

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

ORIGINAL

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 4861 LINCOLN AVENUE SELBY, SD 57472		
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F 000	INITIAL COMMENTS <i>Addendums noted with an asterisk per 3/3/14 telephone to facility administrator. mp/500H/JJ</i> Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/22/14 through 1/23/14. Good Samaritan Society Selby was found not in compliance with the following requirements: F248, F279, F281, F323, F441, and F514.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state laws. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.		
F 248 SS=E	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: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure an effective one-to-one activity program had been maintained for 2 of 11 sampled residents (4 and 5). Findings include: 1. Review of resident 4's 12/10/13 care plan revealed: *A focus area that the resident was dependant on staff for activities, cognitive (mental) stimulation, and social interaction related to cognitive deficits (decline) as evidenced by the resident crying in group activities. *An intervention for the above focus area was to provide one-to-one staff room visits at the residents bedside and activities at the bedside if	F 248	F 248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT Response: Effective February 10th 2014, the Activity Director and staff will do a 1:1 activity with Resident 4 and 5, four times per week. Activity Director will also educate weekend managers on February 4th on how to document activities on the weekend and 1:1 activities throughout the week. Activity Director will provide training to staff on what constitutes as a 1:1 activity, benefits of 1:1 activities, incorporating other identified assessment needs, and documenting the provision or refusal of activity.		

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

Kayley Cartmell

TITLE

Administrator

2-10-14
(X6) DATE

2/13/14

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

RECEIVED
FEB 18 2014
FEB 17 2014
SD DOH L&C

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F 248	Continued From page 1 the resident is unable to attend out of room events. *A focus area that the resident had a potential for pain/discomfort related to a history of frequent falls, generalized pain, and a diagnosis of frequent falls with minor injuries. *The goal for the pain and, or discomfort focus area was the resident would not have an interruption in normal activities due to pain through the review date of 3/11/14. *An intervention to report to the nurse any change in usual activity attendance patterns or the refusal to attend activities related to signs and symptoms or complaints of pain such as grimacing or guarding. Interview on 1/23/14 at 7:35 a.m. with the activities director regarding resident 4 revealed: *She had not been on a one-to-one activity program. *There had been no documentation of one-to-one activities. Surveyor: 28057 2. Review of resident 5's care plan revealed it had not been individualized or had included one-to-one activities to meet his needs. Refer to F279, finding 7.	F 248	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. <i>AUDIT: 1:1 activities will be audited weekly x 1 month, and then monthly x 3 months. Audit findings will be submitted in a report by the Director of Activities or designee to the QA Director monthly for further recommendations by the QA Committee.</i>		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279	F 279 DEVELOP COMPREHENSIVE CARE PLANS Response: See next page		

by the interdisciplinary team MP/Sarah JJ

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F 279	<p>Continued From page 2</p> <p>objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on record review, interview, and policy review, the provider failed to ensure care plans had been individualized, accurate, and updated to reflect current resident status for 6 of 11 sampled residents (1, 3, 4, 5, 8, and 11). Findings include:</p> <p>1. Review of resident 3's incident reports revealed: *An incident report dated 10/23/13 at 3:05 a.m. stated the resident had been found laying on the floor with pajama pants almost off and incontinent of urine. *Resident had a fall with a hip fracture that had been repaired on 10/31/13. The incident reports had not clarified which fall had resulted in the fracture. *An incident report dated 11/9/13 at 7:25 a.m. stated the resident "questionably getting up to bathroom" might have been a contributing factor to that incident. The corrective action was to toilet</p>	F 279	<p>1. Resident 3's care plan was reviewed and updated to include but not limited to the addition of a toileting and repositioning program. All areas of resident 3's care plan were updated to reflect current condition</p>		

*
MP/SQD/H/JS

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F 279	<p>Continued From page 3 in the early a.m. *The resident had four falls after the fall on 11/9/13 (11/12/13, 11/13/13, 11/14/13, and 11/20/13).</p> <p>Review of resident 3's bladder and bowel assessments dated 11/13/13 revealed a recommendation for her to be put on a scheduled toileting program "upon awakening, before and after meals, before bed, and PRN." She had been continent (able to retain urine) before the hip fracture. She needed extensive staff assistance with activities of daily living (ADL).</p> <p>Review of resident 3's comprehensive care plan dated 1/7/14 revealed a toileting program had not been included in the care plan. The care plan had a focus area of ADL self care performance deficit with a goal that she would not decline in her current ADL status. The plan for that focus area stated "toilet use: [resident name] need assist of staff. When restless offer the bathroom. Frequently incontinent."</p> <p>Interview on 1/23/14 at 1:00 p.m. with the director of nursing (DON) revealed there had not been any documentation of a toileting program for resident 3. There was no documentation of certified nursing assistants taking resident 3 to the bathroom. She had been aware a toileting program had not been on resident 3's care plan. It had been discussed at the resident's quality of life conference on 1/7/14 and had not been put on the care plan, because the resident's health and cognition (ability to know and understand) had been declining.</p> <p>Review of the 1/7/14 quality of life conference sheet revealed a statement "focuses resolved</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>due to decline in status; no longer participating in activities and is no longer ambulating, having behaviors or rummaging." There had been no statement addressing how toileting needs had been resolved.</p> <p>2. Review of resident 11's 8/27/13 significant change Minimum Data Set (MDS) revealed a care area assessment (CAA) for falls. Review of the 8/27/13 fall CAA revealed resident 11 had a fall that caused a hip fracture. The form stated "yes" to proceed to care plan, because the resident "has history of falls; has poor balance; last fall resulted in major injury."</p> <p>Review of resident 11's 9/5/13 and 12/5/13 care plans revealed falls had not been included on those care plans. There had been a handwritten note dated 12/9/13 on the 12/5/13 care plan stating "actual fall, no injuries noted, remind resident to stand slowly before ambulating." Goals and approaches for achieving goals for decreasing or eliminating falls had not been addressed.</p> <p>Interview on 1/23/14 at 2:15 p.m. with the MDS coordinator revealed she was not sure why falls had not been addressed and agreed falls should have been on the care plan.</p> <p>Surveyor: 32333</p> <p>3. Review of resident 1's 12/18/13 care plan revealed an intervention to provide a restorative nursing program to maintain improved strength and balance.</p> <p>Interview on 1/23/14 at 1:20 p.m. with the physical therapist regarding resident 1 revealed: *She had not been in the restorative nursing</p>	F 279	<p>2. Resident 11's care plan was reviewed to include but not limited to the addition of a fall focus.</p> <p>3. Resident 1's care plan was reviewed to include but not limited to the removal of a restorative program intervention and a PT intervention was added.</p>	<p>* [Redacted] MP/SOONH/JJ</p> <p>* [Redacted] MP/SOONH/JJ</p>	

