

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

ORIGINAL

PRINTED: 11/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059
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F 000	<p><i>Addendums noted with an asterisk per 11/18/14 telephone to facility administrator. KES/DCH/ME</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/20/14 through 10/22/14. Good Samaritan Society Scotland was found not in compliance with the following requirement(s): F333 and F441.</p>	F 000	<p><i>F 333</i></p> <p>On 10/21/14 the Director of Nursing Services (DNS) provided counseling to the licensed practical nurse (LPN) *B about Novolog Insulin and the fact that this type of insulin is a rapid acting insulin in which manufacturer guidelines do indicate to administer it 5-10 minutes before a meal, or within 30 minutes of eating. On 10/21/14 a learning packet "Novolog, Your Partner at Mealtime" was placed in the nursing office and nurses responsible to administer medications were instructed to review the packet, sign and date it.</p>	
F 333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, manufacturer's guidelines, and policy review, the provider failed to ensure one of one sampled resident (11) had eaten within the required timeframe after administration of Novolog (rapid-acting insulin) per manufacturer's guidelines. Findings include:</p> <p>1. Observation on 10/21/14 at 11:41 a.m. of licensed practical nurse (LPN) B administering insulin to resident 11 revealed: *He was given 10 units of Novolog insulin at the above time. *He was then taken to the dining room for lunch which was scheduled at 12:00 noon. *At noon he still had not eaten.</p> <p>Interview on 10/21/14 at 12:10 p.m. with LPN B regarding resident 11's Novolog administration revealed: *She was unaware the manufacturer's guidelines</p>	F 333	<p>Any resident receiving rapid acting insulin has the potential to be affected by a nurse's failure to administer the insulin as per manufactures guidelines. On 10/21/14 the DNS conducted an audit of all individuals in the nursing facility that receive insulin, and identified each of these residents insulin by type (rapid acting, short acting, intermediate acting, and long acting). [REDACTED] residents receiving rapid acting insulin were noted, and nurses were instructed to be sure to administer these residents' insulin doses within the recommended timeframes per the manufacturer. A reference tool Comparison of Common Insulins was placed in the medication room, which lists administration timeframes for different types of insulin. In addition, on 10/22/14, the DNS discussed with the Certified Dietary Manager the need for meal trays to be delivered to those residents receiving rapid acting insulin within 5-10 minutes after insulin administration.</p> <p>An addendum has been added to the facilities procedure on Insulin Administration II.M.8dd. The addendum adds a note prompting the nurse to "Review the type of insulin to be administered and reference the manufactures guidelines for recommended administration times, or refer to the Comparison of Common Insulins (II.M.8dd.2) that follows this procedure."</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Oliver Ramsey</i>	TITLE <i>Admin</i>	(X6) DATE <i>11-18-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 333	Continued From page 1 advised he should have eaten within five to ten minutes in order to prevent the risk of low blood sugar. *She had thought the provider's policy had stated residents receiving rapid-acting insulin were to have eaten within thirty minutes after they had been given insulin. Interview on 10/22/14 at 9:50 a.m. with the director of nursing regarding the above insulin administration revealed: *She was unaware of the manufacturer's guidelines for residents receiving Novolog stated he was to have eaten within five to ten minutes after administration to prevent the risk of low blood sugar. *It was her expectation the manufacturer's guidelines were to have been followed for patient safety. Review of the undated Novolog manufacturer's guidelines taken from the Novolog insulin box revealed: **"The effects of Novolog start working within 10 to 20 minutes after injection." **"You should eat within 5 to 10 minutes after using Novolog to avoid low blood sugar." **"Do not inject Novolog if you do not plan to eat right after your injection." Review of the provider's September 2012 Insulin Administration policy revealed there was no instruction on what time the insulin should have been administered according to manufacturer's guidelines.	F 333	On 11/11/14 nurses and dietary staff were required to attend an in-service, conducted by the facilities consulting pharmacist (RPh). The Insulin Administration Procedure II.M.8.dd and II.M.8.dd.2 were reviewed. The RPh presented on the topic of diabetes, blood glucose monitoring, different treatments for diabetes, and on the different types of insulin available to treat diabetes and how these work. To ensure ongoing compliance, the Staff Development Nurse (SD nurse) will conduct competency evaluations on each nurse who administers insulin. The competency evaluation will assess each nurses knowledge of the Insulin Administration Procedure, and of the different types of insulin and the recommended times to give these different types of insulin. Each nurse will have this competency evaluation done by December 17, 2014, and then once again in March and in June 2015. Findings of these evaluations will be reported by the SD nurse to the Quality Assurance Performance Improvement (QAPI) nurse for discussion at the QAPI committee meetings following completion of these evaluations. Random audits by the QAPI nurse will also be conducted to assess compliance of insulin administration. These audits will review Medication Administration Records for the electronic time stamp for when a residents insulin was given, if manufacture recommendations for administration were followed, time meal was served and time the resident was eating. These audits will be conducted weekly for four weeks, then bi weekly for a month, and then again in March and June of 2015. Findings will be brought to the QAPI committee meetings for review. After the completion of the June 2015 competency evaluations and the insulin administration audits, the QAPI committee will determine the need for any additional focused monitoring.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

