

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

ORIGINAL

PRINTED: 02/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY WAGNER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 W HWY 46 WAGNER, SD 57380
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/3/14 through 2/5/14. Good Samaritan Society Wagner was found not in compliance with the following requirement: F314.	F 000	Addendums noted with an asterisk per 3/6/14 telephone to facility administrator. DK/SDDOH/JJ	
F 314 SS=D	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. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 32332 Based on observation, interview, record review, and policy review, the provider failed to: *Prevent a pressure ulcer by appropriately turning and repositioning one of two sampled residents (2) with pressure ulcers. *Notify the physician of: -An existing pressure ulcer that failed to heal for one of two sampled residents (2) with pressure ulcers. -The presence of a new pressure ulcer for one of two sampled residents (2) with pressure ulcers. *Have a care plan specific to a resident's needs	F 314	1. Resident 2 had her care plan updated to reflect a repositioning program on 2/25/14. The physician was notified of the new reddened areas and the progress of the pressure ulcer to the sacrum on 2/4/14 and 2/5/14. 2. All residents admitted to the center will have a skin assessment done within 8 hours of admission. A Braden scale will also be done at the time to assist with determining specific needs and the care plan will be developed to reflect these specific needs. The physician will be notified timely if a wound develops or no improvement is seen within 14 days of treatment. 3. The DNS will provide education to all nursing staff on 2/27/14 regarding wound assessments, wound care, positioning, care planning, and when to notify the physician related to lack of progress or new wounds.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle [Signature]</i>	TITLE <i>Admin</i>	(X6) DATE <i>02/26/2014</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.

SD DOH L&C

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F 314	<p>Continued From page 1 for one of two sampled residents (2) with pressure ulcers.</p> <p>1. Multiple observations during the hours of 7:00 a.m. to 6:00 p.m. on 2/3/14 and through 2/4/14 of resident 2 revealed: *She was lying on her back. *The head of the bed was at a 45 degree angle.</p> <p>Observation and interview on 02/03/14 at 5:25 p.m. resident 2's family member revealed: *She often visited twice a week and at different times during the day. *The resident had "always" been on her back when she came to visit. *She was aware of the resident's pressure ulcer on her sacrum (the area where the lower back and buttocks meet.) *The pressure ulcer had been discovered in mid-December, 2013. *The resident had been placed on hospice on 12/26/14 for pain control for the pressure ulcer. *She had "never" seen staff move the resident from side-to-side to re-arrange her position to prevent pressure on her sacrum unless the resident had been provided personal care.</p> <p>Observation, interview, and care plan review on 2/4/14 from approximately 9:35 a.m. to 9:55 a.m. with certified nursing assistant (CNA) A and registered nurse (RN) B in resident 2's room before, during, and after resident 2's pressure ulcer care revealed: *Her bed had been at a forty-five degree angle upon entry into the room. *Her existing unstageable ulcer (inability to stage [how staff describe the extent of an ulcer] due to the presence of slough [dead tissue] in the wound bed) measured 2 centimeters (cm) long by (x) 1</p>	F 314 <i>by the DON or designee DK/SAD/H/JS</i> <i>by the DON or designee DK/SAD/H/JS</i>	<p>4. The DNS or designee will audit wound flow sheets to assure proper assessment is done. Point of Care tasks will be audited to assure positioning schedules are done per the care plan. The Care plans will be audited to assure specific interventions are in place to prevent or heal wounds. DNS or designee will audit physician notification regarding any new wound and the progress of a current wound. These audits will be done weekly X4 and then monthly X4. The DNS or designee will report audit findings to the QA committee monthly and the QA committee will determine if further audits are needed.</p> <p>5. Date</p>	3/20/14