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F 279	<p>Continued From page 5</p> <p>program since she had been back from the hospital. *She had been readmitted to the facility from the hospital on 1/10/14.</p> <p>Review of the provider's therapy services log revealed resident 1 had started physical therapy on 1/14/14.</p> <p>Resident 1's 12/18/13 care plan had not been changed or updated to reflect that she was no longer in the restorative nursing program and that she had started physical therapy.</p> <p>4. Review of resident 4's 10/23/13 incident report revealed: *She was found on the floor in the bathroom sitting with her feet in front of her and her pants around her ankles. *She had an immediate intervention on that fall report for staff not leave her alone in the bathroom.</p> <p>Review of resident 4's current December 2013 care plan revealed there had been no mention of staff not to leave the resident alone in the bathroom.</p> <p>5. Review of resident 8's 1/16/14 physician's order revealed an order that stated "May use lap buddy (a flat cushion that fits over a person's lap and under the armrests of a wheelchair or chair)."</p> <p>Review of resident 8's 12/5/13 care plan revealed no mention of the use of a lap buddy. Refer to F281, finding 1.</p> <p>6. Interview on 1/23/14 at 2:00 p.m. with the director of nursing regarding the above findings</p>	F 279	<p>4. Resident 4's care plan was reviewed and updated to include but not limited to an intervention to not leave her alone in the bathroom when toileting.</p> <p>5. An order was obtained on 1/27/14 for Resident 8's lap buddy used for positioning to be discontinued on 1/27/14 since he has not used it since 8/29/13.</p>	<p>* [Redacted]</p> <p>MP/SACOH/JJ</p>

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F 279	<p>Continued From page 6 confirmed: *She would have expected care plans to have been accurate, updated, and current. *Resident 4's intervention to not be left alone in the bathroom should have been included on her current care plan.</p> <p>Surveyor: 28057 7. a. Review of resident 5's medical record revealed faxed messages to the physician that the resident had fallen on 10/4/13 and 10/27/13.</p> <p>Review of resident 5's interdisciplinary progress notes from 10/4/13 through 1/20/14 revealed he had fallen on 10/4/13, 10/27/13, 10/28/13, 11/20/13, 11/24/13, and 1/11/14.</p> <p>Review of resident 5's Falls Data Collection tool dated from 11/13/13 through 1/11/14 revealed he had fallen on 11/13/13, 11/29/13, and 1/11/14. He had scored a twenty-two on all of those dates for a fall risk on that form. A score of twelve or higher was considered a high risk for falls. The form had stated to proceed to care plan approaches and to review and revise as appropriate. There had been no documentation in the progress notes in regards to the falls on 11/13/13 and 11/29/13 as to what had happened or if there had been any injuries.</p> <p>Review of the resident's current 9/24/13 care plan revealed a problem "Potential for falls R/T (related to) poor cognition (mental function) and incontinence". The goal through 12/24/13 had been "Will remain free from injury". The plans and approaches had been: **"Encourage to sit up, get up and sit down slowly." **"Have bed in lowest position when resident in</p>	F 279	<p>6. IN-SERVICE EDUCATION: On February 6, 2014 in-service education was provided to Professional Nurses on the proper follow up assessments, notification and documentation for falls and all incident reports. At this same time education was provided regarding the policy for the entire care plan process per policy and restraint use per policy.</p> <p>7a.b.c. Resident 5's care plan was updated to include but not limited to an elopement focus and a restructured fall focus.</p>	<p>2-6-14</p> <p>* [Redacted] MPL/soohl/SJ</p>	

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F 279	<p>Continued From page 7 bed." **"To prevent falls keep room clean and free from clutter; offer assistance as needed." **"Be sure floor in room is dry at all times." **"Monitor for needing assistance getting into bed." **"R (restorative): walk to/from meals 15 min (minutes) daily 6-7 x/wk (times per week)." **"Use wheelchair to move about the facility as able since he has had so many falls recently. Legs buckle and give out."</p> <p>Handwritten on that same care plan under the problem of potential for falls as above was written the dates 11/13/13, 11/23/13, 11/29/13, and 1/11/13 (14). Next to the date 11/13/13 was handwritten "Actual fall-small skin tear" with an arrow pointing up to the goal of will remain free of injury. Next to the date 11/23/13 ditto marks had been entered in reference to the documentation entered on 11/13/13. For the dates 11/29/13 and 1/11/13 (14) ditto marks were entered under the words "actual fall" and written in on 11/29/13 a zero with a line through it and the word injury to indicate no injury. They all had an arrow pointing up to the goal of would remain free of injury. Under the plans and approaches "staff continue to monitor whereabouts" had been handwritten.</p> <p>No other revisions had been documented on the care plan for any of the above falls. The goal was no longer appropriate as injuries had occurred from four of the eight falls documented in his medical record. The intervention for staff to continue monitoring his whereabouts had not explained how that was to have been achieved by the staff.</p> <p>Interview on 1/23/14 at 2:35 p.m. with the director of nursing confirmed they had been "at their wits</p>	F 279		

