

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

ORIGINAL

PRINTED: 07/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362
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F 000	INITIAL COMMENTS Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/30/14 through 7/2/14. Good Samaritan Society Miller was found not in compliance with the following requirements: F253, F280, F281, F323, and F371.	F 000	Addendums noted with an asterisk per 8/11/14 telephone to facility administrator. mpjsddh/mf	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and interview, the provider failed to maintain a safe and sanitary environment by maintaining cleanable surfaces in seven random resident rooms (15, 20, 24, 27, 30, 31, and 32). Findings include: 1. Observation of residents' rooms on 7/2/14 at 9:40 a.m. with the director of environmental services (DES) revealed: *Resident room 15 bathroom door had a hole approximately one-quarter inch by one and one-half inch had been in the door panel making the door uncleanable (photo 1). The hallow core of the door had been exposed. *Resident room 20 had a small dresser that had a large piece and numerous other small pieces of laminate that had been splintered off exposing raw wood on the front of the dresser drawer. The	F 253	F253 1.*Environmental Services Director (ESD), repaired the hole in Resident room #15 bathroom door 7/14/14. Bathroom door kick plates for all resident bathroom doors were ordered 7/28/14. Maintenance will install the above ordered kick plates immediately upon their delivery to the Center. All staff were instructed at the All Staff meeting on 7/2/14, to report any doors with damage to ESD or designee by writing on the Maintenance repair list clipboards found at the 2 Nursing Stations and Maintenance Office. ESD or designee will audit the condition of all resident bathroom doors monthly for 3 months and as needed and will report to QA Committee. Any repairs needed will be completed within the week they are found. 8/21/14 1.*ESD removed the small, broken dresser in Resident room #20 and replaced it with a different one in proper working order on 7/2/14. 8 sets of 3-drawer and 4-drawer chests/dressers were ordered on 7/23/14, to be used to replace worn dressers/chests. These new items will be placed in the appropriate rooms upon their delivery to the Center. All staff were instructed at the All Staff meeting on 7/2/14, to report any and all resident room furniture disrepair to ESD or designee by writing on the maintenance repair list clipboards at both nursing stations and	*8/21/14 mpjsddh/mf

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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.

Aurice Caspasil, Administrator 7/29/14

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F 253	Continued From page 1 splintered wood was at shin height which could cause a skin tear to the resident (photo 2). *Resident rooms 24 and 27 had splits in the vinyl floor covering exposing unsealed concrete causing uncleanable surfaces (photo 3). *Resident rooms 30, 31, and 32 had residents' wardrobes placed on top of unsealed concrete causing uncleanable surfaces (photo 4). Interview at that time with the DES confirmed the above findings had been issues that caused uncleanable surfaces. They were also a resident safety issue. The provider did not have a policy for notification of uncleanable surfaces. The DES confirmed all staff had been educated at orientation upon being hired they were to make an entry on the "Maintenance Request Sheet" for a work order. That sheet was stored at each nurses station and at the DES office. That entry then notified maintenance of the repair needed.	F 253	in the maintenance office. ESD or designee will audit the condition of all resident room furniture monthly for 3 months and as needed and report to QA Committee. Any broken furniture will be replaced or repaired within the week the repair work is found. 8/21/14 1.*The vinyl flooring in resident rooms #30, #31, & #32 was replaced on 7/22/14. The splits in the vinyl in Resident rooms #24 & #27 were repaired with caulking on 7/22/14. ESD or designee will audit flooring in all resident rooms monthly for 3 months and as needed and report findings to QA Committee. Any findings will be corrected within the week they are found. 7/22/14. <i>* All QA reporting will be done monthly. mpj/sdd/hmf</i>	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280	F 280 As of 7-28-14 Resident # 1, 3, 4, 5 and 7 all care plans have been updated and reflect the use of assist bars. All other potentially affected residents in the facility have had their care plans updated. All potentially affected residents will be identified through assessment on admission and quarterly at care plan review. Changes that will be made in this providers system to make sure care plans are updated to reflect current care will be, care plans will be updated with any new doctor's orders, change of <i>*by the MDS coordinator mpj/sdd/hmf</i>	<i>* 7/31/14 mpj/sdd/hmf</i>

