra protein. *She agreed there had not been any further documentation by the RD since 11/21/13.</p> <p>Review of the provider's revised March 2007 Pressure Ulcers policy revealed the purpose was to "Provide appropriate assessment and prevention of pressure ulcers as well as treatment when necessary."</p> <p>Review of the provider's revised February 2005 Nutrition policy revealed the purpose was to "Provide quality nutritional assessment and status for residents."</p> <p>Review of the provider's revised August 2012 Monitoring Residents for Impaired Nutrition and Nutritional Risk policy revealed the purpose was to "Identify and monitor residents with impaired nutrition or at nutritional risk."</p> <p>Surveyor: 33265 Preceptor: 32331 2. Observation on 1/6/13 at 1:40 p.m. of resident 2 in her room revealed she was wearing sock booties on both feet while seated in a wheelchair.</p>	F 314		

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F 314	<p>Continued From page 18</p> <p>Interview on 1/7/13 at 2:00 p.m. with resident 2 revealed: *She had a blister on her left heel which appeared after her admission to the facility. *That blister had opened into a large wound on her left heel. *She had scheduled whirlpool baths and a wet-to-dry dressing done each evening before bed. *She thought the wound was slowly improving.</p> <p>Interview on 1/8/13 at 2:30 p.m. with the DON revealed he: *Had not thought the blister would have turned into a wound. *Was not sure the wound was a pressure ulcer. *Could not think of anything else the facility could have done to prevent the wound.</p> <p>Review of resident 2's medical record revealed there was documentation on the skin integrity and blister/wound as listed below: *On 10/25/13 during admission the daily skilled note had not identified any skin issues on lower extremities. *On 10/29/13 no skin integrity issues had been identified on the Interdisciplinary Rehabilitation Rounds form. *On 11/7/13 the documentation on the Daily Skilled Note had identified a change in color and abnormal turgor/elasticity of skin but had not listed the location. The same form included documentation identified as a late entry on 11/8/13: -On 11/7/13 at 5:00 p.m. resident 2 complained of pain in the left heel. A large intact blister covering her heel was noted during assessment. Resident was instructed to not wear shoes. A fax was sent to the physician concerning the blister. No</p>	F 314		

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F 314	<p>Continued From page 19</p> <p>documentation as to the size of the blister was noted in the charting.</p> <p>*On 11/12/13 at 9:10 p.m. the documentation on the Daily Skilled Note had not identified the wound on the check list portion of the form. But it had included a written description of the blister on the left heel as being smaller than at the previous observation.</p> <p>*The fax informing the physician of the blister was not dated or timed by the provider. The notation identified the blister as approximately 4 centimeters (cm) by 4 cm in size.</p> <p>*The response from the physician had been dated 11/13/13, and noted by a provider staff person on 11/14/13 at 8:00 p.m. That was one week from the time the blister was first noted. Two orders were written: - "Do not use Betadine." - Dakin's solution, wet-to-dry dressing change daily.</p> <p>*On 11/15/13 at 8:00 a.m. the documentation on the TAR identified the Dakin's solution had not been received from the pharmacy and the treatment had not been started.</p> <p>*On 11/16/13 at 9:00 p.m. the documentation on the Daily Skilled Note had not identified the wound on the check list portion of the form. But it did include documentation the dressing had been changed and Dakin's solution had been applied. The blister was described as appearing larger without any open areas, drainage, or signs and symptoms of infection.</p> <p>*On 11/17/13 at 5:00 p.m. documentation on the Daily Skilled Note had identified a wound on the check list portion of the form. A written comment identified the wet-to-dry treatment had been completed in the morning. The blister was described as large, blackish/purple in color, and intact.</p>	F 314		