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F 279	<p>Continued From page 8</p> <p>end" and "out of ideas" to address falls for resident 5 and other residents that had frequent falls.</p> <p>Interview on 1/23/14 at 1:35 p.m. with the quality assurance coordinator confirmed the medical director had not offered any input for solutions to the high number of resident falls. She stated medications had been adjusted, and the number of Tabs alarms (personal body movement alarm) being used had increased.</p> <p>Review of the provider's monthly November 26, 2013 Quality Indicators Meeting Agenda revealed there had been twenty-five falls since the last meeting in October 2013. One fall had resulted in a major injury, and twelve falls had resulted in minor injuries. Trends had been identified for three residents including residents 4 and 5. The action plan at that time had been not to leave resident 4 alone in the bathroom and to have the incontinence product fall team provide an in-service in January or February 2014. No action had been documented in regards to resident 5 for December 2013's meeting.</p> <p>Review of the provider's monthly December 17, 2013 Quality Indicators Meeting Agenda revealed there had been a total of nine falls since the last meeting in November 2013 with no major injuries and five minor injuries. No trend had been noted. It had not indicated who had fallen. The action plan was still to have the incontinence product fall team provide an in-service in February. It had not included documentation to explain the cause for the decrease in falls.</p> <p>b. Review of resident 5's medical record revealed he had a diagnosis of Alzheimer's disease and</p>	F 279			

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F 279	<p>Continued From page 9</p> <p>dementia (impaired mental function). On his 11/31/13 Minimum Data Set quarterly assessment he had been unable to complete a Brief Interview for Mental Status test due to his cognitive ability. It was determined he had short term and long term memory loss and was moderately impaired for decision making.</p> <p>Review of resident 5's nursing progress notes dated 1/10/14 at 3:40 p.m. revealed he had eloped (left the building unattended) with no jacket on. He had been looking for his car. He had been easily re-directed into the building.</p> <p>Review of resident 5's current printed care plan last revised on 1/11/13 revealed there had been no revised plan or approach that had addressed the resident's elopement on 1/10/14. The care plan had interventions entered on 9/24/13. One was to check for placement of a Watchmate device daily. That device would cause the doors to alarm if he went outside. Another was to monitor him off of the unit and that he could not be outside alone. Those interventions had been listed under the problem of "Alteration in self cares R/T impaired thought processes M/B (manifested by) assistance needed with all ADL's (activities of daily living)."</p> <p>c. Review of resident 5's care plan revealed no problem/need/concern listed for activities specifically. It had a concern listed "Potential for ineffective coping R/T short and long term memory problems." The goal for that concern had been "Resident will participate in preferred independent activities daily. Will attend large group activity x (times) 2 weekly." The interventions related to activities with that concern had been:</p>	F 279		

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F 279	<p>Continued From page 10</p> <p>**Assist resident to activities.</p> <p>**Respect residents choice in regard to limited or no activity for the day.</p> <p>**Invite on outings.</p> <p>**Provide Catholic service x 1 monthly.</p> <p>It had not included one-to-one activities or any individualized activities based on his interests other than attending church services one time per month. It had not addressed activities related to his past work history.</p> <p>Review of his Activity Participation Report from 10/1/13 through 1/23/14 revealed no one-to-one activities. During that same time frame there had been seventeen weekends with activities on only two of those weekends. Fourteen weekdays the resident had not been involved in an activity or documented as having refused the offered activity during that timeframe. Twenty-one of those days it had been documented he had attended only one activity.</p> <p>Interview on 1/22/14 at 7:45 p.m. with the resident's wife confirmed the resident had worked most of his life. He had worked until he no longer was able to do that. Work had been very important to him. He had very few hobbies. He had played cards socially before his cognitive impairment was present. Church was very important to him. She had asked the provider to have him attend all of the church services, not just the Catholic services as he seemed to enjoy that. She said he did not go to bingo anymore unless she or someone went with him as he could not do it by himself anymore.</p> <p>Review of the provider's September 2012 Activity Program policy revealed program activities were to have been a combination of large and small</p>	F 279		

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F 279	<p>Continued From page 11</p> <p>groups plus one-to-one and self-directed activities. The focus of the activity program was to have addressed the interests and the physical, mental, and psychosocial well being of the resident based on the comprehensive assessment.</p> <p>Interview on 1/23/14 at 2:20 p.m. with the activities coordinator confirmed most of the residents in the facility needed one-to-one activities due to their cognitive impairments. She further confirmed the only activities on the weekends had been church on Sunday. A group of independent card players had gotten together on their own without support from the activities department or the staff.</p> <p>8. Interview on 1/23/14 at 2:35 p.m. with the director of nursing confirmed they had been "at their wits end" and "out of ideas" to address falls for resident 5 and other residents that had frequent falls. She asked this surveyor "what would you do" for activities and interventions to lower the number of falls and meet the residents' activity needs. When asked if they had any recent in-services for working with cognitively impaired residents she confirmed she had offered the "Hand in Hand" training from Centers for Medicare and Medicaid Services to the staff. It had not been required, and she had not been sure who had used it. A consultant team from the company for the incontinence products used by the provider was to come in February and put on an in-service related to falls.</p> <p>Review of the provider's September 2013 Comprehensive Care Plan and Care Conferences policy revealed the purpose of the care plan was to provide an ongoing method to</p>	F 279	<p>Documentation of the watch mate placement and functionality was added to the TAR for the licensed nursing or UAPs to document on. This documentation will be done twice daily. An intervention for an activity 1:1 four times weekly was also added. On 2/4/14 the weekend leadership team was educated on proper documentation of 1:1's in the KIOSK to provide for weekend documentation.</p> <p>For all other potential residents: Residents identified with care planning needs during their admission, quarterly and prn assessments will have care plans implemented that will help the resident maintain the highest level of functioning. These care plans will be individualized and measureable. Care plans will be reviewed by the IDT approximately every 6 weeks through the Quality of Life and Care Conference process.</p> <p>AUDITS will be done addressing timely updating of the care plans on 3 random residents as follows: Weekly for 1 month and monthly for 3 months. Audits will be performed by the Director of Nursing Services and/or designee. Audit findings will be submitted in a report by the Director of Nursing Services and/or designee to the Director of Quality monthly for further review by the QA committee.</p>		

