STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	07/02/2014

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GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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F 000	INITIAL COMMENTS Surveyor: 22452 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 Sioux Falls Village was found not in compliance with the following requirements: F241, F253, F280, F309, F314, F327, F425 and F441.	F 000	Addendums noted with an asterisk per phone telephone to facility administrator. KR/SDDOH/MF **F241 Dignity and Respect of Individuality SS=D** This is the plan of correction for the residents who dine in the Sells dining room who were affected by F241 Dignity and Respect of Individuality and any additional residents who reside at the Good Samaritan Nursing Home. The nursing staff (RNs, LPNs, UAPs, restorative aids, CNAs, and nursing supervisors) along with the dietary staff and all ancillary staff will be educated on the Procedure for Dining Room Service and the Supplemental Information by the Director of Nursing by July 30, 2014. This procedure educates the staff on the importance of serving all residents in a timely manner and serving all the residents who are dining together in an appropriate time frame. To ensure the residents receive their meals in a timely fashion, the nursing staffs' tasks will be reviewed and realigned to ensure staff will arrive in the dining room in increments	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and resident right review, the provider failed to ensure residents were served and assisted with their meals in a timely manner in one of five dining rooms (Sells dining room) for one of two observed meals. Findings include: 1. Observation on 6/30/14 at the supper meal in the Sells dining room revealed: *The supper was scheduled to be served at 5:30 p.m. *By 6:05 p.m.: -Nine tables had not been served. -Five tables had at least one resident eating. Other residents at those same tables had not been served. -One table had two residents that had completed	F 241		8/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/30/14

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.

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F 241	Continued From page 1 eating before their tablemates had been served. *By 6:20 p.m.: -Three tables had still not been served. -One resident at each table had not received his/her food while the other residents had their food. Interview on 7/2/14 at 11:30 a.m. with the director of nursing revealed all residents at the same table should have been eating at the same time. Review of the provider's January 2007 Resident's Bill of Rights for Skilled Nursing Facilities revealed: *"The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." *A resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered." Surveyor: 12218 2. Observation on 6/30/14 at 6:00 p.m. of the evening meal served in the Sells Dining Room revealed: *Three tables had just one resident served their meal, and the other three people sat and watched that resident eat. *A table that seated five had only two residents served, and the other three sat and watched those residents eat. *Only one table of three men had been served, and all three were eating at the same time.	F 241	according to the residents' needs. This will alleviate all the staff arriving to assist in the dining room at the same time and give additional assistance earlier in the dining experience. This will be implemented by August 21, 2014. New staff will be educated on the importance of the dining experience and the procedure during general orientation by staff development. This is the plan of correction for resident #5 who was seated at the dining room table with her food in front of her but no assistance to eat. Education will be provided to the nursing and dietary staff that a meal cannot be placed in front of a resident who needs assistance without a qualified individual to help assist in the dining experience. The supplemental dining education is provided by the Director of Nursing on July 30, 2014. The dining room experience will be audited on how long a resident waits for their meal, if the tablemates are	

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F 241	Continued From page 2 *The rest of the tables had some residents missing who had not been brought into the dining room. Interview on 6/30/14 at 6:10 p.m. with dietary aide R confirmed the residents were brought down to the dining room by the CNAs. She stated the CNAs were taking a long time to get the residents to the dining room that night. She was not sure why as most the residents were usually down for the evening meal soon after 5:30 p.m. She stated she helped serve residents when the CNAs were behind to keep things moving. Further observation at 6:20 p.m. on 6/30/14 revealed there were seven CNAs lined up at the steamtable's serving line ready and available to get the residents' meals served. Surveyor: 34030 Preceptor: 26180 3. Observation on 7/2/14 of the noon meal revealed: *Resident # 5 seated at the dining room table. *At 12:00 noon her food had been placed in front of her. *She had not been assisted to eat until 12:17 p.m. Further observation of the above meal revealed: *Three nursing students had assisted residents to eat at resident 5's table. *They had been talking to each other and not the residents. Review of resident 5's 4/19/14 care plan revealed she needed assistance to eat.	F 241	served at a reasonable time of each other, and if resident who needs assistance waits to have an appropriate person assist them after receiving the meal. An audit will be performed weekly for four weeks, bimonthly for two months, and monthly for three months. The audits will be completed by the nursing supervisors, dietary staff, or designee. The results will be brought to the monthly QAPI committee meeting for review and audits will be discontinued once audits prove the concern has been resolved. *The DNS or designee will report auditing results to QAPI. KR/SDDH/MF	

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F 253 F 253 SS=B	Continued From page 3 483.15(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: 16385 Surveyor: 25107 Based on observation and interview, the provider failed to maintain the stand lifts in a clean condition. There was visible debris on the foot rests. The handles used by the residents were covered with a white grey crusty residue for: *Two of two stand lifts in the 200 hall. *Two of two stand lifts on the 400 hall. *One of one stand lift in the 300 hall. Findings include: 1. Observation on 7/1/14 at 10:30 a.m. revealed one of one stand lift on the 300 hall had a moderate amount of crumbs and debris on the foot rest surface. 2. Observation and interview on 7/2/14 at 10:05 a.m. of the two stand lifts in the 200 hall with certified nursing assistant (CNA) H revealed: *The handles the residents grabbed when using the lifts were covered with a white grey crusty residue (photo 1 and 2). *The two stand lifts had a moderate amount of crumbs and other debris on the foot rests (photo 3 and 4). *She and the staff used a disinfectant wipe to wipe the handles after each use.	F 253 F 253	**F 253 Housekeeping and Maintenance Services SS=B** This plan of correction for the cleanliness of the lifts that were affected on the 200, 300, and 400 hall and any additional lifts used in the building. The nursing staff (RNs, LPNs, UAPs, restorative aids, CNAs, and nursing supervisors) and the house keeping staff will be educated on the procedure for cleaning the lifts by the Director of Nursing by July 30, 2014. The affected lifts and all the other lifts currently used at the Good Samaritan Village will be thoroughly cleaned and inspected by the house keeping supervisor by August 15th. An audit will be performed weekly for four weeks, monthly for three months, and quarterly. The audits will be completed by the house keeping supervisor or designee. The results will be brought to the monthly QAPI Committee meeting for review and audits will be discontinued once audits prove the concern has been resolved.	8/21/14

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F 253	Continued From page 4 *She was not aware of the residue on the handles but confirmed the debris on the foot rest. *She agreed both lifts were not clean. *She thought the evening shift (2:30 p.m. to 11:00 p.m.) was responsible for thoroughly cleaning the lifts. *Scrubbing of the handle with a disinfectant wipe revealed the white grey residue came off. 3. Observation and interview on 7/2/14 at 10:19 a.m. of the two stand lifts in the 400 hall with CNA I revealed: *The two stand lifts had a small amount of crumbs and other debris on the foot rests. *The handles the residents grabbed when using the lifts were covered with a white grey crusty residue (photo 5). *The residue came off when scratched by this surveyor's fingernail. *He agreed the lifts were not clean, especially the handles. *He was not aware there was a residue covering the handles. *He and the staff used a disinfectant wipe to wipe the handles after each use. *The lifts would be thoroughly cleaned as needed. *There was no scheduled or routine cleaning of the lifts other than wiping them with a disinfectant wipe after each use. *Scrubbing of the handle with a disinfectant wipe revealed the residue would come off. *The wipe turned a brown color after scrubbing the handle. 4. Observation and interview on 7/2/14 at 11:45 a.m. with the administrator and director of nursing (DON) revealed: *The lifts in the 200 hall had been cleaned. The crumbs and debris from the foot rests and the	F 253	*Environmental services supervisor will report auditing results to QAPI. KR 8/20/14 MF	

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F 253	Continued From page 5 residue on the handles were gone. *The lifts in the 400 hall had not been cleaned. *They agreed the lifts needed cleaning. *The staff were trained to wipe the lifts after each use with a disinfectant wipe. Interview on 7/2/14 at 2:30 p.m. with the DON revealed there was no policy and procedure in place for the routine cleaning of lifts other than wiping them with a disinfectant wipe after each use.	F 253	**F280 Right to Participate Planning Care –Revise CP SS=D** This is the plan of correction for resident #5 and #9 who were affected by F280 Right to Participate Planning Care-Revise Care plan and all other residents residing at the Good Samaritan Village. Resident # 9 care plan regarding the pressure ulcer were reviewed and updated by July 25, 2014. The dietician is working on a dietary plan and will have it care planned and implemented by July 30, 2014. The resident #5 concerns regarding her need for glasses were reviewed. Family was contacted to inquire about glasses use on three different occasions and they have not returned a call. The social worker will address at the next care plan meeting if resident #5 needs new glasses. Resident #5 had been a risk for hydration. The interdisciplinary team, including the dietician and physician	8/21/14
F 280 SS=D	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, 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. This REQUIREMENT is not met as evidenced by:	F 280		