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F 314	<p>Continued From page 20</p> <p>*On 11/19/13 at 8:45 p.m. the documentation on the Daily Skilled Note had not identified the wound on the check list portion of the form. But it had included a written description of the blister area as open with serosanguinous (yellow liquid drainage) on the dressing. There was a dark red/purple area where the blister had been open, that did not blanch when pressure was applied.</p> <p>*On 11/20/13 the documentation on the Interdisciplinary Rehab Rounds form had identified Dakin's solution had been applied to the left heel blister. No description of the change in the blistered area was given.</p> <p>*On 11/21/13 at 10:10 a.m. the documentation on the Daily Skilled Note had identified a wound on the check list portion of the form. Also included was a description of the area as a "left heel wound blister." No measurement of the size of the blister/wound was included.</p> <p>*On 11/22/13 the check list portion of the Daily Skilled Note did have "left heel" written in under the skin/wound section and included documentation of a dressing change.</p> <p>*The care plan dated 11/27/13 had identified impaired skin integrity as a concern and listed the resident should have been wearing the heel lift booties when in bed.</p> <p>-No documentation to avoid shoes had been written on the care plan.</p> <p>*On 12/2/13 a physician's order had been written for a whirlpool to the left heel in warm soapy water daily for fifteen minutes, followed by the Dakin's solution treatment. That was to continue until the wound had healed.</p> <p>-No whirlpool had been documented as having been completed for five of the first nine days after the order was written.</p> <p>*On 12/3/13 a Wound Flow Sheet had been started and revealed:</p>	F 314		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LENNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST 6TH AVENUE LENNOX, SD 57039	
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F 314	Continued From page 21 - The checklist portion of the sheet was filled in on 12/3/13, 12/9/13, 12/16/13, 12/19/13, 12/26/13, and 12/31/13. -The wound width had changed from 1 cm to 5 cm between 12/3/13 and 12/9/13. -The wound depth had changed from 5 cm to 0 cm during the same six-day period. -The wound description portion of the form had not been completed on the first two dates of 12/3/13 and 12/9/13.	F 314		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, testing, and policy review, the provider failed to: *Maintain proper sanitizing of the wiping cloths at two of two meal observations and during random observations of the kitchen area. *Maintain proper hair covering for staff at two of two meal observations and during random observations of the kitchen area. *Maintain proper cold food temperatures for one of two meal observations. Findings include:	F 371	F tag 371 Food Procurement, Store/Prepare/Serve-Sanitary 1. Maintain proper sanitizing of the wiping cloths. The sanitizing buckets will be available during the kitchen and dining shifts. Wiping cloths are clean, rinsed frequently in a sanitizing solution and stored in the bucket of sanitizing solution between uses. The sanitizing buckets will be checked every 2 hours for appropriate sanitization solution per the test strips and changed according to the test strip results or sooner if visibly dirty. Documentation of the test strip checks and results will be logged and acted upon by the dietary staff. ! a. Maintain proper hair covering for kitchen/dietary staff. Staff will wear hair-nets to ensure their hair is completely covered while they are in the food preparation area, food serving areas or in the food storage area.	

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F 371	<p>Continued From page 22</p> <p>1. Observation on 1/6/14 at 2:15 p.m. in the kitchen on the food production table revealed wet cloths laying next to two large baking sheet pans, a cutting board, and a food whip utensil.</p> <p>Observation on 1/6/14 at 5:15 p.m. in the kitchen on the dirty end of the counter of the three compartment sink revealed a wet cloth laying next to a red sanitizing bucket.</p> <p>Observation and testing on 1/7/14 at 11:40 a.m. was done on the solution in a red sanitizing bucket in the kitchen by the three compartment sink. That bucket contained two wet cloths and the solution tested at one hundred parts per million (ppm).</p> <p>Interview on 1/7/14 at 1:50 p.m. by telephone with an EcoLab sales representative revealed: *The Oasis Multi-Quat (quaternary) 146 Sanitizer needed to have been at no less than one-hundred fifty to two hundred ppm for an acceptable range for sanitizing. *A level of one hundred ppm was not an acceptable level for proper sanitizing.</p> <p>Interview on 1/8/14 at 11:30 a.m. with the consultant dietitian and the certified dietary manager (CDM) revealed: *The red sanitizing bucket in the kitchen was changed with sanitizing solution at the beginning and at the end of every shift. *The sanitizing bucket needed to be at a higher ppm than one hundred ppm for proper sanitizing. *The wet sanitizing cloths should not have been out of the sanitizing bucket when not in use.</p> <p>Review of the provider's May 2004 Sanitizing</p>	F 371	<p>Maintain proper cold food temperatures. Food temperatures will be taken and recorded prior to each meal services to ensure proper temperatures of food and beverages for appropriate cold temps and appropriate temperature of hot foods. Cold food temperatures should have been no more than 41 degrees F and served promptly after being removed from the refrigerator. If temperatures are not within recommended guidelines, cold food will be chilled or replaced until acceptable temperatures are achieved prior to service. Food temperatures will be logged and acted upon by the dietary staff</p> <p>2. INSERVICE: Education of GSS policy/procedure for Kitchen Sanitation, Dress Code, Food Temperatures and Sanitizing Solution with test strip checks. Staff will receive education as to appropriate use of hair-nets and complete covering of the hair while in food preparation, serving and food storage areas This education will be provided to the dietary staff by the Dietary Manager on 2/4/14</p> <p>AUDITS: The Dietary Manager is responsible for the audits to be completed and monitor appropriate food temperatures (cold and hot), appropriate sanitizing solution and testing with the test strips and logging the test strip results. Audits will also</p>	