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F 279	Continued From page 12 provide care. That method would include assessments, implementation, evaluation, and updating of the care plan to maintain the resident's highest level of functioning. Interventions were to have been individualized and included what was to be done, and when and how often it would be done.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and procedure review, the provider failed to ensure: *They had clarified physician's orders and followed facility procedure for 1 of 1 sampled resident (8) with a lap buddy (a flat cushion that fits over a person's lap and under the armrests of a wheelchair or chair) physical restraint. *Follow-up blood pressure assessments had been completed for 1 of 11 residents (10) following a fall. *The quality assurance (QA) committee effectively documented factors related to reported falls and effectiveness of those QA activities for 4 of 11 sampled residents (3, 4, 5, and 11) with falls. Findings include: 1. Review of resident 8's 1/16/14 physician's orders revealed: *An order that stated "May use lap buddy." *There had been no clarification of when or how often to use the lap buddy.	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Response: 1. An order was obtained on 1/27/14 for Resident 8's lap buddy used for positioning to be discontinued on 1/27/14 since he has not used it since 8/29/13.	

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F 281	<p>Continued From page 13</p> <p>Review of the 7/3/12 physical restraint assessment form for resident 8 revealed a lap buddy physical restraint for poor posture and sliding down and out of wheelchair.</p> <p>Review of resident 8's 12/5/13 care plan revealed no mention of a lap buddy physical restraint.</p> <p>Interview on 1/23/14 at 3:05 p.m. with the MDS coordinator revealed there had been no informed consent signed by the resident or a person authorized to sign for the resident for the use of the lap buddy physical restraint.</p> <p>Review of the provider's revised August 2013 Physical Restraints procedure revealed: **Obtain the physician's order for the appropriate restraint, times to be used and the medical symptom for use." **Obtain informed consent using the Permission for Use of Physical Restraints. If the resident is unable to provide consent, documentation must be completed stating the reason. Permission will be obtained from a person authorized to sign for the resident." *Update the resident care plan to include the reason for the restraint, the required monitoring and a measurable goal relating to the rationale for its use." **Be certain that the physician's order, the Physical restraint Assessment, the Permission for Use of Physical Restraints , and the care plan all match for type of restraint use, when it will be used, and how often it is to be released.</p> <p>Surveyor: 32572 2. Review of resident 10's medical record revealed:</p>	F 281		

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F 281	<p>Continued From page 14</p> <p>*She had fallen on 11/7/13 and with that fall there had been a large orthostatic (positional) blood pressure change. There had been no follow-up assessments of orthostatic blood pressures. There had been no follow-up with the physician regarding the blood pressures.</p> <p>Interview on 1/23/14 at 1:30 p.m. with the DON regarding resident 10 confirmed orthostatic blood pressures had not been followed-up on 11/7/13. There had been no follow-up with the physician regarding the orthostatic blood pressure changes.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO., 2013, p. 461, revealed "Orthostatic hypotension (low blood pressure) occurs when the blood pressure becomes low when rising to an upright position." That could cause a resident to become dizzy and fall.</p> <p>Surveyor: 28057</p> <p>3. Review of the monthly report for falls from November 2013 through December 2013 revealed a common factor had not been identified. Not all of the information gathered by the committee and used to address residents' falls had been documented in the QA reports or had been carried forward to the residents' care plans. Refer to F279, findings 2, 4, and 5.</p> <p>Surveyor 32573 Review of the 11/29/13 QA meeting notes revealed a listing of resident incidents from 10/15/13 to 10/31/13 and from 11/1/13 to 11/20/13. There had not been a description of</p>	F 281	<p>2. In regard to Resident 10, on February 6, 2014 IN-SERVICE EDUCATION was provided to Professional Nurses on the proper follow up assessments, notification and documentation for falls and all incident reports. This education included but was not limited to education on obtaining orthostatic blood pressure readings post fall and prn.</p> <p>3. From 2/3/14 to 3/9/14 manual reports will be compiled to address location, time and cause of each incident. These reports will be completed by the Safety Officer and will be reported monthly to the QA director. Starting 3/10/14 and going forward these reports will be compiled electronically through the PCC application. The available reports will be reviewed at least monthly by the QA Director and QA team.</p>	2/6/14	

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F 281	<p>Continued From page 15</p> <p>what type of incident each resident had been involved in. There had not been information regarding how the provider determined what trends existed and how they decided what corrective measures to take to reduce falls.</p> <p>The November 2013 QA notes stated resident 3 had a "trend noted even though we are using TABS (personal alarm that clips to resident's clothing to warn of falls) now." The 1/21/14 quarterly QA meeting notes stated in November resident 3 had been "using a TABS unit now, which is helping." Those statements contradicted each other, and there had been no information about how those conclusions had been reached. There had been no other information regarding how it had been determined if the TABS unit had been effective in reducing falls. Resident 3 had more falls in November than in October; refer to F323, finding 2.</p> <p>There had been no information on what previous QA actions had been taken to reduce falls, if those actions had been effective, or comparisons to show how QA methods had been effective over time. The notes had not shown a complete process and evaluation of fall management.</p> <p>Surveyor 28057 Review of the provider's revised March 2012 Quality Improvement at Good Samaritan Society policy revealed the purpose had been to develop methods that had evaluated actions and systems that affected resident outcomes. The center was to have collected data and evaluated it for outcomes. Action plans would be implemented and evaluated for effectiveness on a regular basis.</p>	F 281	<p>AUDIT: Incident reports will be audited by the Administrator, Director of Nursing Services and Social Service Director no later than the next business day. Immediate interventions will be implemented for incident reports that are found to be lacking. Audit findings will be submitted in a report by the Director of Nursing or Designee to the QA Director for further review and recommendations by the QA Committee.</p> <p>For all other potential residents: Effective with the next QA meeting on 2/18/14 and all upcoming meetings; the root cause analysis will be used to determine the cause of falls and immediate audits will be performed to ensure that practical interventions were put into place. The QA director will record these discussions.</p>	