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F 280	Continued From page 6 Surveyor: 12218 Based on record review, observation, and interview, the provider failed to update and revise resident care plans to show the current condition for 2 of 25 residents (5 and 9). Findings include: 1.Review of resident 9's current care plan revealed: *Focus Area: Nutritional problem related to bursitis, compression fracture, and pressure wound on right buttock. (Date initiated: 1/29/14, Revision on 3/27/14.) *Goals: -Resident will consume 75-100% of meals through review date. (Date initiated: 1/29/14, Target date: 8/13/14.) -Pressure wound to heal by review date. (Date initiated: 3/27/14, Target date: 8/13/14.) *Interventions: -Monitor and record meal intake at each meal. (Date initiated: 3/27/14.) -Weigh resident weekly. (Date initiated: 3/27/14.) -Provide resident with a calm, quiet setting at meal times with adequate eating time. (Date initiated: 1/29/14.) *Focus area: Has pressure ulcer related to compression fracture and decrease in mobility, stage 2 pressure ulcer on right buttock. (Date initiated: 1/29/14, revision on 3/27/14.) *Goal: Resident will heal without complications by/through review date. (Date initiated: 1/29/14, target date: 8/13/14, revision date: 3/27/14.) *Intervention: -Educate resident/family as to the causes of skin breakdown including transfer/positioning requirements; importance of taking care during ambulating, mobility, good nutrition, and frequent repositioning. (Date initiated: 1/29/14.) -Assist to turn/reposition at least every 2 hours.	F 280	determined if it was necessary to monitor intake throughout the day or if the meal intake was sufficient. Resident # 5 care plan was reviewed and updated according to the dietician assessment, family input, and resident input. The CNAs were educated on July 16, 2014 regarding checking the care plan on the kiosk and notifying the charge nurse or coordinator about assessing the resident and updating the care plan. At the meeting a demonstration was given regarding placing an alert on the EMR system so the entire disciplinary team would be aware of updates to the care plan or a change in the resident status. The nurses (RN, LPN, and Nursing supervisors) were educated on July 22, 2014 regarding who is responsible to keep the care plan updated. The expectation is the nurse will make changes to the care plan based on the assessment, needs, or desires of the resident. The nurses were instructed to make a nursing progress note that is tied to the 24 hour report to be	

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F 280	Continued From page 7 (Date initiated 3/27/14, revision on 5/14/14.) -Inform resident/family of any new areas of skin breakdown. (Date initiated: 1/29/14.) -Provide pressure relieving/reducing device on bed and chair. (Date initiated: 1/29/14.) -Monitor nutritional status. Serve diet as ordered, monitor intake, and record. (Date initiated: 1/29/14.) -Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc, noted during bath or daily care. (Date initiated 1/29/14.) Interview with Minimum Data Set (MDS) care coordinateor U on 7/1/14 at 9:30 a.m. regarding resident 9's pressure ulcer revealed: *He currently did not have a pressure ulcer. *She was not sure when it had been resolved. *She stated it was still open when the quarterly MDS had been done on 5/5/14. *She found in his medical record the pressure ulcer had first been documented, and measured on 2/25/14. *She confirmed his care plan had not been updated and revised to show his pressure ulcer was healed. *She confirmed his care plan did not show his current medical condition. *She stated they had not usually updated and revised the care plan until the three month care conference. *She knew they had gotten a new mattress for his bed and a new gel cushion for his wheelchair. *She agreed the care plan did not show those new interventions. *She agreed the interventions under the focus area of nutrition and the pressure ulcer needed improvement. They needed to be more appropriate to the existence and healing of the	F 280	seen by the interdisciplinary team. The Director of Nursing will educate the dietary staff, activities staff, and social services staff will be educated on the procedures and use of the 24 hour report for communicating change in conditions by July 30, 2014. All staff that does not have access to the EMR system will complete a Stop and Watch form to communicate changes in residents. These staff member will be reeducated on the procedure for the use of the Stop and Watch forms. The interdisciplinary team was educated on the care plan policy and the procedure for expectations of updating the care plan including checking the 24 hour report box with any care plan changes. In addition to the floor nurses and interdisciplinary team updating the care plan, the nursing supervisors are responsible to ensure the accuracy of the care plan by reviewing it periodically and with all MDS assessments. *See page 9. KR/SDDOH/MF	

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F 280	Continued From page 8 pressure ulcer. Review of the provider's September 2012 care plan policy revealed: *"Purpose: To develop a comprehensive care plan using an interdisciplinary team approach." *"Policy: Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." *"A qualified team of persons will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition and/or in accordance with state guidelines." *"This care plan of care will be modified to reflect the care currently required/provided for the resident." Surveyor: 34030 Preceptor: 26180 2.Review of resident 5's 4/26/14 significant change Minimum Data Set revealed she: *Had poor vision and had glasses. *Needed extensive assistance with eating and activities. *Had been at risk for hydration (fluid intake) issues. *Had cognitive impairment (decreased mental ability) and difficulty with communication. Review of resident 5's care plan printed 6/30/14 revealed she: *Was to have had her glasses provided to wear. *Had been "assist as needed" for eating. *Had been "monitor and record intake at each meal" but had nothing regarding hydration. *Had been dependant on staff for activities and	F 280	We will use the 24 hours shift report to identify 25% of the residents to audit if the care plan reflects their current condition. The audit will be completed weekly time 4 weeks, bimonthly for 2 months, and monthly for 3 months. The care coordinator will pull the 24 hour report and choose 25% of the weekly, bimonthly, and monthly list of residents with a change of condition. The results will be brought to the monthly Quality Assurance meeting for review and audits will be discontinued once audits prove the concern has been resolved. * Care plans will be reviewed quarterly with all MDS assessments or with significant changes instead of periodically. The DNS or designee will report auditing results to QAPI. KR 6/30/14 MF	

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F 280	Continued From page 9 should have been provided adaptive equipment (equipment to help her perform a task). -Had preferred activities such as reading, music, watching TV, towel folding, social times, and visiting with her pet dog. Random observations on 7/1/14 and 7/2/14 of resident 5 revealed she: *Had not been wearing her glasses. *Had been seated in her room in her wheelchair with a water pitcher on a table behind her. It had remained full. *Had been seated at a table with magazines with another resident but no staff, and she had not been reading. Interview on 7/2/14 at 11:30 a.m. with certified nursing assistant I regarding resident 5 revealed: *They had not monitored her fluids other than at mealtimes. *She agreed the resident had needed assistance to drink. *She had been unaware the resident had glasses, and had not seen her wearing any. Interview on 7/1/14 at 2:00 p.m. with MDS coordinator P regarding resident 5 revealed she agreed the care plan did not reflect her current care needs. Review of the provider's September 2012 Comprehensive care plan and care conferences procedure revealed the purpose was: *"To develop a holistic and resident-specific care plan for the well-being of the mind, body and soul of each individual, upon completion of the assessment, that includes measurable objectives and timetables to meet his or her physical, mental,spiritual, and psychosocial needs."	F 280		

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F 280	Continued From page 10 *"To provide an ongoing method of assessing, implementing, evaluating, and updating the resident's care plan to help maintain the resident's highest level of functioning."	F 280	**F309 Provide Care/services for Highest Wellbeing SS=G**	8/21/14
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 A. Based on observation, interview, record review, and policy review, the provider failed to ensure: *Appropriate care for pressure ulcer care, hydration, meal supervision, bathing, and fluid restriction had been provided for one of one sampled resident (2) who had a current pressure ulcer, and who had a physician order for a daily fluid restriction. *Appropriate pressure ulcer care, collaboration of care with a hospice provider, and following physician's order for fluid intake for one of two sampled residents (10) on who had a current pressure ulcer, was on hospice, and had a physician's order to encourage fluids. Findings include: 1. Observation and interview on 6/30/14 at 4:30 p.m. with resident 2 in his room revealed:	F 309	This is the plan of correction for resident #2 and #10 who were affected by F309 Provide Care/Services for Highest Well Being and for any other resident who resides at the Good Samaritan Village. The procedure was changed for monitoring intake for residents who are on fluid restrictions. The dietician will fill out GSS 195 Fluid Restriction Worksheet that states the break-down of fluid allowed between nursing and dietary. The new procedure will include monitoring intake throughout the day not just at meal times. The Director of Nursing the nursing staff (RNs, LPNs, UAPs, restorative aids, CNAs, and nursing supervisors), dietary staff, and the entire disciplinary team will be educated on the new guidelines for fluid restrictions by July 30, 2014. Audits will be completed by the Dietician or designee to ensure the	