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F 314	Continued From page 2 cm wide x 0.4 cm in depth. *She had a new large reddened area on her right buttock and a small reddened area on her left buttock. *RN B measured the above reddened area on her right buttock, and it was 6 cm wide x 4 cm long; CNA A reported it was warm to the touch. *RN B stated she had not seen that on her buttock before that day and had described the area as Stage 1 pressure ulcer (the skin was still intact). *CNA A: -Was unsure what maximum degree of height the head of the resident's bed should be at to prevent pressure on resident 2's sacral area. -Repositioned her by moving her up in bed if she slouched down. -Had not turned her side-to-side or used props such as pillows under one side of the resident at a time (to lift one side of the resident's body to re-arrange pressure from her sacral area.) -Had received training but was not sure how to properly reposition or how often it was needed. -Had not applied lotion to the resident's skin during repositioning. *The current care plan dated 2/3/14 stated: -The resident should be turned and repositioned "at least every 2 hours throughout the day and night." -Her skin should have lotion when repositioned. *RN B found the ulcer had actually been discovered on 2/3/14 *It had not been reported to resident 2's physician or other nursing staff by the treatment nurse on duty. Interview and medical record review on 2/4/14 at 11:08 a.m. with the director of nursing (DON) regarding resident 2 revealed:	F 314			

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F 314	<p>Continued From page 3</p> <ul style="list-style-type: none"> *She stated the resident's physician had mentioned to the family previously that the provider had failed to reposition the resident properly. *She agreed the care plan had not been updated to meet the resident's individualized needs. *She had been unaware of the new pressure ulcers. *She had expected staff to be turning and repositioning according to order and current wound care standards. *The resident's head of her bed should not have been over a thirty degree angle to prevent pressure ulcer formation. *She agreed staff needed further training and skills checks in relation to pressure ulcer prevention and care. *She agreed the pressure ulcer had been preventable. *She agreed staff had not: <ul style="list-style-type: none"> -Appropriately assessed the existing ulcer for failure to heal. -Appropriately documented more regarding the pressure ulcer in the medical record as she would have expected. -Notified the physician of the failure to heal of the existing unstageable ulcer and the presence of a new Stage 1 ulcer. -Provided appropriate nursing interventions regarding the pressure ulcers. *She agreed even though the resident had been provided a low pressure air bed current wound care standards and the manufacturer's guidelines of the bed still required the resident needed to be repositioned frequently. <p>Interview and medical record on 02/04/14 at 3:30 p.m. with the administrator and DON regarding resident 2's pressure ulcer revealed they had</p>	F 314		

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F 314	<p>Continued From page 4 agreed: *It was the provider's responsibility to notify the physician of delayed healing of an existing pressure ulcer and the development of a new pressure ulcer. *The care needed to address the resident's individual needs. *The staff should have repositioned the resident appropriately from side-to-side and more frequently than every two hours with the presence of pressure ulcers according to current wound care standards .</p> <p>Review of the provider's revised January 2014 Skin Assessment and Pressure Ulcer Prevention policy revealed the physician would be notified of the resident's condition.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter 48-Skin integrity and Wound Care, pages 1176-1229, revealed: **Nurses constantly observe for skin integrity and identify at-risk patients from developing pressure sores. Nursing interventions focus on prevention." **Nurses understand factors affecting pressure ulcer formation and wound healing." **Nurses apply the WOCN (wound, ostomy, and continence nurse) standards for prevention of pressure sores and assessment for skin integrity, prevention and treatment."</p> <p>Review of Madeleine Flanagan's, Wound Healing and Skin Integrity - Principles and Practice, 1st Ed., Hoboken, NJ, 2013, page 131, revealed, "Regular repositioning and selection of an appropriate support surface are crucial elements for the prevention and management of pressure ulcers."</p>	F 314		

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F 314	Continued From page 5 "Guideline synthesis: Prevention of pressure ulcers," National Guideline Clearinghouse, revised January 2011, http://www.guideline.gov/syntheses/synthesis.aspx?id=25078 , stated the head of bed height should not exceed over thirty degrees as it dramatically increases the risk of developing pressure ulcers.	F 314			