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F 323 F 323 SS=E	Continued From page 16 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review and interview, the provider failed to ensure interventions were in place to prevent avoidable accidents for 3 of 11 residents (3, 4, and 10). Findings include: 1. Resident 10's medical record revealed: *She had the following diagnoses and had been on medications for: -Hypertension (high blood pressure). -Atrial fibrillation (irregular heart beat). -Chronic kidney disease. -Depression. -Diabetes. *She had fallen five times from 11/7/13 through 1/10/14. *Those falls occurred in or on the way to the bathroom. *They had occurred between the hours of 1:00 p.m. to 10:20 p.m. *Two of the five falls revealed orthostatic (positional) blood pressure problems or complaints of dizziness. *Staff had not re-assessed the orthostatic blood pressure issues or notified the physician of them.	F 323 F 323	F 323 FREE OF ACCIDENT HAZARDS/SUPERVISION /DEVICES Response: 1. For Resident 10 INSERVICE EDUCATION was provided on February 6, 2014 to the Professional Nurses including but not limited to incident report completion, assessment and follow up including orthostatic blood pressure assessment.		

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M/S/DOH/PT

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F 323	<p>Continued From page 17</p> <p>Interview on 1/23/14 at 1:30 p.m. with the director of nursing confirmed the orthostatic blood pressures had not been assessed after three of the five falls that had a change in orthostatic blood pressures. She stated the Incident Details form is not always complete such as the orthostatic blood pressure being evaluated.</p> <p>Surveyor: 32573 2. Review of resident 3's medical records revealed: *She had three falls on 10/23/13. She had been sent to the physician in the morning after the first fall, then had two more unwitnessed falls later that day. -The 10/23/13, 3:05 a.m. fall incident reports immediate interventions, corrective actions, investigation results, and follow-up sections had been left blank. -The 10/23/13, 4:30 p.m. fall incident reports corrective actions section had been left blank. *The 10/26/13, 5:00 p.m. fall incident reports assessment/evaluation and immediate interventions, corrective actions, and investigation results sections had been left blank. *She had been transferred to the hospital on 10/30/13 and had surgery for a hip fracture on 10/31/13. *Documentation had been unclear on which fall had caused the fracture. *She returned to the facility from the hospital on 11/4/13. *She had five falls in November 2013 (11/9/13, 11/12/13, 11/13/13, 11/14/13, and 11/20/13). -The 11/9/13, 7:25 a.m. fall incident reports corrective actions section stated to anticipate resident's needs and toilet in early a.m. That was the first corrective actions that had been called for</p>	F 323	<p>2. For Resident 3, INSERVICE EDUCATION was provided as stated previously.</p>	<p><i>AP/SAAH/JS</i> 2.13.14</p>

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F 323	<p>Continued From page 18 after she returned from the hospital. *She had four falls after that 11/9/13 fall occurred. *Progress notes had not revealed any information about when resident 3 had been toileted and if any corrective actions from 11/9/13 incident report had been implemented after that fall to prevent future falls.</p> <p>Surveyor: 32333 3 Review of resident 4's 10/23/13 incident report revealed: *She was found on the floor in the bathroom sitting with her feet in front of her and pants around her ankles. *She had an immediate intervention for staff not to leave her alone in the bathroom.</p> <p>Review of resident 4's current December 2013 care plan revealed there had been no mention of staff leaving the resident alone in the bathroom.</p> <p>Interview on 1/23/14 at 8:30 a.m. with the director of nursing confirmed resident 4's care plan should have included the intervention not to leave her alone in the bathroom.</p>	F 323	<p>3. On 2/3/14 Resident 4's care plan was reviewed and updated to include but not limited to an intervention to not leave resident alone in the bathroom.</p> <p>For all other potential residents: Residents identified with care planning needs during their admission, quarterly and prn assessments will have care plans implemented that will help the resident maintain the highest level of functioning. These care plans will be individualized and measureable. Care plans will be reviewed by the IDT approximately every 6 weeks through the Quality of Life and Care Conference process</p>	<p>* [Redacted]</p> <p>MP/SD00H/JJ</p>
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>	F 441	<p>F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>Response:</p> <p>1-5. On 2/6/14 for Professional Nurses and on 2/13/14 for All Staff, INSERVICE EDUCATION was provided on proper hand hygiene, glove use and emptying of catheter drainage bags. Professional nurses were also educated on proper technique for dressing changes, BGM usage, and transdermal patch application.</p>	

Significant Change,
MP/SD00H/JJ

and as needed
MP/SD00H/JJ

* [Redacted]
MP/SD00H/JJ

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F 441	<p>Continued From page 19</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Sanitary technique was used by registered nurse (RN) A during one of one sampled resident's 7 observed dressing change with wound care. *Personal care was provided in a sanitary manner for two of two residents (5 and 6) observed during personal care by one of one certified nurse</p>	F 441 <i>by a quality assurance team member: mpls20011/JJ</i>	<p>AUDITS regarding proper hand washing/ hand hygiene, proper BGM usage, proper dressing change, proper transdermal patch application will be done as follows:</p> <p>Weekly for 1 month, monthly for 3 months. Audit findings will be submitted in a report by the Director of Nursing or Designee to the QA Director for further review and recommendations by the QA Committee.</p> <p>For all other potential residents: A random sampling of residents will be included in the above audits to ensure that proper infection control practices are being followed for all residents.</p>	* 2/13/14 mpls20011/JJ