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F 309	Continued From page 11 *He was lying on his back in his bed. *He stated "I am thirsty." *His lips appeared dry, and his tongue looked pale with a whitish coating on it. *He stated he had to ask the nurse for something to drink. *He had a catheter drainage bag that contained red colored urine. Interview on 6/30/14 at 5:30 p.m. with certified nursing assistant (CNA) A regarding resident 2 revealed: *He had some "bladder issues" and did not like to come to the dining room for meals. *He had a Foley catheter (drains urine from the bladder into a collection bag). *He ate very little at meal times. *He usually had a tray brought to his room for meals. *She was unsure as to the reason the resident had no fluids to drink in his room. Observation on 6/30/14 at 6:00 p.m. in the main dining room with resident 2 revealed: *He was in a wheelchair (w/c) and was sitting at a table by himself. *He had a plate of food, a glass of juice, and a cup of hot chocolate. *He had padded silverware to assist him with his grip. *He ate very little and had drank no fluids. *He attempted to eat his dessert, and he dropped the dessert in his lap. *The staff had not stopped to assist the resident or asked him if he needed assistance with his meal. Review of resident 2's complete medical record revealed:	F 309	resident is receiving proper hydration. This audit will be completed weekly for one month, biweekly for two months, and monthly for three months. The results will be brought to the monthly Quality Assurance meeting for review and audits will be discontinued once audits prove the concern has been resolved. *The DNS or designee will report auditing results to QAPI. KR/SDD04/MF Resident #2 has a change in his care plan to receive assistance with dining. He was moved to an assistance table so he can receive cuing from staff. He is encouraged to come out for meals, but if he chooses to be in his room, staff will assist him. He is classified as high risk so the dietician will continue to monitor his nutritional and hydration intake. The Director of Nursing will educate the nursing staff (RNs, LPNs, UAPs, restorative aids, CNAs, and nursing supervisors), dietary staff, and the entire disciplinary team will be educated on the policies regarding proper nutrition and assisting residents with dining by July 30, 2014.	

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F 309	Continued From page 12 *On 5/1/14 he was admitted to the rehabilitation unit. *He had weakness, hyponatremia (low sodium which regulates the amount of water in and around your cells [an important electrolyte for normal body functions]), and anemia (not enough healthy red blood cells to carry an adequate oxygen supply to the tissue and making one feel very tired) after a recent hospitalization. *On 5/22/14 there was a physician's order for DuoDerm (dressing) topically (on the skin) to the coccyx (tailbone area) every 72 hours for skin breakdown. *On 5/24/14 he was transferred to the 300 wing for further care. *He was alert, orientated, and able to make his needs known. *He had a small open area on his coccyx area (tailbone area) and received a dressing change every three days. *He had the following diagnoses: -Diabetes. -Neuropathy (lack of sensation, tingling, and numbness to parts of the body). -Hypertension (high blood pressure). -Anemia. -Atrial fibrillation (irregular heart beat). -Malaise (a feeling of discomfort, illness, or lack of well-being). -Fatigue (weakness and feeling tired all the time). -Hyponatremia (low amount of sodium). Review of resident 2's 5/15/14 Minimum Data Set (MDS) revealed he: *Was alert but had trouble recalling words. *Was feeling tired and having very little energy. *Had a poor appetite. *Had trouble concentrating on things. *Needed extensive assistance of two staff for bed	F 309	Audits will be completed to ensure residents who need assistance with dining receive the assistance appropriately. The audits will be performed weekly for four weeks, bi monthly for two months, and monthly for three months. The audits will be completed by the nursing supervisors, dietary staff, or designee. The results will be brought to the monthly QAPI Committee meeting for review and audits will be discontinued once audits prove the concern has been resolved. *The DNS or designee will report auditing results to QAPI KR/SDDOH/MF *2 KR/SDDOH/MF Resident # has a daily Wound Data Collection schedule to be completed by the staff nurse and a weekly Wound RN Assessment to be completed by the wound nurse. Daily assessments of pressure ulcers are scheduled on the EMR. Nurses have been educated by the Director of Nursing that the Wound Data Collection needs to be completed daily by the nurse until the wound is closed. The wound nurse will complete the Wound RN Assessment	

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F 309	Continued From page 13 mobility, transfers, and toileting. *Needed extensive assistance of one staff person for dressing and personal hygiene. *Was independent with eating after set-up assistance. *Had a weight of 144 pounds (lb) and had no swallowing problems. *Had been at risk for skin breakdown. The treatments were a pressure reducing device for his chair and his bed. *There was no turning or repositioning program documented. Review of resident 2's 5/29/14 MDS revealed he: *Was alert and had some trouble with orientation. *Continued to have little energy and was feeling tired. *Had a poor appetite. *Needed extensive assistance of two staff for bed mobility, transfers, and toileting. *Needed extensive assistance of one staff person for dressing. *Required supervision and set-up assistance for eating. *Had a weight of 141 lb. He had a 5 percent (%) weight loss since his admission. *Was at risk for pressure ulcers. *Currently had a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed). He was on a pressure reducing device for his bed, chair, now was on a turning and repositioning program, and pressure ulcer care. Review of resident 2's 5/1/14 care plan revealed: *He had impaired cognitive (memory) function. *He had diabetes, and staff were to check all of his body for skin breakdown. Staff were to monitor dietary choices and document any	F 309	including measurements on a weekly basis. The wound nurse will be notified of any new wounds by having the nursing staff complete an incident report. The wound nurse is responsible to ensure the Wound Data Collection schedule is followed and that the weekly Wound RN Assessment is completed. This education was provided at the nurses meeting on July 22, 2014. Additional written information will be provided by July 30, 2014. This information will consist of Pressure Ulcer Policy, Pressure Ulcer Practice Guidelines, and Skin Assessment and Pressure Ulcer Prevention along with the Wound RN Assessment and Wound Data Collection. Audits will be completed to ensure the assessments and treatments of pressure wounds are completed as directed. The wound nurse will audit the Wound Data Collection for completion and accuracy weekly. The care coordinator will complete an audit on the Wound RN Assessment	

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F 309	Continued From page 14 problems. The staff were to notify the health care provider for increased thirst and poor wound healing. *He had activity of daily living self care performance deficit related to increased weakness. He required assistance with repositioning and turning in bed, and assistance of one staff person for dressing, bathing, and hygiene. One or two staff assistance with toileting. Extensive assistance of one staff person to empty his catheter bag every shift. *His care plan indicated he was able to feed himself independently. *He had a potential nutritional problem related to diet and fluid restrictions. *The staff were to monitor and record his intake at each meal. *Weigh weekly. "FLUID RESTRICTION: Resident is on a fluid restriction, 1500 milliliters (ml)/day. See charge nurse before giving any fluids between meals. Document all fluids provided." *He had a stage 2 pressure ulcer on his coccyx. *The staff were to assist to turn/reposition at least every 2 hours using two staff. The staff were to assess/record/monitor wound healing, report improvements and declines to the health care provider. *Monitor nutritional status. Serve diet as ordered, monitor intake and record. Review of resident 2's 6/17/14 Braden scale for predicting pressure ulcers revealed: *He scored a 15 that was a mild risk. *The friction and shear area on the Braden scale form revealed he could move freely and required minimal assistance. (The 5/29/14 MDS revealed he was an extensive staff assist with mobility). *The Braden scale form and the MDS documentation were not consistent.	F 309	on a monthly basis. The results from the two audits will be brought to the monthly Quality of Life for review. The results will be brought to the monthly Quality Assurance meeting for review and audits will be discontinued once audits prove the concern has been resolved. *The DNS or designee will report auditing results to QAPI. KR/DOC/HMF Resident #2 will be offered his bath/shower according to his care plan and task will be documented in the EMR system. The nursing staff (RN, LPN, UAP, CNA, and nursing supervisors) will be educated by July 30, 2014 on the proper bathing procedure and documentation. Audit will be completed by the care coordinator on a weekly basis times 4 weeks, bimonthly for 2 months, and quarterly for 3 months. The results will be brought to the monthly Quality Assurance meeting for review. *The DNS or designee will report auditing results to QAPI. KR/DOC/HMF Resident #2's care plan will be reviewed and updated by July 30, 2014. The same procedure will be	

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F 309	Continued From page 15 Review of resident 2's wound monitoring documentation revealed: *He had a pressure ulcer to his coccyx that had been found on 5/20/14. The coccyx pressure ulcer measured 0.5 centimeter (cm) in length, 0.7 cm in width, and was 0.1 cm depth. *The only other measurement documented was on 6/28/14. The area measured 1.0 cm by 0.75 cm. The documentation was not completed and signed until 6/29/14. The coccyx area had worsened. *There had been no documentation of the assessment, and monitoring of the coccyx pressure ulcer performed weekly by the registered nurse. Review of resident 2's May 2014 repositioning sheet revealed there was no documentation any repositioning had been done. Review of resident 2's total fluid intake record from 6/24/14 through 6/30/14 revealed: *On 6/24/14 he had a total of 480 cubic centimeters (cc). *On 6/25/13 it was 540 cc. *On 6/26/14 it was 600 cc. *On 6/27/14 it was 840 cc. *On 6/28/14 it was 700 cc. *On 6/29/14 it was 240 cc. *On 6/30/14 it was 540 cc. *He had not reached his fluid restriction of 1500 cc per day. Review of resident 2's May and June 2014 electronic medication administration record (eMAR) revealed there had been no documentation of oral fluid intake recorded by the nursing staff.	F 309	followed as F280 Right to Participate Planning Care-Revise Care plan to ensure this resident's care plan is up to date and included input from the entire interdisciplinary team. Audits will be completed with F280. DON contacted resident #2's physician and records state there were hemoglobin's checked on May 1, June 2, June 15, and July 1,2,3 of 2014. Resident #10 received deodorant drops in his catheter bag starting on 7/2/2014. The drops were ordered on 6/26/14 but were not available July.	