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F 371	<p>Continued From page 23 Solutions policy revealed: *Chemicals should have been in the recommended concentration of levels for maximum efficiency (effectiveness). *There should have been a checking of solution concentrations frequently with a test kit. *The solution concentrations could have become depleted when they killed microorganisms and binded with food. *The sanitizing solution should have been changed when it became depleted or visibly dirty.</p> <p>Review of the provider's March 2009 Cleaning-Sanitation of Non-Food Contact Surfaces policy revealed: *Wiping clothes must be in sanitizing solution until used. *Sanitizing solutions must be checked with test strips for proper solution strength.</p> <p>2. Observation on 1/6/14 at 5:15 p.m. in the kitchen revealed cook H: *With a dark-colored hairnet that had not completely covered all her hair. *Was working over the food in the steam table.</p> <p>Observation at the same time as the above revealed the CDM had a white, disposable, non-woven fabric hair covering on. Her bangs were outside of that covering.</p> <p>Observation on 1/7/14 at 11:30 a.m. in the kitchen revealed: *Dietary assistant I had a light-colored hairnet on that did not completely cover her bangs. *Cook H had a dark-colored hairnet on that did not completely cover all her hair.</p> <p>Observation on 1/8/14 at 12:10 p.m. in the</p>	F 371	<p>include monitoring the use of hair nets in the food prep and storage areas with complete covering of the hair. Audits will be completed by the Dietary Manager and/or designee weekly x 1 month and monthly x 3 months. The Dietary Manager is responsible to report audit findings monthly to the QA Committee for review and further recommendations.</p>	2-17-14

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F 371	<p>Continued From page 24</p> <p>kitchen revealed: *Dietary assistant J had a pink-colored baseball hat with exposed hair outside the sides and back of the hat. *Cook K had a light-colored hairnet on that did not completely cover her bangs.</p> <p>Interview on 1/8/14 at 11:30 a.m. with the consultant dietitian and the CDM agreed the staff that worked in the kitchen needed to completely cover their hair with a hair covering.</p> <p>Review of the provider's March 2009 Dress Code policy revealed: *Hairnets would be in place while in the food preparation or food storage area. *Hair was to have been completely covered.</p> <p>3. Observation and testing on 1/6/14 at 5:15 p.m. in the kitchen in a plastic rectangular bucket located next to the steam table revealed: *The provider's dial food thermometer used by cook H tested the: -Macaroni and pea salad at 60 degrees Fahrenheit (F). -Pureed coleslaw at 60 degrees F. *The temperature of the food items should have been no more than 41 degrees F.</p> <p>Observation and testing on 1/6/14 at 5:27 p.m. on a prepared tray in a tiered-cart located next to the steam table revealed: *The provider's dial food thermometer used by cook H tested the: -Four-ounce Mighty Shake (a nutritional supplement) for resident 19. -Mighty Shake at 50 degrees F. *The temperature of the food item should have been no more than 41 degrees F.</p>	F 371			