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F 441	<p>Continued From page 20 assistants (CNA) A.</p> <p>*Appropriate handwashing and glove use during one of one observation of a resident's (13) medicated patch application by unlicensed assistive personnel (C).</p> <p>*The blood glucose meter (BGM) (used for checking blood sugar levels) was properly cleaned by RN D after one of one randomly observed BGM test for resident 10.</p> <p>Findings include:</p> <p>1. Observation on 1/22/13 at 9:45 a.m. of RN A while she completed a dressing change for resident 7 revealed she:</p> <p>*Laid all of the dressing supplies directly on the resident's bedspread without putting down a barrier between the supplies and bedspread. Those supplies had included unpackaged gauze pads, tape, and a bottle of wound cleanser.</p> <p>*Changed her gloves three times during the dressing change. Two of those three times when she changed gloves she had not washed or sanitized her hands.</p> <p>*Had not cleaned the scissors that had been in the pocket of her uniform top before she used them.</p> <p>*Set the bottle of wound cleanser on the floor after she had used it.</p> <p>*Returned hat same bottle of wound cleanser to the medication cart's bottom drawer without cleaning or sanitizing it.</p> <p>Interview on 1/23/14 at 10:45 a.m. with the director of nurses (DON) confirmed she would have expected RN A to have:</p> <p>*Washed her hands between glove changes.</p> <p>*Placed a clean barrier down for the dressing change supplies to have been laid on.</p> <p>*Cleaned the scissors after they had been</p>	F 441			

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F 441	<p>Continued From page 21 removed from her pocket and before she had used them. *Not set the bottle of wound cleaner on the floor.</p> <p>Review of the provider's last revised November 2013 Wound Dressing Change Procedure revealed: *Hand hygiene should have been performed after soiled gloves had been removed. *A field (clean barrier) should have been created for the clean unused dressings.</p> <p>Surveyor: 28057 2. Observation on 1/22/14 at 2:45 p.m. revealed CNA A assisted resident 5 to the bathroom. During those cares CNA A had removed the resident's disposable brief and placed it into a trash bag. She then removed her soiled gloves and threw them away. She opened and closed the door as she left the room but she had not washed her hands. She returned with a clean incontinence product for the resident. She placed it on the resident so it would be ready to be pulled up when he stood up from the toilet. CNA A then: *Washed her hands for less than ten seconds and put clean gloves on. *Cleaned the resident's bottom as he had a bowel movement. *Removed her gloves and pulled his pants up. *Pulled the privacy curtain back and opened the door. *Assisted the resident to wash his hands before she had washed her hands. *Washed her hands for less than five seconds that time. She confirmed this had been her usual procedure for cares.</p>	F 441		

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F 441	<p>Continued From page 22</p> <p>Interview on 1/23/14 at 2:35 p.m. with the DON confirmed she would have expected the CNA to have washed her hands before she left the room.</p> <p>Review of the provider's revised November 2013 Hand Hygiene and Handwashing policy revealed hands were to have been washed for at least twenty seconds. It had not addressed glove use.</p> <p>Review of the provider's revised February 2005 Gowning, Gloves, Masks, and Goggles policy revealed it had not addressed the need to wash hands before or after glove use.</p> <p>Surveyor: 32572</p> <p>3. Observation on 1/22/14 at 9:30 a.m. in resident 6's room of CNA A while she had provided personal care for the resident who had a diagnoses of Methicillin Resistant Staphylococcus Aureus (MRSA) (a tough type of infection) in her urine revealed:</p> <ul style="list-style-type: none"> *She had placed an empty urinal (container for males to urinate into) onto the floor without placing a barrier between the floor and urinal. *The resident's catheter bag (collects urine) had then been emptied into that urinal. *The urinal had then been washed with soap and water and placed into the storage area behind the curtain. <p>Interview on 1/22/14 at 2:30 p.m. with the infection control nurse confirmed she would have:</p> <ul style="list-style-type: none"> *Expected a barrier to have been used when emptying the catheter. *The urinal to have been cleaned with an appropriate cleansing agent. <p>The provider's revised July 2009 Standard Precautions policy stated the purpose of the policy was "To prevent the risk of transmission of</p>	F 441		

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F 441	<p>Continued From page 23</p> <p>pathogens from both recognized and unrecognized sources of infection, by following procedures for standard precautions." "Reusable equipment will not be used for the care of another resident until it has been appropriately cleaned and disinfected." Surveyor: 32333</p> <p>4. Observation on 1/22/14 at 10:00 a.m. of unlicensed assistive personnel C while applying a Lidoderm patch to resident 13 in the tub room revealed she: *Put on gloves and had not washed her hands. *Opened the Lidoderm patch and applied it to the resident's lower back. *Removed her gloves and had not washed her hands before exiting the tub room.</p> <p>5. Observation on 1/22/14 at 5:20 p.m. of RN D while checking resident 10's blood sugar revealed she: *Had set the glucose meter directly onto the resident's bed without using a protective barrier. *Checked the resident's blood sugar. *Then left the resident's room and set the glucose meter on top of the medication cart that had been in the hallway. *Took out a Super Sani-Cloth wipe and wiped the glucose meter for less than thirty seconds. *Then returned the glucose meter to a drawer in the medication cart. Review of the Super Sani-Cloth wipes label revealed to disinfect a surface allow that surface to remain wet for two minutes.</p> <p>Interview on 1/23/14 at 2:00 p.m. with the director of nursing revealed: *She agreed staff should use appropriate hand hygiene in-between glove changes.</p>	F 441		

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F 441	Continued From page 24 *All residents that needed their blood sugar monitored should have had their own blood glucose meter. *RN D should not have used the facility's extra blood glucose meter to check resident 10's blood sugar. Review of the provider's November 2011 Cleaning and Disinfecting Blood Glucose Meter policy revealed "After the disinfecting is complete, using any of the methods listed above, the meter should be left for a few minutes to ensure it is dry."	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on record review, policy review, and interview, the provider failed to ensure 4 of 12 sampled residents (3, 4, 5, and 10) medical records had sufficient documentation reflected to	F 514	F 514 . RECORDS-COMPLETE/ACCURATE/ACCESSIBLE Response: As stated previously INSERVICE EDUCATION was provided to professional nursing staff on 2/6/14 to include but not limited to education on post fall assessment, orthostatic blood pressures and progress note documentation. On 1/27/14 documentation of placement and functionality of the watch mates was moved to the TAR for twice daily documentation by Nurse or UAP. *3, 4 and 5's M/A Saari/JJ Resident, [redacted] care plan was updated to include but not limited to a plan for elopement.	2-6-14 * [redacted] M/A Saari/JJ * [redacted] M/A Saari/JJ