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F 309	Continued From page 16 Observation on 7/2/14 at 2:30 p.m. in the 300 wing nurses station revealed there was a typed undated note placed in the nurses station for resident 2 that read: *"Read dietary card -No water with meals. Bkfst (breakfast)- 8 ounce (oz) coffee, 6 oz juice, 4 oz milk for cereal. Lunch-8 oz coffee. Supper -8 oz cocoa. *No water mug in room. *NSG (nursing) give pills with his med (medication) pass nutrition supplement-only use 4 oz water to mix with his fiber medication-He will have 120 cc leftover for NSG discretion or extras like ice cream or soup." Review of resident 2's hygiene record for May and June 2014 revealed he had bathes documented on May 7, June 11, and June 28. Observation on 7/1/14 at 7:25 a.m. of resident 2 revealed: *He was lying in his bed on his back. *His Foley catheter drainage bag was anchored to his bed rail and had bright red blood in the drainage bag. Interview on 7/1/14 at 7:40 a.m. with licensed practical nurse (LPN) C regarding resident 2 revealed his urine had been very bloody for the past week. He had not been eating or taking fluids well. Observation on 7/1/14 between 8:30 a.m. and 9:40 a.m. of resident 2 revealed: *He was sitting in his w/c at the dining room table by himself. *Staff assisted him with buttering his toast. *He was unsupervised during the rest of the	F 309		

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F 309	Continued From page 17 meal. *He ate and drank very little. *He was returned to his room and placed beside his bed in his w/c at 9:00 a.m. *He then was assisted by two staff to his bed and was lying on his back in his bed at 9:40 a.m. Interview on 7/1/14 at 9:40 a.m. with registered nurse/MDS care coordinator D regarding resident 2 revealed: *On 5/24/14 he was transferred from the rehabilitation unit to the 300 wing. *She was unsure of the reason he had no fluids to drink in his room but was sure he had gotten fluids in his room. The staff must have been changing drinking mugs at the time of the observation. *The dietary department would have kept track of his oral intake at meals. *She had been unsure if the nursing staff had been keeping track of his oral intake. *The nursing staff would be responsible for updating the care plan when there was a change in a resident's condition. *She agreed the care plan should have been updated to reflect the resident's need for supervision during meals. *He was losing weight, and his current weight was 134.6 lb on 6/27/14 which was an approximate 10 lb weight loss in two months. *She thought he had been receiving a nutritional supplement. *He had a pressure ulcer to his coccyx, but she was unaware if the area had worsened or improved. The nurses changed the dressing every three days. The wound nurse measured the wound weekly. *The residents usually received a weekly bath. *She was unsure why there was no weekly	F 309		

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F 309	Continued From page 18 documentation for that resident. The staff must have forgotten to chart the bath. She agreed it looked as though the resident had only three baths since his admission on 5/1/14. Interview on 7/1/14 at 9:45 a.m. with CNA E regarding resident 2 revealed: *She had not offered him any fluids in his room, because he was on a fluid restriction. *The only fluids he was allowed to have were given to him at meal times. *She had never recorded any fluids that he had taken outside of his meals. Observation on 7/1/14 at 12:30 p.m. of resident 2 in the dining room revealed: *He had only ice cream, pudding, and a liquid supplement in front of him. *There were no staff assisting him. Interview on 7/1/14 at 12:40 p.m. with dietitian N following the above observation of resident 2 revealed: *He had not been eating well. *He was refusing to eat his regular lunch menu. *She had asked him what he wanted and thought maybe he would take some nourishment he liked. *She was not aware staff should have been assisting him in the dining room during meals. *He was to have received 1020 cc from the dietary service with his meals. *She agreed he had not been consuming the total allotment for his fluid intake at meals. *She agreed nursing should have been monitoring and supplementing his oral intake to ensure he had received his 1500 cc per day. Interview on 7/1/14 at 2:00 p.m. with licensed practical nurse (LPN) C regarding resident 2's	F 309		

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F 309	Continued From page 19 condition revealed: *He had been transferred to the hospital by ambulance at 1:34 p.m. today. *There was a STAT (immediate) order for a hemoglobin (blood test) because of his anemia and bloody urine. The hemoglobin test result was 8.7 (normal is 13.5 to 17.5). His last noted hemoglobin was 9.1 on 5/1/14. His hemoglobin had not been rechecked in sixty days, and there was no physician order to check his hemoglobin on a regular basis. *She had notified his primary physician after the results of the hemoglobin were obtained and had been instructed to transfer him to the hospital for further care. Interview on 7/2/14 at 9:20 a.m. with the director of nursing (DON) regarding resident 2 revealed: *The care plans were not updated immediately after the change in the resident. The staff would observe for a few days to see if it was a permanent change, and then the care plan would have been updated. The staff would use word-of-mouth to communicate any changes at report time between shift changes. *The care plan should have been updated to reflect the resident's need for supervision and assistance at meals. *The residents were scheduled for baths weekly, and she was unsure as to the reason there was only documentation of three baths in two months. Interview on 7/2/14 at 12:00 noon with the assistant director of nursing (ADON)/wound nurse and RN/MDS care coordinator D regarding resident 2 revealed: *The wound data collection was done by the RN. The data review had not been done since 6/21/14.	F 309		

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F 309	Continued From page 20 *The assistant DON was the wound nurse. She was not aware resident 2 had a pressure ulcer. *The nurses should have communicated with her about the pressure ulcer. *The ADON agreed the wound assessment by the RN was eleven days overdue. *They both agreed the wound documentation was inconsistent, and there was a lack of communication between nursing staff and the wound nurse. *They both confirmed the current system for pressure ulcers was not working. *MDS/care coordinator D was unsure as to the reason a hemoglobin laboratory test had not been rechecked on resident 2 since his hemoglobin was low on 5/1/14 at 9.1. She stated that would have been up to the physician to have ordered a recheck of the lab work. Interview on 7/2/14 at 3:00 p.m. with director of dietary services B regarding resident 2 revealed: *He was to receive the following fluid intake with his meals: -540 cc for breakfast. -240 cc for lunch. -240 cc for supper. *The total would be 1020 cc for meals. There was 480 cc left for nursing to use. *He agreed the resident had not reached his 1500 cc fluid restriction amount. *He agreed if the resident had not been consuming all of his fluids at meal times he should have been offered those fluids by the nursing staff in his room. That would have ensured he had been receiving the required oral intake. *The nursing staff had not been reviewing the resident's intake at mealtime and adjusting his fluids as needed.	F 309		

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F 309	Continued From page 21 Review of the provider's September 2012 Care Plan policy revealed: *"Residents would receive and be provided the necessary care and services to attain or maintain the highest practible well-being in accordance with the comprehensive assessment. *Each resident would have an individualized comprehensive plan of care that would include measurable goals, and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. *Through the use of departmental assessments, the Resident Assessment Instrument, review of the physician's orders, any problems, needs, and concerns identified would be addressed. *Care plans would be reviewed, evaluation and updated when there was a significant change in the resident's condition and/or in accordance with state guidelines. This plan of care would be modified to reflect the care currently required/provided for the resident." Review of the provider's June 2014 Bathing procedure revealed the purpose of bathing was to: *Promote cleanliness and general hygiene. *Stimulate circulation of the skin. *Promote comfort and relaxation and well-being. *Observe the resident's skin condition. *Assist the resident with personal care. Surveyor: 26180 B1. Review of resident 10's 5/28/14 significant change MDS revealed he: *Had a stage 3 pressure ulcer. *Had a diagnosis of diabetes. *Weighed 157 pounds. *Had a catheter.	F 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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F 309	Continued From page 22 *Was on Hospice care. Review of resident 10's June 2014 physician orders revealed: *He was to have fluids encouraged. *An additional order on 6/26/14 requested a deodorant to have been used in his urine/catheter bag. Random observation of resident 10 from 6/30/14 through 7/2/14 revealed there was a strong urine odor around him. Observation of resident 10 at meals on 6/30/14, 7/1/14, and 7/2/14 revealed he: *Was provided with two 6 ounce glasses of fluids. *Received no encouragement to drink those fluids. Interview on 7/1/14 at 5:30 p.m. with RN G regarding resident 10 revealed: *She was unaware the resident had an order to encourage fluids. *He had a history of having difficulty with a urine odor. *She confirmed the odor of his urine could have been due to not getting enough fluids. Interview on 7/2/14 at 9:00 a.m. with RN F regarding the urine odor around resident 10 revealed: *She was not sure if the odor was related to his prostate cancer but agreed there was a strong, lingering urine odor around him. *They had tried different things including the current deodorizer in his catheter bag. *They also cleaned the bag with vinegar. Review of resident 10's diet card revealed it had	F 309		

