

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/27/2014</b>
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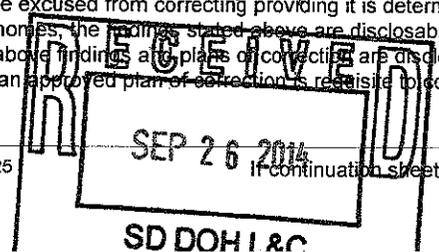
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY HOWARD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 WEST HAZEL AVENUE HOWARD, SD 57349</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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><b>INITIAL COMMENTS</b></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 8/26/14 through 8/27/14. Good Samaritan Society Howard was found not in compliance with the following requirement: F441.</p>	F 000		
F 441 SS=E	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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</p>	F 441	<p><u>F441 – Infection Control, Prevent Spread, Linens</u></p> <p>This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>Nail Clippers storage area in the whirlpool room was cleaned on 9/23/2014. Staff working in the whirlpool room were educated on</p>	10/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>K. Halverson, Administrator</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/24/2014</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.



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

PRINTED: 09/08/2014  
FORM APPROVED  
OMB NO. 0938-0391

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F 441	Continued From page 1 hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	8/27/2014 on sanitation of nail clippers.  Beauty Shop curlers were cleaned and sanitized on 9/19/2014. Each resident will have bags label with personal curlers. Resident care item storage area was cleaned on 9/19/2014. Rusty hinge was repaired 9/19/2014  Blood Glucose Meters are cleaned with Super-Sani Wipes and will follow manufacture recommendation with keep surface wet for 2 minutes. All Nurses were educated on the procedures for disinfecting blood glucose meters on 8/27/2014.  DNS, Administrator, and Infection Control reviewed the policies and procedures on Nail Care, Blood Glucose Testing, Housekeeping Procedures for Beauty Shop and Whirlpool Room, Infection Control in Center Beauty Shop, and SDS on Super Sani-Cloth. Education was provided to all staff at the All Staff In-service on September 22, 2014.  The DNS or designee will audit nail clipper storage and sanitation weekly for 12 weeks. DNS will submit a monthly report to the QAPI	
	This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, product label review, and policy review, the provider failed to ensure: *Multiple use items (nail clippers and curlers) had been cleaned and disinfected between resident use in one of one beauty shop and one of one whirlpool tub room. *Resident care items (hair products) had been stored in a clean and sanitary manner in one of one beauty shop resulting in the potential for cross-contamination and infection. *A blood glucose (sugar) meter had been disinfected after registered nurse RN (B) checked one of one randomly observed resident's (11) blood sugar. Findings include:  1. Random observations on 8/26/14 through 8/27/14 in the whirlpool tub room and the beauty shop revealed: *Nail clippers were stored in a small plastic bin that had nail trimmings and debris both on the nippers and the bottom of the plastic bin. *Beauty shop curlers were found with large amounts of hair present and debris on them. *Resident care items (shampoos, conditioners,			

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F 441	Continued From page 2 hair spray) had been stored behind the sink in a built-in hinged cupboard with a lid. The cupboard: -Was found to have large amounts of debris and hair in amongst the bottles. -The hinges were rusty, and the lid and cupboard were visibly dirty with hair and debris on them.	F 441	Committee for further recommendations.  The Environmental Services Supervisor or designee will audit the sanitation of the beauty shop 1 time per week for 12 weeks. Environmental Services Supervisor will submit a monthly report to the QAPI Committee for further recommendations.		
	Interview on 8/26/14 at 1:30 p.m. in the beauty shop with licensed beautician A revealed she: *Had not disinfected the hair curlers in between resident use. She estimated nine of twenty residents who received her services used the curlers. *Would clean the curlers on average once per month to once every two months. *Stored various resident use items in the built-in hinged cupboard behind the sink. *Was unaware who cleaned that cupboard. *Agreed the cupboard and the lid had been visibly soiled with hair and debris, and the hinges were quite rusty. *Was unaware she needed to disinfect curlers between resident use.  Interview on 8/27/14 at 3:00 p.m. with the infection control coordinator revealed she: *Agreed multiple use items needed to be cleaned and disinfected between resident use. *Was unaware resident care items were stored in the cupboard behind the sink. *Expected the licensed beautician would be responsible for the cleaning of the multiple use items and the cupboard behind the sink. *Was unaware nail clippers had not been cleaned and expected those would also be cleaned and disinfected between resident use.  Review of the provider's June 2012 Center Beauty Shops policy revealed all equipment must		The DNS or designee will audit the cleaning of the blood glucose meter weekly for 12 weeks. DNS will submit a monthly report to the QAPI Committee for further recommendations.		