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F 514	<p>Continued From page 25 falls, elopements, and Watchmate device usage. Findings include:</p> <p>1. a. Review of resident 5's nursing progress notes revealed there had been no documentation for falls that had occurred on 11/13/13 and 11/29/13. Refer to F279, finding 6.</p> <p>b. Review of resident 5's 9/24/13 care plan revealed he had a Watchmate (door alarm activator) device on his ankle. It would cause the door to alarm if he went outside unattended. It was to have been checked daily for placement and documented in the computer by the staff on duty.</p> <p>Review of the computer entries from 11/02/13 through 1/23/14 revealed there had been forty-one days that it had not been documented as checked for placement by the certified nursing assistants.</p> <p>c. Review of resident 5's nursing 1/10/14 progress notes revealed he had eloped (left the building unattended) from the facility. There was no explanation as to how he had gone out unattended or how they had planned to prevent that from happening again. Refer to F279, finding 7. Surveyor: 32333</p> <p>2. Review of resident 4's current December 2013 care plan revealed: *A focus area for the potential for elopement related to Alzheimer's disease, cognitive (mental) impairment, and exhibited wandering behavior. *A goal the resident would not leave the facility unattended. *An intervention for a Watchmate personal alarm</p>	F 514	<p>AUDIT: All of these areas will be audited by the Director of Nursing Services or designee as follows: Weekly for 1 month and monthly for 3 months. Audit reports will be submitted to the Quality Director for review and recommendation by the QA Committee <i>* monthly. mpls000H/DJ</i></p> <p>In regard to Resident 10 it remains the decision of the IDT to not put her on a toileting program due to her decline in ADL status. This resident now requires a mechanical lift for all transfers. According to Good Samaritan Society toileting program policy this factor would disqualify her from a toileting program.</p> <p>For all other potential residents: It will become practice of the Good Samaritan Society Selby to include watchmate functionality and placement checks on the TAR. Professional nursing staff will be educated annually regarding proper post fall incident reporting and documentation as well as care planning.</p>

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F 514	<p>Continued From page 26</p> <p>and to check the placement and functionality daily.</p> <p>Review of resident 4's care plan approaches report from 12/1/13 through 1/23/14 revealed resident 4's Watchmate had not been checked daily to ensure proper placement and functioning. During that time frame the Watchmate had not been checked twenty-two times. Surveyor: 32572</p> <p>3. Review of resident 10's medical record revealed *Her blood pressure medications had been adjusted on 11/5/13. *She had fallen face first in the bathroom on 11/7/13 at 1:00 p.m. and had received a facial laceration (cut). *Review of the 11/7/13 Incident Details form regarding that fall revealed the resident had a significant drop in orthostatic (changing of positions) blood pressure. *Review of the vital signs record in the medical record that had been reported to the physician regarding that fall revealed orthostatic blood pressures were not assessed taken after the fall.</p> <p>Review of resident 10's 12/05/13 care plan revealed: *She had an identified problem area of falls because of dizziness and room clutter. *Interactions included use of mobility aid of walker, encourage to sit up and get up and sit down slowly, keep room free from clutter, encourage resident to call for assistance. *On 12/20/13 physical therapy (PT) as ordered. *No problem area of incontinence or urinary frequency.</p>	F 514			

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F 514	<p>Continued From page 27</p> <p>Review of the 12/7/13 Incident Details form stated resident 10 had fallen in the bathroom on 12/17/13 at 10:20 p.m., and "She lost her balance." Orthostatic blood pressures were not assessed after that fall.</p> <p>Review of the 12/26/13 Incident Details form for resident 10 revealed she had fallen in the bathroom on 12/26/13 at 8:15 p.m. There had not been an evaluation of the contributing factors. Orthostatic blood pressures were not assessed after the fall.</p> <p>Review of the 1/8/14 Incident Details form for resident 10 revealed she had fallen on the way to the bathroom on 1/8/14 at 8:00 p.m. The form stated the resident "Reported she was using walker to walk to bathroom, lost balance and fell to floor landing on Lt (left) side, she states she was not dizzy b/4 (before) falling." Orthostatic blood pressures revealed a slight change in blood pressure readings.</p> <p>Review of nursing progress notes dated the following revealed: *On 1/9/14 there had been a note stating the resident "required extensive assistance of one with transfers and toileting." *On 1/10/14 at 7:10 p.m. she had fallen "Forward in the bathroom over her walker with her head toward the sink." She had been assisted to a wheelchair and was leaning to the left. Mechanical lift had been used to transfer her."</p> <p>Interview on 1/23/14 at 1:30 p.m. with the DON regarding resident 10 confirmed orthostatic blood pressures had not been assessed after three of the four falls that had shown a change in orthostatic blood pressures. She stated the</p>	F 514		

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F 514	<p>Continued From page 28</p> <p>Incident Details form was not always complete such as the orthostatic blood pressure being evaluated. She stated the resident would not be a candidate for a toileting program, because she took herself to the bathroom at times, and she had to void frequently.</p> <p>Review of the provider's revised January 2011 Toileting Programs policy revealed: *A prompted voiding program was recommended for residents: -"Who can learn to recognize some degree of bladder fullness or the need to void." -"Can request assistance or respond when prompted to toilet." -"Can respond to their name or can tell you their name." -"Who have cognitive (thinking) impairment but not severe." -"Who are a one person or less to transfer." -"Will cooperate if assisted to the bathroom." -"Who initiate voiding when taken to bathroom." Surveyor: 32573</p> <p>4. Review of resident 3's medical record revealed the resident had nine falls from 10/23/13 to 11/20/13. The fall incident reports for the month of October had not been fully completed. Refer to F323, finding 2.</p>	F 514		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/22/14. Good Samaritan Society Selby was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiencies identified at K038, K056, K069, and K143 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 2/18/14 telephone to facility administrator. CH/SDDOH/JJ	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure eight of nine exits were readily accessible at all times (main entrance; 100 wing: south, east, and north; offices north; 200 wing: south and north; and dining room south). Findings include: 1. Observation beginning at 9:30 a.m. on 1/22/14 revealed the following eight exits were equipped with magnetic door locks: main entrance; 100 wing: south, east, and north; offices north; 200	K 038	K 038 Response All exit doors in the facility (8 total doors) will be replaced with delayed egress doors. We are asking for a waiver for a six month extension. We are in the process of getting quotes from two companies at this time.	*3/14/14 CH/SDDOH JJ