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F 280	<p>Continued From page 2</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057</p> <p>Surveyor: 32572 Based on record review, observation, and policy review, the provider failed to revise and update the care plan for five of five sampled residents (1, 3, 4, 5, and 7) with Assist Bars. Findings include:</p> <p>1. Observations on 7/1/12 from 8:00 through 5:00 p.m. and on 7/2/14 from 8:00 a.m. through 3:00 p.m. of resident 4 revealed she had an Assist Bar attached to the side of her bed nearest the door. Review of resident 4's care plan with a last revision date of 3/20/14 revealed there had been no mention of an Assist Bar (horse-shoe shaped hand bar used to assist with moving one's self).</p> <p>Surveyor: 28057</p> <p>2. Random observations on 7/1/14 from 3:30 p.m. and 7/2/14 at 12:30 p.m. of resident 3 revealed she had an Assist Bar attached to both sides of her bed. Review of resident 3's care plan last revised on 6/4/14 revealed the use of an Assist Bar had not been addressed.</p> <p>3. Random observation on 6/30/14 at 3:30 p.m. revealed resident 7 was in bed with assist bars in</p>	F 280	<p>condition, MDS reviews quarterly, Quality of Life reviews that are held weekly. Care plans will be monitored/reviewed to measure effectiveness of system change. DNS and QA Coordinator will monitor that care plans reflect the current care required for the resident. DNS and QA Coordinator will audit 3 care plans each week for four weeks, then monthly for four months and then quarterly for one year. Audit reports of the monitoring will be reported to the Quality Assurance Performance Improvement committee at their monthly meetings. All nurses and CNA's were educated at their monthly meetings in regards to care planning assist bars. All other staff, residents and families will be educated through a letter that will be sent out by July 31, 2014. Anticipated correction date will be July 31, 2014.</p>		

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F 280	<p>Continued From page 3 place on both sides of her bed. Review of resident 7's care plan last revised on 4/6/14 revealed the use of an Assist Bar had not been addressed.</p> <p>Surveyor: 32572 4. Random observations from 7/1/14 through 7/2/14 of resident 1's bed revealed Assist Bars at the head of the bed on both sides of that bed. Review of resident 1's care plan last revised on 1/26/14 revealed the use of an Assist Bar had not been addressed.</p> <p>5. Random observation from 7/1/14 through 7/2/14 of resident 5's bed revealed an Assist Bar at the head of the bed on the wall side of that bed. Review of resident 5's care plan last revised on 12/24/13 revealed the use of an Assist Bar had not been addressed.</p> <p>Surveyor:29162 Review of the provider's September 2012 Care Plan policy revealed: *Each resident was to have had an individualized plan of care that had been directed towards achieving the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. *Any problems, needs, and concerns identified were to have been addressed. *The care plans were to have been modified as needed to reflect the current care required for the resident.</p>	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		