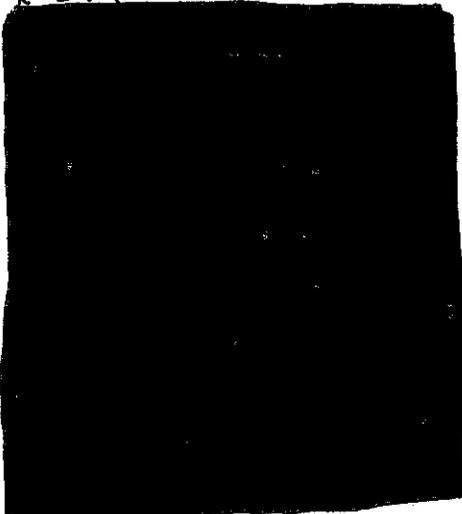
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F 371	Continued From page 25 Interview on 1/6/14 at the time above with the CDM regarding the macaroni and pea salad, pureed coleslaw, and the Mighty Shake revealed: *The food items would have been served at the above temperatures. *The food items needed to be chilled or replaced until acceptable temperatures were achieved before serving them to residents. *The food thermometers had been calibrated (checked and adjusted for accuracy) weekly. *The temperature of the food items should have been no more than 41 degrees F. Review of the provider's March 2009 Food Temperatures policy revealed: *Food temperatures would be taken and recorded before each meal service. *Food would be cooled to ensure proper serving temperatures before meal service. *Food and fluids would be chilled until acceptable temperatures were achieved before serving. *Cold foods would be kept at or below 41 degrees F and served promptly after being removed from the refrigerator.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

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F 441	Continued From page 26 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. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure proper infection control techniques for two of two sampled residents' dressing changes (1 and 9) done by two of two nurses (D and G). Findings include: 1. Observation on 1/7/14 at 1:35 p.m. in resident 1's room revealed:	F 441	F tag 441 Infection Control, Prevent spread, Linens <i>* DK/5000H BT</i>  For resident # 1 and # 9: and for all other potential residents. The provider must provide privacy for the resident during cares and treatment. The staff must inform the resident what they are planning to do. The staff must ensure they are following GSS policy/procedure for proper hand-hygiene, proper hand-hygiene with glove usage. The licensed nurse will ensure the appropriate technique is followed for wound cleaning, treatment and dressing changes and discarding of the dressings occur without contamination to the resident or soiling of the resident's furnishings or equipment.	

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F 441	<p>Continued From page 27</p> <p>*Registered nurse (RN) D, licensed practical nurse (LPN) G, and certified nursing assistant (CNA) E were in resident 1's room.</p> <p>*Resident 1 was in his Broda chair. RN D and CNA E attached the sling to the total mechanical lift. Without informing the resident they transferred him into bed with the lift. Across the room was his roommate who was laying in bed. They had not closed the divider curtain before transferring the resident.</p> <p>*After he was in bed LPN G closed the divider curtain.</p> <p>*Without performing hand hygiene, RN D, LPN G, and CNA E put clean gloves on. They then assisted the resident with turning from side to side in bed while the brief was pulled down.</p> <p>*With the same pair of gloves RN D:</p> <ul style="list-style-type: none"> -Removed the dressing from the resident's buttock area. -Took a new dressing, removed the new dressing from the package, and layed it on the resident's bed spread. *RN D removed his gloves and without performing hand hygiene put a new pair of gloves on. Then: -Without cleaning the wound site applied the new dressing to resident 1's wound area. -Assisted the LPN and CNA with applying a clean brief. -With the same pair of gloves he handed the personal alarm and call light to CNA E. *Then he removed his soiled gloves. <p>2. Observation on 1/7/14 at 4:15 p.m. in resident 9's room revealed:</p> <ul style="list-style-type: none"> *RN D and LPN G had put clean gloves on. *Resident 9 was laying in bed on her left side. *RN D and LPN G assisted the resident onto her back. They then removed resident 9's slacks and 	F 441	<p>IN-SERVICE: Education of GSS policy/procedure for hand hygiene, glove usage, GSS policy / procedure for infection control with appropriate wound dressing changes will be provided by the DNS and/or designee for all staff on 2/4/14.</p> <p>AUDITS: The DNS/ Infection Control Nurse will be responsible the audits be completed to monitor appropriate hand hygiene, glove usage, the appropriate technique for dressing changes and resident privacy during treatments. Audits will be completed by the Infection Control Nurse and/or designee weekly x 1 month and monthly x 3 months. The Infection Control Nurse is responsible to report audit findings monthly to the QA Committee for review and further recommendations.</p>	2-17-14