11-11-14

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F 441	<p>Continued From page 2</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441		

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F 441	<p>Continued From page 3</p> <p>Surveyor: 33488</p> <p>Based on observation, interview, and policy review, the provider failed to prevent cross-contamination (the potential transfer of infection from one surface to another) of bottles that contained eye medication and wound cleanser during one of one sampled resident (1) medication administration and wound treatment observations provided by registered nurse (RN)</p> <p>A. Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 10/21/14 at 10:15 a.m. of registered nurse (RN) A providing treatments to resident 1 revealed: <ul style="list-style-type: none"> *She brought supplies into the resident's room, washed her hands and put on gloves. *She instilled eye drops to both of her eyes. *She then placed the eye drop bottle on the protective barrier that was placed on the chair. *She then removed her gloves, washed her hands, and put on new gloves. *She began the dressing change to the resident's hip. *She removed the soiled dressing. *She then applied a skin barrier around the wound. *After she had applied the barrier, she picked up the clean bottle of wound cleanser with her soiled gloves. *She cleansed the resident's wound and set the contaminated bottle back on the clean protective barrier on the chair next to the eye drop bottle. *She finished the dressing change, removed her soiled gloves, and washed her hands. *She then grabbed the contaminated bottles with her clean hands, removed them from the room, and placed them back into the treatment cart. <p>No interview was obtained from RN A regarding</p>	F 441	<p><i>F441</i></p> <p>Resident #1 contaminated OTC eye drop medication bottle and the wound cleanser bottle have been removed from the treatment cart and properly destroyed. A new, uncontaminated bottle of each was replaced.</p> <p>All residents who require eye drop medication or wound care have the potential to be affected by a nurse's failure to proper infection control practices. Nurses will place a barrier down on all surfaces prior to placing medication or treatment items. Nurses will adhere to the hand washing procedure with all resident contacts. All medication and/or treatment supplies will be handled carefully to avoid contamination, if contamination occurs the container will be appropriately cleaned, if unable to clean the container will be discarded.</p> <p>On 11/11/14, all nurses were required to attend an in service education reviewing the facilities procedures on Hand Hygiene and Hand Washing (Infection Prevention Manual II.G.2), Eye Medication Administration (Nursing Services Manual II.M.8cc), and Wound Dressing Change (Nursing Service Manual II.W.4f). It was discussed that each time a wound dressing was removed, gloves should be removed, hands should be cleansed and only clean hands or clean gloved hands should ever touch a wound cleanser bottle in order to prevent contamination of that bottle.</p>	<p><i>11-11-14</i></p>