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F 281	<p>Continued From page 4</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure accurate weights for 2 of 12 sampled residents (9 and 12) were documented in the electronic record. Findings include:</p> <ol style="list-style-type: none"> Review of resident 9's medical record revealed: <ul style="list-style-type: none"> *He had been admitted on 10/10/13. *He had the following diagnoses: <ul style="list-style-type: none"> -Dementia (decline in thought process). -Syncope (dizziness). -Anemia. -Hypertension (high blood pressure). -Hypothyroidism (low thyroid function). -Osteoarthritis (arthritis). -COPD (chronic obstructive pulmonary disease, breathing problems). *Review of the Weights and Vitals Summary tab of the electronic record from 4/1/14 through 7/2/14 revealed he weighed the following: <ul style="list-style-type: none"> -On 4/4/14, 175 pounds (lb). -On 4/24/14, 173.5 lb. -On 5/5/14, 177 lb. -On 5/15/14, 176.5. This had been identified as a "warning" on the weight record. -On 5/30/14, 180 lb. -On 6/20/14, 182 lb. *Review of the nurses Progress Notes tab from 4/1/14 through 7/2/14 revealed no entries indicating the physician had been notified of the weight gain. 	F 281	<p>F 281</p> <p>On 6/27/14 Dietician reviewed resident 12 and stated that weight was stable over the past year and energy and fluid intake was judged adequate and no change in nutritional care. Resident 12's weight as of 7/28/14 was 219. Resident has been assessed and she has no congestion in her lungs and no edema in her lower extremities. Resident moved to our skilled facility from our assisted living facility and began to eat three meals a day. Resident 9's current weight is 181.5. Resident has been assessed for weight fluctuation by RN. Residents lungs are essentially clear and no lower extremity edema noted. Resident has been on a therapeutic home visit and has a drawer full of snacks. All other residents with a three pound weight gain or loss will be assessed or re-weighed by July 31, 2014. Changes that will be made to this providers system will be to educate staff on policy and procedure for weight variation. Education was provided at the nurses and CNA meetings held July 22 and 23. Bath aide instructed to report weight change to charge nurse. Nurses were instructed to address weight alerts at the end of their shift. The DNS and QA Coordinator will monitor its performance to identify future noncompliance by auditing weight</p>	* 7/31/14 MPS/ODD/H/ME

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F 281	Continued From page 5 2. Review of resident 12's medical record revealed: *She had been admitted on 5/28/14. *She had the following diagnoses: -Mood disorder. -Hypertension. -Hypothyroidism. -Macular degeneration (poor eyesight). -Urinary incontinence (unable to control release of urine). -Constipation. -Dyspepsia (disorder of the stomach). *Review of her weight record since admission revealed: -Admission weight 210 lb. -On 6/11/14, 218.5 lb. This had been identified as a "warning" on the weight record. -No further weights had been entered. *Review of the nurses Progress Notes from admission to 7/2/14 reveled no entries indicating the physician had been notified of the weight gain. 3. Interview on 7/2/14 at 9:30 a.m. with the director of nursing and charge nurse A confirmed a three to four pound weight change for a resident should have been alerted the certified nursing assistant to re-weighed. The nurses then would have made a nutritional note in the electronic medical record. Both confirmed residents 9 and 12 did not have the nutritional notes or re-weights completed. Review of the provider's revised June 2014 Weight and Height policy revealed: *The purpose was to "accurately measure weight and height." **"To monitor weight loss or gain in a resident."	F 281	summary report weekly for four weeks, then monthly for four months and then quarterly for a year. Results of audits will be reported to the Quality Assurance Performance Improvement Committee at their monthly meeting. Anticipated correction date will be July 31, 2014.		

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F 281	Continued From page 6 *The procedure stated: -"If weight varies by more than three pounds, re-weigh resident and document. Report weight to licensed nurse. The rationale for the three pound re-weigh is to ensure that the wight taken is accurate before documenting the wight in the medical record. Using this as a best practice will eliminate the need for time intensive re-weighs at a later date." -"The licensed nurse should immedicately notify the medical provider (physician) regarding any significant weight change as described..."	F 281			
F 323 SS=E	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: 28057 Based on observation, record review, interview, manufacturer specifications, and policy review, the provider failed to ensure Assist Bars had been used in a safe manner to prevent potential injury for 5 of 12 sampled residents (1, 3, 4, 5, and 7). Findings include: 1. Random observations on 7/1/14 from 3:30 p.m. and 7/2/14 at 12:30 p.m. of resident 3 revealed she had an Assist Bar attached to both sides of her bed. During those observations the resident	F 323			