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F 309	Continued From page 23 not addressed the need to encourage fluids. Review of resident 10's June and July 2014 fluid intake records revealed his fluid intake ranged from 360 cubic centimeters (cc) of fluid per day, upwards to 900 ccs. Interview on 7/2/14 at 9:30 a.m. with registered dietitian (RD) N revealed she: *Recommended 30 ccs of fluid per kilogram (kg) of body weight to maintain hydration for all residents. *Was unaware resident 10 had an order to have fluids pushed. *She was not sure the documentation of fluid intake was accurate. *They only monitored the fluids the resident received at meals. Based on the 30 ccs of fluid recommended by RD N and resident 10's current weight he should have received 2140 cc of fluid per day. 2. Interview on 7/1/14 at 8:30 a.m. with registered nurse F regarding resident 10 revealed: *He had a pressure ulcer on his right foot. *That ulcer and dressing change was completed on Fridays by the nurse from Hospice. -They only observed the dressing to the ulcer and the area around the dressing of the ulcer *The assistant director of nursing (ADON) was the wound nurse, and she completed the assessments on all pressure ulcers. Interview on 7/1/14 at 11:00 a.m. with the ADON/wound nurse regarding resident 10 revealed: *She had been unaware the resident had a pressure ulcer on his foot until he went to an	F 309		

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F 309	Continued From page 24 appointment at the clinic. -They had debrided it (removal of dead or damaged tissue) during that clinic visit. *She was unsure what had caused the ulcer. *She completed weekly assessments of any resident who had a pressure ulcer. Review of resident 10's 5/27/14 clinic referral documentation revealed: *He had been seen by a podiatrist (a physician who treats problems with feet and ankles) at the clinic. *He was to have several areas evaluated including the right lateral foot and top of his foot, his left index finger, and his right great toe. *It described an area to his lateral right foot that measured 0.9 centimeters (cm) x 1.1 cm x 0.01, red. No drainage noted. *He returned with a physician's order for Mepilex white foam and silvadene cream to right foot ulcer daily. *He was to return in one week to evaluate shoes and assess wounds in wound clinic. Review of resident 10's 6/3/14 physician's progress note revealed: *The resident had advanced stage prostate cancer. *He was a new hospice patient. *It had not addressed the pressure ulcer on his right foot. Review of resident 10's wound data collection documentation revealed: *The assessments that had been completed by the ADON/wound nurse on 5/16/14 and 5/23/14 revealed: -During that time the measurements were 1.0 cm (length), the width went from 0.7 cm to 1.0 cm.,	F 309		

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F 309	Continued From page 25 and depth was 0.2 cm. -There were no other assessments completed by the ADON/wound nurse provided to the surveyor. *Additional wound date collection assessments were provided that had been completed by nurses assigned to care for the resident on specific days. *Those assessments included many unanswered and incomplete data including: -Information identifying the location of the wound. -Measurements. -Daily monitoring for complications. -Wound bed characteristics. Interview on 7/2/14 at 12:05 p.m. with the ADON regarding resident 10 revealed: *There should have been wound data documented every day by the nurse taking care of the resident. *The nurses could not assess a wound if they had not looked at it. *She confirmed she should have done a weekly assessment on the pressure ulcer on his right foot. -That had not been done. -The last assessment she had completed on him was done on 6/13/14. *She confirmed the nursing assessments that had been completed had many unanswered questions on them. -They had not been completed as they were intended to have been done. *She was unable to find documentation the resident's physician had been informed of the pressure ulcer on his right foot. Review of resident 10's 5/28/14 interdisciplinary care plan revealed: *He had a terminal prognosis related to prostate	F 309		

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F 309	Continued From page 26 cancer and received Hospice services. *The approaches for the above terminal illness included: -"Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met." -It listed the frequency that each hospice service would have been provided every month. -Those services included a registered nurse, social worker, clergy, volunteer, and a home health aide. *Another problem included the resident had a potential for a pressure ulcer development related to prostate cancer and health decline. -Approaches for the prevention of the pressure ulcer included to provide pressure relieving/reducing device on bed, chair, etc. *It addressed the resident having a urinary catheter. -One of the approaches was to monitor and document intake or output. *The care plan had not: -Clearly identified the services hospice would have provided. -Been updated when the resident developed an actual pressure area on his foot. -Specified Hospice was responsible for the care of the pressure ulcer on his foot. -Specified how the provider's nurses would monitor the pressure area on his foot when the dressing changes were completed by hospice. *Addressed encouraging fluids or the problems with the urine odor. Review of the provider's June 2014 Skin Assessment and Pressure Ulcer Prevention policy revealed: *The purpose of the policy was to: -"Systemically assess residents with regard to	F 309		

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F 309	Continued From page 27 risk of skin breakdown. -Accurately document observations and assessments of residents. -Appropriately use prevention techniques and pressure redistribution surfaces on those resident at risk for pressure ulcers. *If a pressure ulcer is identified. The registered nurse should record the type of wound and the degree of tissue damage on the Wound Assessment for the pressure ulcer. The licensed nurse records the location of the area, the measurements and the ulcer/wound characteristics. Document the information on the Wound Data Collection sheet. *When a pressure ulcer was present, daily monitoring with accompanying documentation when a complication or change is identified should include the following: -An evaluation of the ulcer, if no dressing was present. -An evaluation of the status of the dressing; if present whether it is intact and whether it was draining, if present, or was not leaking. -The status of the area surrounding the ulcer. *The pressure ulcer should have been assessed/evaluated at least weekly and documented on the Wound RN Assessment sheet. Observations of the ulcer's characteristic may be documented by a licensed nurse and should include the following: -Measurement-length, width, depth. -Characteristics of the ulcer-including wound bed, undermining and tunneling, exudate, surround skin. -Presence of pain. -Current treatments." Review of the provider's February 2013 Residents at Risk for Dehydration/Fluid	F 309		

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F 309	Continued From page 28 Maintenance revealed: *Nursing would notify the director of dietary services using a PCC alert, of a new diagnosis of dehydration, UTI (urinary tract infection) pressure sores, or other infection, weight loss, or medications that were ordered which may affect fluid status. *The plan of care would include approaches to encourage the resident to achieve and or maintain hydration status if the resident had symptoms which could lead to dehydration such as: -Dependence on staff for the provision of fluid intake. -Limited fluid intake. *If the physician had ordered a specific amount of fluid or a fluid restriction for the resident, the DDS would interview the resident and or family about the resident's fluid preferences and habits. *The fluid allocations would have been added to the resident's care plan. The fluid restriction would contain the details of the fluid allocation. *Staff would document fluid intake with meals and between meals in the PCC-POC (plan of care). Fluids provided at med pass would be documented on the eMAR (electronic medical record). *Nursing would monitor the record to determine if the fluid goals or calculated fluid need were being met consistently and document in the progress notes. *Nursing/dietary would adjust the plan of care as necessary to meet the goals.	F 309		
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	F 314	**F314 Treatment/SVCS To Prevent/Heal Pressure Sores SS=D** This is the plan of correction for resident #9 who was affected by F314 Treatment/SVCS to prevent/heal pressure sores and any other residents who reside at the Good Samaritan Village. The resident's care plan was reviewed and updated by July 27, 2014. The resident was	8/21/14

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F 314	Continued From page 29 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: 12218 Based on record review and interview, the provider failed to assess, monitor, and document a pressure ulcer for one of six sampled residents (9) with pressure ulcers. Findings include: 1. Review of resident 9's 3/27/14 revised care plan revealed the resident had a stage 2 pressure ulcer (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed) on the right side of the butt. The care plan stated it was related to a compression fracture and decreased mobility (decreased movement due to pressure on the bone). Interview with Mimimum Data Set (MDS) care coordinator U at 9:30 a.m. on 7/1/14 revealed resident 9 did not currently have a pressure ulcer. The first documentation of the pressure ulcer was on 2/25/14, and it had been resolved on 5/26/14. She agreed the care plan had not been updated and revised to reflect his current medical condition. Review of resident 9's admission medical record revealed: *He had been admitted to the Rehabilitation unit on 1/29/14.	F 314	started on a repositioning schedule at that time. The wheel chair cushion and bed surface was evaluated to ensure an appropriate surface for resident #9 was used on July 27, 2014. The Wound Data Collection was started on July 19, 2014 for a scratch on his back. The scratch was healed and the Wound Data Collection and Wound RN Assessment were discontinued as of July 27, 2014. The Director of Nursing educated the RNs, LPNs, and nursing supervisors at the July meeting on July 22, 2014 and the nursing staff (RNs, LPNs, UAPs, restorative aids, CNAs, and nursing supervisors) were educated in writing on July 30, 2014 on the Pressure Ulcer Policy, Pressure Ulcer Practice Guidelines, and Skin Assessment and Pressure Ulcer Prevention. Plan of correction for updating the care plans and monitoring wounds was written above under F280 and 309. Audits will be the same as F 309. Audits will be completed to ensure the assessments and treatments of	