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

Rayley Carmill

TITLE

Administrator 2/13/14

(X6) DATE

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

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K 038	<p>Continued From page 1 wing: south and north; and dining room south. Two of the nine exits, main entrance and dining room south, were equipped with a device that would magnetically lock the door when a resident with a wander management device came in close proximity to the exit. A keypad was mounted adjacent to the doors that would unlock the magnet with the proper code input. A code to unlock the doors was posted at each of the exits.</p> <p>Testing of the magnetically locked 100 wing south, east, and north exit doors revealed the locks were not delayed-egress. Interview with the maintenance supervisor at the time of the observations confirmed all the locks were access-control type magnets, not delayed-egress type.</p> <p>Access-control locks are not acceptable for use in a path of egress unless they meet the exceptions in the Life Safety Code 101, 2000 Edition, Chapter 7.2.1.6.2. Posting the code to unlock the magnet with the keypad does not meet the standard.</p> <p>Failure to maintain the means of egress as required increases the risk of death or injury due to fire for all residents in the facility. The deficiency affected eight of nine exterior doors in the building's means of egress.</p>	K 038		
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the</p>	K 056	<p>K 056 Response:</p> <p>The sprinkler system has now been installed completely. The DOH will inspect the system on 2/5/14.</p>	<p>*3/14/14 CH/SDDOE/ JJ</p>

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K 056	Continued From page 2 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a complete sprinkler system (100 wing sitting room office) as required. Findings include: 1. Observation at 11:00 a.m. on 1/22/14 revealed the 100 wing sitting room office was not equipped with a sprinkler. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He notified the contractor during the survey and arranged for installation of the sprinkler. The deficiency affected a single component of the automatic sprinkler system in one of numerous rooms in the building.	K 056		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the	K 069		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435123	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 4861 LINCOLN AVENUE SELBY, SD 57472	
(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 069	Continued From page 3 provider failed to conduct required cleaning of the kitchen range's exhaust ductwork. Findings include: 1. Review of the kitchen hood maintenance inspection reports revealed no documentation indicating the range hood exhaust duct had been cleaned from the rooftop ventilator to the kitchen hood. Interview with the maintenance supervisor at 2:45 p.m. that same day confirmed that finding. He stated staff had cleaned the filters and ductwork from the kitchen floor location in 2013. However the ventilator on the rooftop was not hinged to allow cleaning from that location. The above deficiency affected a single element of the required preventive maintenance for the kitchen range hood system.	K 069	K 069 Response: The environmental services director will clean the kitchen hood when weather improves to access the roof area. Once cleaning has been completed, the environmental services will bring the audit results to QA. Once the cleaning has been completed, it will be done on a yearly basis and documented. Due to the weather, we are asking for a waiver to extend the time in which we have to clean the rooftop ventilator to the kitchen hood. We are asking for a three month extension. AUDITS: Audits will be completed by the Director of Environmental Services and/or designee yearly and audit reports will be forwarded to the Quality Director for review and recommendation of the QA Committee.	*3/14/14 CH/SDDOH, JJ
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143	K 143 Response: Effective February 10th 2014, the [redacted] will be housed in the east storage room which is separated from the facility by a fire resistant door. This room has a concrete floor and we will be installing a ventilation system that will ventilate to the outside. We will also remove all combustible material from this room. *This room will be added to the preventive maintenance schedule to ensure compliance with liquid transferring requirements. CH/SDDOH/JJ	*3/14/14 CH/SDDOH, JJ

liquid oxygen bottle
CH/SDDOH/JJ

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SELBY		STREET ADDRESS, CITY, STATE, ZIP CODE 4861 LINCOLN AVENUE SELBY, SD 57472		
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K 143	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain a fire barrier separation of one-hour fire resistive construction for one of one liquid oxygen transferring room (oxygen storage room). Findings include:</p> <p>1. Observation at 11:45 a.m. on 1/22/14 revealed the oxygen storage room had four compressed gas oxygen bottles and one liquid oxygen tank (approximately 30 inches tall and 12 inches in diameter). Interview with the maintenance supervisor at the time of the observation revealed the provider transferred liquid oxygen from the tank in the room into smaller individual-use containers for residents within that room.</p> <p>Liquid oxygen transferring rooms must be provided with one-hour fire-rated construction, must be mechanically ventilated, sprinklered, and have ceramic or concrete flooring. The area must have signs indicating transferring is occurring. The corridor door was an unrated solid bonded wood core (SBWC) door without a closer. The floor of the room was covered with 12 inch square vinyl floor tile. The SBWC door would meet only a 20 minute fire-rating.</p> <p>Interview with the administrator at 2:30 p.m. that same day revealed the liquid oxygen tank had been purchased approximately three months prior to the survey. She stated the vendor supplying the liquid oxygen told her the transferring would be acceptable for use at her facility.</p>	K 143		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 4861 LINCOLN AVENUE SELBY, SD 57472		
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K 143	Continued From page 5 The deficiency affects one of six smoke compartments in the building.	K 143			

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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10676	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 4861 LINCOLN AVE. SELBY, SD 57472
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S 000	<p>Initial Comments</p> <p>Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/22/14 through 1/23/14. Good Samaritan Society Selby was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bayley Cartmill

TITLE (X6) DATE

Administrative **RECEIVED** 01/23/14

STATE FORM

021199

DP0E11

If continuation sheet 1 of 1