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F 441	<p>Continued From page 3</p> <p>be sanitized between each resident use.</p> <p>Surveyor: 32333</p> <p>2. Observation and interview on 8/26/14 at 5:25 p.m. with registered nurse B while she checked resident 11's blood sugar revealed she:</p> <p>*Went into the residents room and obtained her blood sugar.</p> <p>*Brought the glucose meter to her medication cart that had been in the hallway.</p> <p>*Wiped the glucose meter with a Super-sani cloth for 5-10 seconds.</p> <p>*Put the glucose meter back into her medication cart.</p> <p>*Confirmed the blood glucose meter had been a multiple resident use item.</p> <p>Review of the Super-sani cloth label revealed the treated surface must remain visibly wet for two minutes. Use additional wipes to ensure continuous two minute wet contact time.</p> <p>Interview on 8/27/14 at 3:50 p.m. with the director of nursing revealed she would have expected the blood glucose meter to have been disinfected after each use.</p> <p>Review of the provider's Cleaning and Disinfecting Blood Glucose Meters policy/procedure revealed:</p> <p>*"It is preferable that each resident has his/her own glucose meter."</p> <p>*"After disinfecting is complete, using any of the methods listed above, the meter should be left for a few minutes to ensure it is dry."</p>	F 441			

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**ORIGINAL**

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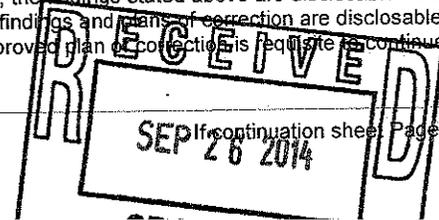
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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/27/14. Good Samaritan Society Howard was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/27/14 upon correction of the deficiencies identified below.  Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on measurement and document review, the provider failed to maintain proper exit access door widths for two of two randomly observed sets of cross-corridor doors (north and east of the nurses station). Findings include:	K 028		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>R Halvorsen</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9/24/14</i>
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K 028	Continued From page 1  1. Measurement at 2:00 p.m. on 8/27/14 revealed each leaf in the pair of one hour fire rated cross-corridor doors to the north of the nurses station measured 30 inches in clear width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed that condition was part of the original construction.  Measurement at 2:15 p.m. on 8/27/14 revealed each leaf in the pair of one hour fire rated cross-corridor doors to the east of the nurses station measured 31.5 inches in width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed that condition was part of the original construction.  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to ensure at least two conforming	K 032		F

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K 032	<p>Continued From page 2</p> <p>exits existed from each floor of the building. The basement did not have a conforming exit. Findings include:</p> <p>1. Observation at 1:00 p.m. on 8/27/14 revealed the basement did not have a conforming exit. The primary exit was the basement stairway that discharged onto the main level corridor system. The second exit was through a window to an area well equipped with a fixed ladder. Review of the previous survey report confirmed the condition had existed since the original construction.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.</p>	K 032			

South Dakota Department of Health

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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 8/26/14 through 8/27/14. Good Samaritan Society Howard was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*R. Halverson*

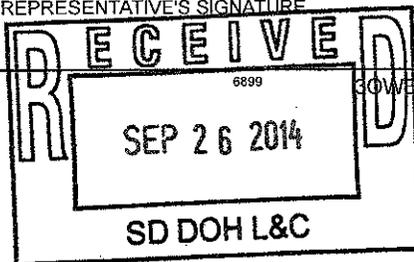
TITLE

Administrator

(X6) DATE

9/24/14

STATE FORM



If continuation sheet 1 of 1