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F 314	Continued From page 30 *His diagnoses included compression fracture, back/hip/leg pain, and trochanteric bursitis (fluid flilled sac near the hip becomes inflamed and painful) *He was alert and cognitive (aware and knowledgeable of his surroundings). Review of resident 9's 2/5/14 admission MDS revealed he: *Required two person extensive assistance for the following activities of daily living: -Bed mobility. -Transfers. -Toilet use. -Dressing. *Required one person extensive assistance for locomotion (movement by wheelchair or walker) on and off the unit. *Had walked only once or twice in the room with one person physical assistance. *Had not walked in the corridor (hallway). *Was coded for a wheelchair and a walker. *Was able to understand others and make others understand him. *Had no mood or behavior problems except for having trouble concentrating on things. *Fed himself with only supervision and some setup help. *Had no skin problems or pressure ulcers, but he was a high risk for a pressure ulcer. *Had a pressure reducing device on his bed and in his wheelchair. *Was not coded for a turning/repositioning program. *Received physical therapy and occupational therapy five times per week. *Was not steady in his balance and only able to stabilize with person assistance. *Was on scheduled and as needed (PRN)	F 314	pressure wounds are completed as directed. The wound nurse will audit the Wound Data Collection for completion and accuracy weekly. The care coordinator will complete an audit on the Wound RN Assessment on a monthly basis. The results from the two audits will be brought to the monthly Quality of Life for review. The results will be brought to the monthly QAPI Committee meeting for review. * The DNS or designee will report auditing results to QAPI. KR/SDOH/MF	

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F 314	Continued From page 31 medications as well as non-medical interventions used. *Had a pain intensity level of eight out with ten being the most intense. Review of resident 9's 5/5/14 quarterly MDS revealed: *He was still coded for two person extensive assistance needed for bed mobility. *He had improved to one person limited assistance needed for: -Walking in room and corridor. -Locomotion on and off corridor. -Dressing. *He was coded for one stage 2 unhealed pressure ulcer. *He had scheduled pain medication, and as needed pain medication for almost contant pain at a level of five out of ten. Review of resident 9's admission Braden Scale for Predicting Pressure Sore Risk revealed a score of 15. A resident with a Braden score of 15 to 18 had a mild risk for developing a pressure ulcer. One of the interventions for that score was frequent turning (such as every two hours). Review of his Braden scores revealed questionable scores: *On 2/25/14 a score of seventeen (the day the stage 2 pressure ulcer was found). *On 3/11/14 and on 3/18 14 a score of seventeen when he still had a stage 2 pressure ulcer. *On 5/5/14 a Braden score of eighteen when he still had the stage 2 pressure ulcer. Record review and interview at 2:00 p.m. on 7/2/14 with MDS care coordinator U and V regarding resident 9 revealed: *He had been in the Rehabilitation unit from	F 314		

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F 314	Continued From page 32 1/29/14 until 3/24/14, and then was transferred to the long-term care unit. *He developed a stage 2 pressure ulcer that was first documented, assessed, and measured 0.8 centimeter (cm) by 0.5 cm. on 2/25/14. *They were not sure how it had been acquired. *They could not find any turning/repositing monitoring documentation until 3/27/14 when he became a resident of the long-term care unit. *They reviewed the original care plan and agreed it did not plan for a turn/reposition program. The activity of daily living for bed mobility did state the resident required one staff assistence to reposition and turn in bed. (The admission MDS was coded for the need of two person extensive assistance for bed mobility.) *His pressure ulcer measured: -On 3/2/14: 1.0 cm x 0.6 cm with open area. -On 3/9/14: 1.0 cm x 0.6 cm x 0.2 cm with open area. -On 3/15/14: 0.5 cm x 0.4 cm x 0.05. *This pressure ulcer was coded as healed on 4/2/14 and 4/9/14. *This pressure ulcer was open again and measured 1.0 cm x 0.5 cm on 4/24/14, and it was still open on 5/13/14 with a measurement of 1.0 cm in length. *The assist to turn/reposition every two hours monitoring sheets were started on 3/27/14 and showed consistent documentation until 4/23/14 when documentation stopped. *Then it started again on 5/14/14 through 5/31/14 when it was documented for four or five times per day and not every two hours. *They agreed the care plan should have been updated and reflected when the pressure ulcer was first documented and when it was healed. *They stated his physician ordered a new air mattress with overlay on 5/14/14.	F 314		

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F 314	Continued From page 33 *They stated the resident had a hard surface cushion in his wheelchair which was also changed to a gel cushion when the physician requested a different cushion for his wheelchair. *They agreed the bed mattress and chair cushion should have been reviewed earlier. Review of registered dietitian W's nutritional assessment on 3/27/14 for resident 9 revealed the following recommendations: *Additional protein to help the healing process. The resident agreed to peanut butter on his toast. *A nutritional supplement in the form of flavored clear liquid Ensure. *A multiple vitamin to help provide additional nutrients. Review of resident 9's March 2014 Medication Admininstration Record revealed the nutritional supplement and the multiple vitamin were both started on 3/29/14. Review of the current 3/27/14 care plan did not reveal it had been updated to include those additions in the nutritional focus area for helping heal the pressure ulcer. Review of the provider's September 2012 Care Plan Policy revealed: "A qualified team of persons will review care plans at least quarterly. Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition and /or in accordance with state guidance. This plan of care will be modified to reflect the care currently required/provided for the resident."	F 314		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with	F 327	**F327 Sufficient Fluid to Maintain Hydration SS =D** This is the plan of correction for resident #5 who was affected by F327 Sufficient Fluid to Maintain Hydration and any other residents at risk who reside at the Good Samaritan Village. Resident #5 had been a risk for	8/21/14

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F 327	Continued From page 34 sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Preceptor: 26180 Based on observation, interview, record review, and procedure review, the provider failed to ensure 1 of 11 sampled residents (5) at risk for dehydration (not having sufficient body fluid amounts) had her fluid needs met. Findings include: 1. Review of resident 5's 4/26/14 significant change Minimum Data Set (MDS) revealed she: *Needed extensive assistance with eating and activities of daily living. *Had a brief interview for mental status (BIMS) of 3. -Thar score was based on a scale ranging from 0-15 with a score of 3 meaning severe mental impairment. *Had a care area assessment focus area for hydration (fluid) needs. *Had problems with communication. Review of resident 5's 4/19/14 care plan revealed: *She had been "assist as needed" with eating which varied from her MDS evaluation. *It had not addressed her risk for dehydration nor had any staff interventions for that problem area. Random observations of resident 5 on 7/1/14 and 7/2/14 from 10:00 a.m. to 11:30 a.m. revealed: *She sat in her wheelchair in her room facing the door and had not moved.	F 327	hydration. The dietician scheduled 120cc of water to be offered in between meals and 240 cc fluids at each meal plus supplements. This resident will have all fluid intake charted until the interdisciplinary team deems the resident is no longer at risk. The dietician will monitor residents with assessments and will inform the interdisciplinary team if the resident is at risk for dehydration and the team will determine if all fluid intakes should be monitored or if the meal intake is sufficient. The Director of Nursing will educate the interdisciplinary team on the Hydration policy and Hydration of Residents procedure by July 30, 2014. Audits will be completed by the Dietician or designee to ensure the resident is receiving proper hydration. This audit will be completed weekly for one month, biweekly for two months, and monthly for three months. The results will be brought to the monthly Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	07/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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F 327	Continued From page 35 *Her water pitcher was on the table behind her. *No staff had offered her a drink. Review of resident 5's daily fluid intake record from 6/24/14 through 6/30/2014 revealed: *Her fluid intake from meal times ranged from 205 cc (cubic centimeters) to 860 cc of fluid. *At no other times had fluid intake been recorded. Interview on 7/1/14 at 2:00 p.m. with registered nurse J revealed the above fluid intake for resident 5 had not been recorded outside of meal times. Interview on 7/2/14 at 11:30 a.m. with certified nursing assistant I regarding resident 5 revealed: *They had not monitored fluids other than at mealtimes. *She agreed the resident needed assistance to drink. *She agreed intake outside of meals should have been monitored and had not been. Interview on 7/2/14 at 10:00 a.m. with registered dietician N revealed: *She believed hydration outside of meals had been "up to nursing staff to address." *Daily fluid requirements for a resident were 30 cc per kilogram of body weight. -Fluid requirements for resident 5 should have been 1,770 cc per day. *Agreed the amount of recorded fluids for resident 5 had not met her daily fluid requirements. Review of the provider's February 2013 Hydration of Residents and Residents at risk for Dehydration/Fluid Maintenance procedures revealed:	F 327	meeting for review and audits will be discontinued once audits prove the concern has been resolved. Same audit in F309. *The DNS or designee will report auditing results to QAPI. KR/SDDCH/MF	