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F 441	<p>Continued From page 28</p> <p>soiled brief.</p> <p>*RN D took a package of wet wipes from the closet and cleaned off the resident's buttocks with several wet wipes. He discarded the wet wipes on top of the resident's bedspread.</p> <p>*RN D removed his gloves and without performing hand hygiene put a new pair of gloves on.</p> <p>*He took the wound cleaner and two wipes and sprayed the resident's wound area between her anal crease and buttock.</p> <p>*Then he took the wipes, wiped around that area, and discarded the soiled items on top of the resident's bedspread.</p> <p>*RN D then applied a new dressing to the wound area.</p> <p>*At that time the resident had the soiled items on her feet and small blanket at the end of the bed.</p> <p>*The resident began to move her legs and knocked the soiled items onto the floor.</p> <p>*RN D and LPN G put a clean brief and slacks on the resident.</p> <p>*The bedspread was not changed following the above activities.</p> <p>3. Interview on 1/8/14 at 8:40 a.m. with the director of nursing (DON) revealed:</p> <p>*He agreed the dressing changes for residents 1 and 9 had not been done correctly.</p> <p>*His expectations were for the staff to do hand hygiene during the dressing changes.</p> <p>*His expectations were for the soiled items not to be placed on the resident's bed.</p> <p>Review of the provider's revised November 2013 Hand Hygiene and Handwashing policy revealed:</p> <p>***Use an alcohol-based hand rub for routinely cleaning your hands:</p> <p>*Before having direct contact with residents.</p>	F 441		

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F 441	<p>Continued From page 29</p> <p>*After having direct contact with a resident's skin. *After having contact with body fluids, wounds, or broken skin. *After touching equipment or furniture near the resident. *After removing gloves."</p> <p>Review of the provider's revised November 2013 Wound Dressing Change Procedure revealed "Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. Remove gloves and discard in same plastic bag. Perform hand hygiene."</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LENNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST 6TH AVENUE LENNOX, SD 57039
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/7/14. Good Samaritan Society Lennox was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiency identified at K029 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Life/Safety K029 Door Latch The door closer has been adjusted so the door latches as of 1/13/14. The maintenance supervisor or designee will educate staff at the in-service on 2/4/14 to report any doors that do not close properly to the maintenance department to be adjusted. The maintenance supervisor or designee will audit the linen door weekly x 1 month and monthly x 3 months to ensure proper closure. The maintenance supervisor is responsible for reporting the audit montly to the QA Committee for review and further recommendations.	
K 029 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas in one randomly observed area (corridor door to soiled linen holding room) would not close	K 029		2-17-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cody M. Anderson</i>	TITLE <i>Administrator</i>	(X6) DATE 1-31-14
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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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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435082	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/07/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LENNOX			STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST 6TH AVENUE LENNOX, SD 57039		
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K 029	Continued From page 1 and latch. Findings include: 1. Observation at 10:00 a.m. on 1/7/14 revealed the corridor door to the soiled linen holding room adjacent to the laundry was a 60 minute fire rated door with a door closer. When the door was allowed to close using the door closer it would not latch into the door frame. Interview with the director of maintenance at the time of the observation confirmed adjustment to the door was necessary. The door had worked properly during the most recent quarterly door inspection.	K 029			