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F 323	<p>Continued From page 7</p> <p>had not used those rails to reposition herself in the bed. During an observation on 7/2/14 an unidentified nurse aide had transferred the resident into bed after she had used the bathroom. During that transfer the resident had not used the assist bar and had depended on the nurse aide for assistance into the bed.</p> <p>Review of resident 3's medical record revealed: *A diagnosis of mental impairment. *No assessment that indicated a need for an Assist Bar. *No physician's order for an Assist Bar. *The use of an Assist Bar had not been included on her most recent care plan last revised on 6/4/14. *A Brief Interview for Mental Status (BIMs) assessment with a score of 4 out of a possible 15. *That score indicated severe mental impairment.</p> <p>2. Random observation on 6/30/14 at 3:30 p.m. revealed resident 7 was in bed with assist bars in place on both sides of her bed.</p> <p>Random observation on 7/1/14 at 9:10 a.m. revealed certified nursing assistants B and C had changed resident 7's incontinence product (disposable brief) while she had been in bed. The resident had been turned from side-to-side by the CNAs during that care. She had not used the assist bars attached to both sides of her bed when being turned. She had depended on the nursing assistants to turn her at that time.</p> <p>Observation during an interview with the resident's husband on 7/1/14 from 3:45 p.m. to 4:00 p.m. revealed the resident was in bed with</p>	F 323	F 323 <p>Corrective action for resident 3- assessment for physical device was done. Assist bar was found appropriate for this resident. The assist bar has been included on her care plan. Corrective action for resident 7- assessment was done for physical device and deemed appropriate for this resident as she does use them to assist with repositioning. Assist bar was then added to care plan. Corrective action for resident 1- physical device assessment was done and found appropriately for her. This assist was then added to the care plan. Corrective action for resident 5- assessment done for physical device and was deemed appropriate for use on this resident as he does use it to reposition. Assist bar was added to care plan. Corrective action for resident 4- assessment done for physical device and was deemed appropriate for this resident as she uses the bar to reposition. Assist bar added to care plan. All other residents who have assist bars have had the physical device assessment done and have had them care planned. This provider will monitor its performance to identify future noncompliance through quarterly MDS reviews and weekly Quality of Life meetings. The DNS and QA Coordinator will review ten residents a month that have assist bars to ensure that the appropriate assessments have been done and that the assist bars have been care planned every month for three months, and quarterly for one year. Results will be reviewed at the</p>	* 7/2/14 MPS/DDH/MF	

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F 323	<p>Continued From page 8</p> <p>both assist bars in place. She had not used them during that time to reposition herself in bed.</p> <p>Review of resident 7's medical record revealed: *A diagnosis of seizure disorder, dementia, hemiplegia/paresis (inability to move or feel one side of the body). *No assessment that indicated a need for an Assist Bar. *No physician's order for an Assist Bar. *The use of an Assist Bar had not been included on her most recent care plan last revised on 4/6/14. *A BIMs score of 1 that indicated severe mental impairment. Surveyor: 32572 3. Observation on 7/1/14 at 3:50 p.m. revealed resident 1's bed had one-quarter Assist Bars attached to the head of her bed on both sides.</p> <p>* Review of resident 1's medical record revealed: *She had been admitted on 2/28/13. *She had the following diagnosis: -Alzheimer's disease (problems with thought processes). -Urinary tract infection. -Gout (inflamed joint). -Hypertension (high blood pressure). -Depression. -Pain. -Anxiety. *Review of the 5/12/14 physician's orders did not reveal an order for assist bars. *Her 4/15/14 Minimum Data Assessment (MDS) revealed a Brief Interview for Mental Status (BIMs) score of 1 indicating severe impairment in thinking. -That MDS revealed a bed mobility score of extensive assistance with the assistance of two</p>	F 323	<p>Quality Committee Performance Improvement Committee Meeting at their monthly meetings. Nurses and CNA's were educated about the need to do assessments on assist bars and what assessment needs to be completed and that these need to be monitored on at least a quarterly basis. All other staff, residents and family will be educated through a letter that will be sent out by July 31, 2014. Anticipated correction date is July 31, 2014.</p>	