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F 327	Continued From page 36 *"The registered dietician (RD) will assess all residents for estimated fluid requirements using the dietician assessment." *"The DDS (director of dietary services), in collaboration with the RD, will review medical records and observe the resident to determine whether the resident is consuming adequate fluids for needs, including beverages, foods that are liquid at room temperature and fluid in foods." *"The plan of care will include approaches to encourage the resident to achieve and/or maintain hydration status if the resident has symptoms which can lead to dehydration such as the following: Dependence on staff for the provision of fluid intake." *"Nursing staff will write the problem/goal for dehydration/fluid maintenance on the care plan."	F 327		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	**F425 Pharmaceutical SVS- Accurate Procedures, RPH SS=D** This is the plan of correction for the controlled substances that were affected by F425 Pharmaceutical SVC-Accurate Procedures, RPH and all controlled substances schedule II through V at the Good Samaritan Village. The four medications that did not have the count sheets attached, had new count sheets and medication verified by July 7th, 2014. The facility will count all schedule II through V medications every shift per procedure Controlled Substances. The Director of Nursing will educate all the nursing staff that the RNs and LPNs need to count all narcotics	8/21/14

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F 425	Continued From page 37 This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, and interview, the provider failed to ensure their policy for accountability of scheduled medication were followed for four of four sampled residents (29, 30, 31, and 32). Findings include: 1. Observation on 7/2/14 at 2:00 p.m. of medication carts 1 and 2 on the 200 wing revealed the following scheduled medications were not secured in the locked narcotic box: *A bottle of lorazepam (schedule IV anti-anxiety medication) for resident 29. *A medication card of hydrocodone (schedule III pain medication) for resident 30. *A medication card of hydrocodone for resident 31. *A bottle of zolpidem (schedule IV sleeping medication)for resident 32. Interview on 7/2/14 at 2:15 p.m. with licensed practical nurses L and M regarding the above revealed: *The above medications should have been stored in the locked narcotic box. *A blue sheet for medication reconciliation every shift should have been made out for each of the medications when they had been placed in the medication carts. *Their policy stated all scheduled III, IV, and V medications should have been locked in the narcotic box and reconciled every shift.	F 425	II through V every shift. The controlled II substances will remain double locked and the III through V will be single locked. Audits will be performed on each cart weekly for four weeks, bimonthly for 2 months, and monthly for 3 months. The results will be brought to the monthly QAPI Committee meeting for review and audits will be discontinued once audits prove the concern has been resolved. *The DNS or designee will report auditing results to QAPI. KR/SDDDH/MF	

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F 425	Continued From page 38 Review of the provider's September 2012 Controlled (Scheduled) Substance policy revealed: *"At change of shift, on-duty and oncoming nurses count all controlled substances." *"If new controlled drugs are delivered, the licensed nursing staff on duty at the time of the delivery is responsible for counting and locking up these substances and adding to the count in the individual resident narcotic record."	F 425	**F441 Infection Control, Prevent Spread, Linens SS=D** This is the plan of correction for the proper procedure for glucometer use and administering eye medication that was affected by F441 Infection Control, Prevent Spread, and Linens. Staff Development had a skills day on July 15, July 16, and July 17th that contained the proper procedure to use the glucometer and also covered infection control. The RNs and LPNs demonstrated proper hand hygiene during the skills in-service. The Staff Development Nurse will educate the staff member A who did not follow appropriate procedure for obtaining a glucometer reading. This education pertains to washing hands prior to applying gloves and after taking off the gloves. It also included wiping down the glucometer after use with an appropriate germicidal cleaner by July 30, 2014. The Staff Development Nurse will educate the LPN that did not use	8/21/14
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		

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F 441	Continued From page 39 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, and policy review, the provider failed to ensure appropriate: *Cleaning of the glucometer (blood sugar) machine after three of three observed resident uses for three of three residents (33, 35, and 36). *Hand hygiene for one of two nursing staff (licensed practical nurse (LPN) S during one of two eye drop administrations and two of five glucometer uses. Findings include: 1. Observation on 6/30/14 at 5:00 p.m. with unlicensed assistive personnel A during a glucometer (blood sugar) procedure for resident 35 revealed she: *Had not washed or sanitized her hands prior to starting the procedure. *Removed the glucometer from the medication cart. *Obtained the blood from the resident, and then placed the glucometer machine back into the medication cart without sanitizing the machine. *Had not washed or sanitized her hands after the procedure was completed.	F 441	proper hand technique while administering eye drops on the hand hygiene procedure and the procedure of eye medication administration by July 30, 2014. The Director of Nursing will provide education to the RNs, LPNs, and UAPs about proper hand hygiene, glucometer procedure, and eye medication administration by July 30, 2014. Audits will be completed by staff development on the proper procedure for obtaining a blood glucose level using a glucometer including hand hygiene weekly for 4 week, bimonthly for 2 months, and monthly for 3 months. Another audit will be completed by staff development on the proper procedure of administering eye medication including hand hygiene weekly for 4 week, bimonthly for 2 months, and monthly for 3 months. The results will be brought to the monthly QAPI Committee meeting for review and audits will be discontinued once audits prove the concern has been resolved.	

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F 441	Continued From page 40 2. Observation on 7/1/14 at 11:00 a.m. with LPN S during an eye drop administration with resident 36 revealed she: *Placed gloves on her hands without washing or sanitizing her hands. *Administered the eye drops to the resident. *Removed her gloves and had not performed any hand hygiene after removing her gloves. Then went into another resident's room to obtain a blood pressure without washing or sanitizing her hands. 3. Interview on 7/2/14 at 9:20 a.m. with the director of nursing (DON) in regards to the above observations revealed: *She would have expected staff to wash their hands or sanitize their hands before and after glove use. *The glucometer machine should have been cleansed and sanitized after each resident use. Review of the provider's June 2012 Hand Hygiene and Handwashing policy revealed: *"If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: -Before having direct contact with residents. -After having direct contact with a residents skin. -After having contact with body fluids, wounds or broken skin. -After touching equipment or furniture near the resident. -After removing gloves." Surveyor: 22452 4. Observation on 6/30/14 at 4:40 p.m. of registered nurse (RN) K revealed she: *Put on gloves without washing her hands or using hand sanitizer prior to a glucometer blood	F 441	* The DNS or designee will report auditing results to QAPI. KR/SDOH/MF	

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F 441	Continued From page 41 test procedure. *Used the glucometer to obtain a blood sugar results for resident 33. *Removed her gloves after the procedure without washing her hands or using hand sanitizer. *Put on another pair of gloves to clean the glucometer machine. *Removed the gloves without washing her hands or using hand sanitizer. Observation on 6/30/14 at 5:02 p.m. of LPN L revealed she: *Put on gloves without washing her hands or using hand sanitizer prior to a glucometer procedure. *Used the glucometer to obtain a blood sugar for resident 34. *Removed her gloves after the procedure without washing her hands or using the hand sanitizer. Interview on 7/2/14 at 11:00 a.m. with the infection control RN S regarding the above revealed hand washing or the use of the hand sanitizer should have occured before putting on gloves and after removing gloves.	F 441		

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

ORIGINAL

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	435045	A. BUILDING **01 - SIOUX FALLS GOOD SAMARITAN VILLAGE** B. WING _____	**07/01/2014**

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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 7/1/14. Good Samaritan Society Sioux Fall Village 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 7/1/14 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 intent to correct the deficiency identified at K018, K029, and K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 8/13/14 telephone to facility administrator. JB/SDDOH/MF	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**POC K018 NFPA 101 Life Safety Code Standard SS=D** The north set of double-doors from the Sells Dining room have been repaired and now close and latch properly. To ensure that the doors continue to close and latch properly, an audit will be conducted 1 time per month. Results of this audit will be routed to our QAPI Committee by our Environmental Services Director. * for 3 months. JB/SDDOH/MF * monthly for 3 months JB/SDDOH/MF	8/21/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain the smoke tight rating of corridor wall assemblies for the Sells Dining room . The double-doors from the dining room to the corridor would close and latch. Findings include: 1. Observation at 10:30 a.m. on 7/1/14 revealed the north set of double-doors from the Sells Dining room to the corridor were equipped with positive latching hardware. The west door (active leaf) would not close and latch into the east door (inactive leaf) when allowed to operate with the door closer. Interview with the maintenance director at the time of the observation confirmed those findings.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029	**POC K029 NFPA 101 Life Safety Code Standard SS=D** The soiled linen room on the 400 wing corridor and the dirty utility room on the south end of the 400 wing have both been fixed and now close and latch properly. To ensure that the doors continue to close and latch properly, an audit will be conducted 1 time per month * for 3 months. Results of the audit will be routed to the QAPI Committee by our Environmental Services Director. *monthly for 3 months JDS DDCH/MF	8/21/14 JDS DDCH/MF