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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 2/4/14. Good Samaritan Society Wagner 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 K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required quarterly flow and tamper switch testing performed during the previous twelve months. Record review of the previous twelve months fire sprinkler system inspections revealed testing documentation was not available. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports revealed quarterly flow	K 062	1. Quarterly flow and tamper switch testing with documentation was documented twice during 2013. 2. Flow and tamper switch testing with documentation will occur quarterly. 3. Flow and tamper switch testing with documentation will be done by Environmental Service Director or designee quarterly. Monitoring will occur as Environmental Service Director or designee will report to Administrator and to QA/CQI team each quarter through 2014. QA/CQI team will determine if further audits need to occur. 4. Date	3/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle Spitzer</i>	TITLE <i>Admin.</i>	(X6) DATE <i>02/26/2014</i>
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K 062	Continued From page 1 and tamper switch testing documentation was not available. Interview with the maintenance director at the time of the record review indicated he was unaware of the quarterly flow testing requirements. Record review of previous survey documents indicated the quarterly flow and tamper switch testing was discussed with the provider during the final inspection of the sprinkler system.	K 062			

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S 000	<p>Initial Comments</p> <p>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 2/3/14 through 2/5/14. Good Samaritan Society Wagner was found not in compliance with the following requirements: S195 and S301.</p>	S 000	<p>Addendums noted with an asterisk per 3/6/14 telephone to facility administrator.</p> <p style="text-align: right;">DK/SDDOH/JJ</p>	
S 195	<p>44:04:03:02 GENERAL FIRE SAFETY</p> <p>Each licensed health care facility covered under this article must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system must be sounded each month.</p> <p>This Rule is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to sound the fire alarm each month from January 2013 through January 2014. Findings include:</p> <p>1. Review of fire drill and fire alarm records revealed the fire alarm was not sounded for the months of April, May, August, and November 2013, and January 2014. No fire drills were conducted for the months of April, May, and August 2013, and January 2014. A silent fire drill was only completed in November 2013. There was no documentation indicating the fire alarm had been sounded at any other time during those</p>	S 195	<p>1. To avoid danger to the lives and safety of our residents the fire alarm system will be sounded each month.</p> <p>2. The Environmental Services Director or designee will oversee the alarm being sounded and will document that it did occur each month.</p> <p>3. Alarms will be sounded each month; Environmental Services Director or designee will document and will report to Administrator and to QA/CQI committee during monthly meetings. Reports will be given monthly x4. The QA Committee will determine if further audit/reports will be needed.</p> <p>4. Date</p>	3/20/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle Jaffer</i>	TITLE <i>Admin</i>	TITLE <i>Admin</i> (X6) DATE <i>02/26/14</i>
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If continuation sheet 1 of 3

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 195	Continued From Page 1 months. Interview with the maintenance supervisor at the time of the record review revealed he was unaware of the requirement to sound the fire alarm monthly.	S 195			
S 301	44:04:07:16 Required dietary in-service training The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Rule is not met as evidenced by: Surveyor: 12218 Based on record review and interview, the provider failed to conduct annual in-services on food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements for all the dietary employees. Findings include: 1. Interview on 2/3/14 at 11:25 a.m. with the dietary manager revealed: *She was not aware of all the required in-services for employees in the kitchen and those handling food. *She stated they had not been done for a couple of years.	S 301	1. Dietary Inservice training covering Safe Food Handling was done by 7 of the dietary staff during 2013. 2. Education will occur covering the following topics: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements for all dietary employees. This education will be done by Dietary Consultant and Dietary Manager on March 13, 2014. *Dietary Consultant will provide education annually. 3. Dietary Manager will report to QA/CQI committee regarding the education that has occurred. Discussion will occur to see if additional education and audits need to occur. 4. Date	3/20/14 <i>OK/saah/JJ</i>	

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S 301	Continued From Page 2 *The consultant registered dietitian (RD) had done an all staff in-service on diabetic diets in January 2014. *The RD was scheduled to come back in two months to complete another all staff in-service. *There was a new cook and a new dietary aide that had started in the last two weeks. *There was a video on food service that staff were required to watch. It was not discussed in a dietary in-service as to how it related to their kitchen operations food safety, food handling and distribution, and sanitation requirements.	S 301			