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F 323	<p>Continued From page 9 staff members.</p> <p>*Review of the paper and electronic medical record did not reveal a restraint assessment that would be indicated for the use of assist bars.</p> <p>*Review of the revised 1/26/14 care plan revealed a problem area of "ADL [activities of daily living] self care performance deficit."</p> <p>-The intervention for bed mobility had been "Resident requires assist of one-two to reposition and turn in bed."</p> <p>-There had been no indication of Assist Bar use.</p> <p>4. Observation on 7/1/14 at 3:50 p.m. revealed resident 5's bed had a one-quarter Assist Bar attached to the head of the bed on the left side (closest to the wall).</p> <p>Review of resident 5's medical record revealed:</p> <p>*He had been admitted on 7/2/13.</p> <p>*He had the following diagnosis:</p> <ul style="list-style-type: none"> -Cerebral vascular assident (CVA [stroke]). -Abdominal aortic aneurism (bulge in a large blood vessel in the abdomen). -Obstructive sleep apnea (quits breathing when sleeping). -Chronic obstructive pulmonary disease (emphysema). -Cachexia (severe weight loss). -Anemia. -Dyspepsia (stomach problems). <p>*Review of the 6/16/14 physician's orders did not reveal an order for assist bars.</p> <p>*His 5/27/14 MDS revealed a BIMS score of 7 indicating severe impairment in thinking.</p> <p>-That MDS revealed a bed mobility score of extensive assistance with the assistance of one staff member.</p> <p>*Review of the paper and electronic medical record did not reveal a restraint assessment or</p>	F 323		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362
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F 323	<p>Continued From page 10 assist bar assessment.</p> <p>*Review of the revised 12/24/13 care plan revealed a problem area of "ADL self care performance deficit."</p> <p>-The intervention for bed mobility had been "Resident requires one to two staff participation to reposition and turn in bed."</p> <p>-There had been no indication of Assist Bar use.</p> <p>Surveyor: 29162</p> <p>5. Observation and interview on 7/1/12 from 8:00 through 5:00 p.m. and on 7/2/14 from 8:00 a.m. through 3:00 p.m. of resident 4 revealed she had an Assist Bar attached to the side of her bed nearest the door. She stated she used that Assist Bar to move around in bed.</p> <p>Review of resident 4's medical record revealed:</p> <p>*No assessment that indicated a need for an Assist Bar.</p> <p>*No physician's order for an Assist Bar.</p> <p>*The use of an Assist Bar had not been included on her most recent care plan last revised on 3/20/14.</p> <p>6. Interview on 7/2/14 at 8:50 a.m. with the social service designee revealed:</p> <p>*Safety assessments were not completed for the use of Assist Bars.</p> <p>*They did not consider the Assist Bars a restraint, and therefore no assessments had been completed on any residents including the above resident.</p> <p>Interview on 7/2/14 at 3:00 p.m. with the administrator and director of nurses revealed they did not consider the Assist Bars a restraint. They had not completed any type of entrapment (caught in) evaluation for their beds.</p>	F 323		
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F 323	Continued From page 11 Review of the 2008 NOA Medical Industries, Inc., Operation and Maintenance Manual for Assist Bars revealed: **"WARNINGS/CAUTION NOTICES in the manual apply to hazards or unsafe practices could result in personal injury and/or property damage." **"Close supervision by a caregiver is necessary when this product is used near CHILDREN OR PEOPLE WITH DISABILITIES." **"The entrapment zones involve the relationship of components controlled by the the healthcare facility or individual user. Compliance to the dimensional guidelines for reducing the risk of entrapment is primarily the responsibility of the health care facility or the individual user."	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to ensure: *The kitchen environment was maintained in a clean and sanitary manner for safe food preparation. *Food temperature testing was done in a safe	F 371	F 371 1.*The missing portion in the base board near the entrance to the dry good store room will be replaced by 8/21/14, by Environmental Services. 8/21/14. 1.* the two 3-shelf silver carts were cleaned by Dietary Services on 7/21/14. 2 replacement carts were ordered on 7/23/14. The 2 carts in need of replacement will be replaced when the new carts arrive. 1.*The shelves on the 2 five-tiered silver carts were cleaned on 7/17/13. 1.*The plate warmer was cleaned on 7/17/21 and the rubber-like bumper near the bottom of the plate warmer was removed 7/21/14. 1.*Dishwashing Area: * The floor with the missing grout was cleaned on 7/29/14, and will be replaced/repared by 8/21/14. * The wall under the dishwasher was power washed 7/24/14, and repairs done by 8/21/14. * The enclosed grey boxes and the "Booster Heater Box" were cleaned 7/21/14 & 7/29/14 and will be repaired by 8/21/14.	*7/21/14 mp/sdc/llm