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K 029	Continued From page 2 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas for the soiled linen room in the laundry and dirty utility room in south of the 400 wing. The corridor doors of both rooms would not close and latch into the frames. Findings include: 1. Observation at 10:30 a.m. on 7/1/14 revealed the door from the soiled linen room to the corridor would not close and latch into the frame when operated with the door closer. Interview with the maintenance supervisor at the time of observation confirmed those findings. The deficiency was corrected prior to exiting the building. 2. Observation at 11:45 a.m. on 7/1/14 revealed the dirty utility room in the south end of the 400 wing would not close and latch into the frame when operated with the door closer. Interview with the maintenance supervisor at the time of the observation confirmed those findings.	K 029		
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	K 032	**POC K032 NFPA 101 Life Safety Code Standard SS=C**	F

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K 032	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain two conforming exits from each floor of the building. The basement did not have a conforming exit. Findings include: 1. Observation at 11:00 a.m. on 7/1/14 revealed the basement level was not provided with conforming exits. One exit was through the boiler room (hazardous area), and the other discharged into the main level kitchen area. Previous survey data confirmed those conditions. 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 032		
K 033 SS=C	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: 14180 Based on observation and record review, the provider failed to maintain a continuous one hour fire resistive path of escape from the basement to	K 033	**POC K033 NFPA 101 Life Safety Code Standard SS=C**	F

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	435045	A. BUILDING 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(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 033	Continued From page 4 the exterior of the building. Findings include: 1. Observation at 11:10 a.m. on 7/1/14 revealed the basement stairway discharged into the main level kitchen area. A one hour fire resistive path of escape was not maintained to the exterior of the building. Review of previous survey data confirmed that condition. 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 033	**POC K038 NFPA 101 Life Safety Code Standard SS=D**	
K 038 SS=D	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: 14180 Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at one randomly observed exit. The exit from the Sells Dining room had a landing that ended approximately 45 feet from the nearest street. Findings include: 1. Observation at 12:30 p.m. on 7/1/14 revealed the exit from the Sells Dining room had a 4 foot by 4 foot pad with approximately 45 feet of grass to the nearest paved surface. Interview with the maintenance director at the time of the observations confirmed the sidewalk was never	K 038	Based on observation there was not a paved path of exit discharge from the Sells Dining room to the public way. To correct this, we have arranged to have a new concrete sidewalk poured. An estimate has been received and we are scheduled for the work to be completed by August 31 Following completion of the work, an audit will be completed verifying that it has been done. This audit will be routed to the QAPI Committee by our Environmental Services Director.	8/21/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING **01 - SIOUX FALLS GOOD SAMARITAN VILLAGE** B. WING _____	**07/01/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	**3901 S MARION RD** **SIOUX FALLS, SD 57106**

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K 038	Continued From page 5 installed. This condition had existed since the original construction.	K 038		

ORIGINAL

PRINTED: 07/15/2014
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10680	A. BUILDING: _____ B. WING _____	07/02/2014

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY SIOUX FALLS VI

STREET ADDRESS, CITY, STATE, ZIP CODE: 3901 S MARION ROAD, SIOUX FALLS, SD 57106

(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) COMPLETE DATE
S 000	Initial Comments Surveyor: 25107 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. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement: S166.	S 000	Addendums noted with an asterisk per 8/8/14 email from facility administrator. KR/TN/SDDOH/MF **S166 Occupant Protection** Based on observation the three exterior doors from the Friendship Dining room revealed there was no audible alarm at the nurse's station when the doors were opened. The Environmental Services Director contacted the Wander guard contractor immediately and the doors were properly re-programmed to alarm at the nurse's station and at each door. This work was completed prior to the end of the survey. A second observation revealed that the 400 South and North exit doors did provide an audible alarm at the 400 Nurses station, however since the nurses station was not attended at the time the alarm was going off, it was observed that the doors were not responded to in an appropriate timeframe. In order to ensure that	8/21/14
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: My Mon

TITLE: Administrator

(X6) DATE: 7/30/14

STATE FORM 6899 SFT011 If continuation sheet 1 of 4

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10680	A. BUILDING: _____ B. WING _____	07/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VII	3901 S MARION ROAD SIOUX FALLS, SD 57106

(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) COMPLETE DATE
S 166	Continued From page 1 (7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 25107 Based on observation, testing, interview, and policy review, the provider failed to: *Provide door alarms for three of three exterior doors from the friendship dining room. *Respond to door alarms during meal times. Findings include: 1. Observation and testing on 6/30/14 at 1:58 p.m., 2:05 p.m., and 2:30 p.m. of the three exterior doors from the friendship dining room revealed there was no audible alarm and no staff response when the doors were opened. Observation, testing, and interview on 6/30/14 at 2:45 p.m. of the above listed doors with the director of environmental services revealed: *The doors should have alarmed at the nurses station when they were opened. *He was not aware they were not alarming at the nurses station. *He did not know why they were not working.	S 166	**S166 Occupant Protection** Based on observation the three exterior doors from the Friendship Dining room revealed there was no audible alarm at the nurse's station when the doors were opened. The Environmental Services Director contacted the Wander guard contractor immediately and the doors were properly re-programmed to alarm at the nurse's station and at each door. This work was completed prior to the end of the survey. A second observation revealed that the 400 South and North exit doors did provide an audible alarm at the 400 Nurses station, however since the nurses station was not attended at the time the alarm was going off, it was observed that the doors were not responded to in an appropriate timeframe. In order to ensure that	

South Dakota Department of Health

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	10680	A. BUILDING: _____ B. WING _____	07/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VI	3901 S MARION ROAD SIOUX FALLS, SD 57106

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S 166	Continued From page 2 Testing and interview on 7/2/14 at 10:30 a.m. of the three exit doors listed above with the director of environmental services revealed: *The director of environmental services had called in a service technician to check out the door alarms. The technician was reprogramming the door alarms to make them work as door alarms. *Two of the three doors had an audible alarm at the door and at the nurses station when the door was opened. The technician was working on the third door alarm. *The three doors in question were tested monthly to see if the door alarms worked and tested weekly to see if the wander system worked. The wander system only alarmed when the door was opened, and a wander system pendant was detected by the alarm system. Review of the provider's revised January 2014 Alarms: Bed, Chair, And Door policy revealed: *Standard door alarms were to be checked weekly by environmental services. *Wandering alert door alarms were to be checked weekly by environmental services. 2. Observation and testing on 6/30/14 from 6:00 p.m. to 6:34 p.m. in the 400 hall revealed: *Testing of the south door alarm revealed no staff responded to the door when this surveyor opened it. *Staff were observed in the hall providing various services to residents. *At 6:07 p.m. the north and south door alarms were making audible noise at the nurses station. *The nurse station was not attended. Staff were observed providing services to residents in the 400 hall and dining room. *The door alarms chimed from 6:07 p.m. to 6:18	S 166	* The DNS or designee will audit exit door response times one time per week for four weeks and then monthly for three months. Environmental services will audit door alarms on a weekly basis. KR/TN/DDOH/MF	

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GOOD SAMARITAN SOCIETY SIOUX FALLS VII	3901 S MARION ROAD SIOUX FALLS, SD 57106

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S 166	Continued From page 3 p.m. *Staff were observed providing services to residents in the 400 hall and dining room but never were observed checking the exit doors or resetting the door alarms. *At 6:18 p.m. this surveyor left the 400 hall and returned at 6:34 p.m. The nurses station was still unattended. Staff were observed providing services to residents in the 400 hall and dining room. The north and south door alarms were still chiming. Interview on 7/2/14 at 11:30 a.m. at the 300 nurses station with certified nursing assistant J, director of nursing (DON), and administrator revealed: *The nurses station was not attended during meal times. *Staff were busy on the floor providing services to residents. Further interview at that time with the DON and administrator revealed: *The staff had been trained to prioritize services to the residents. *Staff had also been trained to respond to door alarms. *They agreed the staff were not able to respond to the door alarms, because they were busy providing services to residents. They were not sitting at the nurses station where the alarm was chiming. *They agreed their alarm system would need to be improved to notify staff when a door alarm was activated.	S 166		