ORIGINAL

PRINTED: 01/21/2014
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

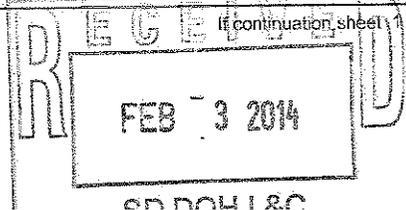
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10642	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LENNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST 6TH AVENUE LENNOX, SD 57039
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S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/6/14 through 1/9/14. Good Samaritan Society Lennox was found not in compliance with the following requirements: S288 and S294.	S 000	Addendums noted with an asterisk per 2/20/14 telephone to facility administrator and DON. DK/SDDOH/JJ	
S 288	44:04:07:02.02 NUTRITIONAL ADEQUACY The dietetic service must ensure that food prepared is nutritionally adequate in accordance with the Recommended Dietary Allowances and is chosen from each of the five basic food groups listed in the Food Guide Pyramid, 1996 or 2005, Center for Nutrition Policy and Promotion, U.S. Department of Agriculture, in accordance with consideration for individual needs and reasonable preferences. This Rule is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure the menus were written to provide the correct portions and adequate amounts of daily fruit servings for all residents on oral diets. Findings include: 1. Observation of the evening meal on 1/6/14 at 5:30 p.m. revealed the written base menu items were served consisting of two to three ounces (oz) of breaded fish sticks, approximately one-half cup of French fries, one-fourth cup of coleslaw, and one-half cup of chocolate pudding.	S 288	S 288 44:04:07:02.02 Nutritional Adequacy The provider must ensure the menus are written to provide the correct portion and adequate amounts of daily fruit servings for all residents. The provider will ensure the menu consists of two or more servings of fruit per day which can include 6 oz. of orange, grape, prune or cranberry juice. One-half cup of raw, canned or cooked fruit, one medium banana. The dietitian and dietary manager will refer to the Food Guide Pyramid and the GSS Nutritional Adequacy of Menus and dietary manual. The dietitian will review the menus for adequacy. IN-SERVICE: Education of GSS policy/procedure for nutritional adequacy, menus and food guide pyramid will be provided by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lois M. Anderson</i>	TITLE <i>Administrative</i>	(X6) DATE <i>1-31-14</i>
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S 288	<p>Continued From Page 1</p> <p>Review of the written base menu for the week of 1/6/14 through 1/12/14 revealed the following fruit servings: *On 1/6/14 the total for the day was four oz of orange juice. *On 1/7/14 the total for the day was four oz of grape juice. *On 1/10/14 the total for the day was four oz of prune juice, one-half fruit jello, and one-half banana. *On 1/11/14 the total for the day was four oz of cranberry juice and one-half cup of grapes.</p> <p>Review of the 1996 Food Guide Pyramid revealed the basic menu pattern had been established for two or more fruit servings per day. A fruit serving consisted of: *Six oz orange, grape, prune, or cranberry juice. *One-half cup raw, canned, or cooked fruit. *One medium banana.</p> <p>Interview on 1/8/14 at 11:30 a.m. with the consultant dietitian and the certified dietary manager regarding the written base menu and the fruit servings confirmed: *The fruit juices served were four oz, and that amount was less than a fruit serving. *An additional fruit serving was not always served each day to all residents on oral diets.</p> <p>Review of the provider's revised January 2009 Nutritional Adequacy of Menus policy revealed: *The menus would be prepared to provide adequate nutrition using a standard menu-planning guide in accordance with physician orders. *Menu planning guides had included the Food Guide Pyramid.</p>	S 288	<p>Dietary Manager and/or Dietitian for the dietary staff on 2/4/14. AUDITS: The Dietitian/Dietary manager will be responsible for audits to be completed to monitor that the menus consist of two or more servings of fruit each day and adequate amounts or portions of fruit each serving. Audits will be completed by the Dietary Manager and/or dietitian weekly x 1 month and monthly x 3 months. The Dietary Manager will be responsible to report audit findings monthly to the QA Committee for review and further recommendations.</p>	2-17-14