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F 371	Continued From page 12 and sanitary way by cook D during one of two meal services observed. Findings include: 1. Observations from 6/30/14 at 3:30 p.m. through 7/2/14 at 11:00 a.m. of the kitchen revealed: *A missing portion in the base board near the entrance to the dry good store room creating a sharp, noncleanable area. *The lowest bars on two, three-shelf silver carts were rusty and had a thick, sticky, dust build-up on them (photo 5). *All of the shelves on two, five-shelf silver carts had scattered debris and dust on them. *The rubber like bumper area near the bottom of the plate warmer was cracked and gouged. It had a layer of dust with tan, black, and brown debris on it (photo 6). *The dishwashing area: -Floor had missing grout/filler and created grooves that contained moisture, debris particles, and other unknown build-up (photo 7). -Wall under the dishwasher had a brown, thick, sticky build-up (photo 8). -Enclosed grey boxes and the "Booster Water Heater" box in the dishwasher area had a thick, brownish, sticky build-up on them (photos 9 and 10). *The area where the wall meets the floor had loose white and tan food particles and thick, clear, sticky stains (photo 11). *The upper surface of the mixer had a sticky, soft, white substance on it. *The splash guard of the mixer had a sticky, white, soft substance on it. *The corner area on the ramp entering into the walk-in cooler had a black, sticky, grime build-up (photos 12 and 13).	F 371	* The area where the wall meets the floor was cleaned by maintenance 7/25/14 & 7/29/14. The caulking of the grout and replacement of broken tile will be completed by an outside contractor by 8/21/14. 1. * The upper surface of the mixer was cleaned 7/11/14, and will be cleaned after each use. 1. * The corner area of the ramp entering into the walk-in cooler was cleaned 7/21/14. The area was repaired and re-caulked by maintenance 7/25/14. 1. * The reach-in doors to the walk-in cooler were cleaned by Dietary Manager 7/25/14. * The white pipes under the dishwasher were cleaned by Dietary Manager 7/21/14. All of the asterisk items(*) in the above for this State deficiency were and will be addressed in the following manner: The Dietary Manager updated and combined the daily, weekly and monthly cleaning lists in 7/11/14, to include all areas noted above. All dietary staff were instructed on the new check lists and the need to complete them by Dietary Manager by 7/29/14. Dietary Manager or designee will monitor all areas on check lists on weekly/monthly basis for 3 months as and needed and report findings to QA Committee. Any areas found not to be in compliance will be corrected/cleaned immediately after they are found. Consulting Dietician will conduct separate monthly audits of overall Dietary Department cleanliness for 6 months and as needed and report to Administrator, Dietary Manager or designee who in turn. will report findings to QA Committee.	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER			STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362		
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F 371	<p>Continued From page 13</p> <p>*The reach-in doors to the walk-in cooler had food particles on the ledge, and the corners by the hinges had a black sticky build-up.</p> <p>*The white pipes under the dishwasher and food preparation sink had stains of dark yellow and brown colored build-up on them.</p> <p>2. Observation on 7/2/14 at 11:30 a.m. of cook B while she tested the temperature of nine different food products revealed she poked the thermometer directly through the aluminum foil covering the pans. She temperature tested nine different pans of food in that same way.</p> <p>Interview on 7/2/14 at 10:50 a.m. with the dietary manager revealed she agreed the above identified areas had been unclean and unsanitary. She agreed the food testing thermometer should not have been poked directly through the aluminum foil on the pans.</p> <p>Review of the provider's last updated November 2010 dietary services Cleaning Schedules policy revealed:</p> <p>*It had been the responsibility of the director of dietary services to post daily, weekly, and monthly cleaning assignments in the dietary area.</p> <p>*Each dietary staff person had been responsible to know their assigned duties and to have carried them out.</p> <p>*The director of dietary service had been responsible to monitor staff and ensure the cleaning duties had been completed satisfactorily.</p> <p>*The assignments were to have included detailed information as to what to clean, and how to clean equipment, materials, or chemical recommended for the procedure.</p> <p>Review of the provider's last updated March 2009</p>	F 371	<p>2. All Dietary staff was educated on proper food temperature taking procedures on 7/21/14, and a return demonstration was completed. All new Dietary staff will receive specific training on proper technique for food temperature taking during their orientation. All staff will continue to receive annual education. Dietary Manager or designee will do weekly audits for compliance 4 weeks and then monthly for 2 months and report findings to QA Committee. Any Dietary staff out of compliance will be corrected immediately and if non-compliance continues, corrective action will ensue.</p> <p>8/21/14.</p>		