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F 441	<p>Continued From page 4 the above observation.</p> <p>Interview on 10/22/14 at 9:15 a.m. with the infection control nurse regarding the above treatments for resident 1 revealed her expectation was: *Clean bottles should not have been contaminated by dirty gloves. *Once contaminated the bottles should not have been placed back onto the clean protective barrier with the eye drop bottle. *Contaminated bottles should not have been placed back into the clean treatment cart.</p> <p>Interview on 10/22/14 at 9:50 a.m. with the director of nursing regarding the above treatments for resident 1 revealed her expectation was: *Gloves should be changed between tasks during a dressing change to prevent cross-contamination.</p> <p>Review of the provider's September 2012 Wound Dressing Change policy revealed once the dirty dressing had been removed the nurse should have removed her dirty gloves, washed her hands, and put on clean gloves prior to handling the wound cleanser bottle.</p>	F 441	<p>To ensure ongoing compliance, the Staff Development Nurse (SD Nurse) will conduct competency evaluation audits for each nurse who administers eye medication and/or does wound care dressing changes. These evaluations will assess each nurse's knowledge on the procedures for administering these treatments, as well as their infection control practices. Each nurse will have this competency evaluation done by December 17, 2014, and then again once in March and in June 2015. Findings of these evaluations will be reported by the SD nurse to the Quality Assurance Performance Improvement (QAPI) nurse for discussion at the QAPI committee meetings following the completion of these evaluations. After completion of the June 2105 competency evaluation audits for the procedures of Hand Hygiene, Eye Administration and Wound Care Dressing Changes, the QAPI committee will determine the need for any additional focused monitoring.</p>		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/23/14. Good Samaritan Society Scotland 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 10/27/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K025, K130, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 10/10/14 telephone to facility administrator. CH/SDDOH/MF	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julie Ramsey</i>	TITLE <i>Admin</i>	(X6) DATE <i>11/18/14</i>
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K 025	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the 30 minute fire resistive rating of smoke barrier walls. One of two smoke barrier walls (at resident rooms 208 and 209) had an unsealed opening around a pipe penetration above the ceiling. Findings include:</p> <p>1. Observation at 2:30 p.m. on 10/23/14 revealed the smoke barrier wall at resident rooms 208 and 209 had an unsealed opening around a four inch diameter sprinkler pipe penetration above the corridor ceiling. Interview with the maintenance manager at the time of the observation confirmed that finding. He stated the contractor must not have finished sealing the concrete block wall after installing the new fire sprinkler system in August 2013.</p> <p>This deficiency could potentially affect all thirty-six residents of the facility.</p>	K 025	<p>K 025</p> <p>Finding:</p> <p>Smoke barrier wall at resident rooms 208 and 209 had unsealed opening around a 4 inch diameter sprinkler pipe.</p> <p>Corrective Action: As of 11/13/14; the smoke barrier walls at rooms 208 and 209 have been sealed around the sprinkler pipe. A complete inspection of the smoke barrier walls and sprinkler pipes throughout the facility was conducted on 11/13/14. Any identified unsealed openings were sealed as of this date. * The Administrator will report the completion of this repair to the QA committee. <i>CHISDORHMF</i></p>	<p><i>11-13-14</i></p> <p><i>OC</i></p>
K 033 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p>	K 033	<p>K033 <i>X</i></p>	

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K 033 Continued From page 2
Based on observation and record review, the provider failed to maintain a protected path of egress from the basement to the exterior of the building for one of two basement stairways (south) that discharged onto the main level. Findings include:

1. Observation at 1:45 p.m. on 10/23/14 revealed the south basement stairway discharged onto the main level adjacent to the staff lounge corridor. A continuous one hour fire resistive enclosure was not provided to the exterior of the building. Review of previous survey data identified the stairway was part of the original facility construction.

K 033

K033

F

K 130 SS=D
The facility meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.

K 130

NFPA 101 MISCELLANEOUS

OTHER LSC DEFICIENCY NOT ON 2786

K130

Finding:

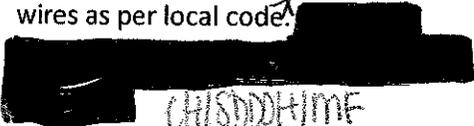
Two commercial dryers' exhaust ducts were assembled with sheet metal screws. Assembly with screws catch lint and reduces the efficiency of the exhaust.

Corrective action: As of 11/13/14; the metal screws were removed from the dryers' exhaust ducts and replaced with vent tape.

11-13-14 *[Signature]*

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K 130	Continued From page 3 the two commercial clothes dryers' exhaust ducts in the laundry room were put together with sheet metal screws. Ducts for exhausting clothes dryers shall not be put together with sheet-metal screws or other fastening means that extend into the duct, thereby catching lint and reducing the efficiency of the exhaust. Interview with the maintenance manager at the time of the observation confirmed that condition.	K 130	*The Administrator will report the completion of this repair to the QA committee. CH/SDDH/MF	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a remote stop button for one of one generators. Findings include: 1. Observation at 1:30 p.m. on 10/23/14 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator. He stated he had been	K 144	K 144 Finding: No emergency remote stop button has been installed for the generator. Corrective Action: As of 11/18/14 received and approved estimate to install remote e-stop for generator. Certified electrician needs to be contacted and arrangements for them to run required wires as per local code.  CH/SDDH/MF	*10/11/14 CH/SDDH/MF

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K 144	Continued From page 4 employed by the provider from February 2014 through October 2014. The deficiency affected a single location required to be equipped with remote emergency stops.	K 144		
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South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH ST SCOTLAND, SD 57059
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 10/20/14 through 10/23/14. Good Samaritan Society Scotland was found in compliance.	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Cruce Ramay

TITLE

Admin

(X6) DATE

11/18/14

STATE FORM

6899

Y3SM11

If continuation sheet 1 of 1

NOV 21 2014