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S 294	Continued From Page 2	S 294		
S 294	44:04:07:04 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days. This Rule is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure the menus were written to provide the correct food and portions for one of one sampled resident (13) on a renal (kidney) diet. Findings include: 1. Review of resident 13's complete medical record revealed: *He had a diagnosis of chronic kidney disease. *He was on dialysis (a process used to remove accumulated waste products and excess fluids from the blood) three times per week. *He had a 11/6/13 physician's order for a renal	S 294	S294 44:04:07:04 Written Menus For resident # 13: The provider must ensure the written menu consists of the correct foods and portions. For Resident # 13 with a physician order for renal (kidney) diet and fluid restriction of 1.5 liters per day; the menu extension should list the food items and portions sizes the resident can consume and also identify food items the resident should not be served. The dietary staff must identify the amount of fluids the resident should be offered at meal time and communicate with nursing if the fluids were or were not consumed. The dietitian should visit with the resident to determine preferences and choices are identified on the diet card. The dietitian will monitor specific values for protein, calories, phosphorus, potassium, fluids and calcium. For all other potential residents who have physician orders for a therapeutic diet or need of menu extension, the provider must ensure the written menu consists of the correct food and portions per the menu extension. The dietary staff should identify food items that are allowed and/or not allowed per the menu extension and	

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S 294	Continued From Page 3 diet with 1.5 liters (six and one-fourth cups) fluid restriction per day. Review of the week's daily written menus for the week of 1/6/14 through 1/12/14 for the renal diet revealed: *A diet heading typed as "Renal" was located on the upper-right side of each menu extension. *There was nothing listed below the renal diet heading for food items or portion sizes. Review of resident 13's diet card revealed: *He was on ground meat. *He was on a fluid restriction with 120 cc (cubic centimeters) juice and water each meal. *He was to receive no bread, green beans, baked beans, broccoli, raw vegetables, cabbage, cheese, peanut butter, cauliflower, corn, combination dishes, raw salads, sandwiches, coffee, tea, bacon, chocolate, and cranberry juice. Interview on 1/8/14 at 11:30 a.m. with the consultant dietitian and the certified dietary manager regarding resident 13's renal diet agreed: *The above food items and portion sizes were not on the daily written menu extensions. *The cooks who served the menu each day did not have the written menu items and the portion sizes for the daily renal menus. Interview on 1/8/14 at 2:30 p.m. with the director of nursing confirmed the physician's order for resident 13 was a renal diet with a fluid restriction. That needed to be followed on the daily written menus. Review of the provider's revised March 2009 Portion Control policy revealed the portion sizes: *On the menu extensions would be followed.	S 294	any fluid restrictions. The dietitian should visit with the resident to determine preferences and choices are identified on the diet card and monitor the specific values for protein, calories, phosphorus, potassium, fluids and calcium. The dietary manager should communicate with the dietitian when residents receive physician orders for therapeutic diets and require menu extensions. IN-SERVICE: Education of GSS policy/procedure for nutritional adequacy and menu extensions. The Dietary Manager and/or Dietitian will provide education for the dietary staff on 2/4/14 AUDIT: The dietitian and/or dietary manager are responsible that audits will be completed to monitor the menu extensions for adequate food items, fluids and portions for accurate diet card. Audits will be completed to ensure the dietitian is reviewing the menu extensions. Audits will be completed by the dietary manager and/or dietitian weekly x 1 month and monthly x 3 months. The Dietary manager is responsible for reporting the audit f monthly to the QA committee for review and further recommendations.	2-17-14

on four residents per week. DK/SOAH/JJ

DK/SOAH/JJ

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S 294	Continued From Page 4 *For the menu extensions must be referred to during meal service. *Would be adjusted per resident preference as needed and noted on the diet card. Review of the provider's 2011 Diets for Chronic (long term) Kidney Disease diet manual revealed: *Diet prescription recommendations were individualized depending on the type of chronic kidney disease present and based on specific values for protein, energy (calories), phosphorus, potassium, fluid, and calcium. *All of those diets would be customized based on the needs of the resident.	S 294		