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F 371	Continued From page 14 Food Temperatures policy revealed to correctly take temperatures the thermometer was to have been inserted into the center of the thickest part of the food. The thermometer was not to have touched the pan sides.	F 371		

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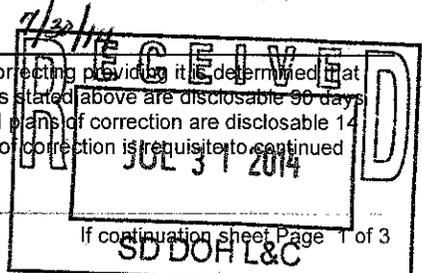
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/09/14. Good Samaritan Society Miller 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 7/10/14. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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: 18087 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. The only basement exit did not meet the standard for a means of egress. Findings include:	K 032		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Lawrence J. Pospisil, Administrator



Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 032	Continued From page 1 1. Observation revealed the basement was not provided with an approved means of egress. The only exit from the basement discharged into the main level corridor system. Review of previous life safety code survey data confirmed that finding.	K 032			
K 033 SS=C	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. NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and record review, the provider failed to maintain a one hour fire resistive path of egress from the basement to the exterior of the building. Findings include: 1. Observation revealed the only basement stairway adjacent to the west nurses station discharged into the main level corridor system. A one hour fire resistive path of egress was not provided to the exterior of the building. Review of previous life safety code survey data confirmed that finding.	K 033		F	

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K 033	Continued From page 2 The facility meets the FSES. Please mark an "F" in the completion date column to indicate the facility's intent to correct the deficiencies identified in K000.	K 033			

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 E 4TH STREET MILLER MILLER, SD 57362
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S 000	<p>Initial Comments</p> <p>Surveyor: 29162 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 6/30/14 through 7/2/14 and on 7/09/14. Good Samaritan Society Miller was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Laurie J. Pospisil, Administrator

TITLE _____

RECEIVED (X6) DATE
 JUL 31 2014
 SD DOH L&C

If continuation sheet 1 of 1