

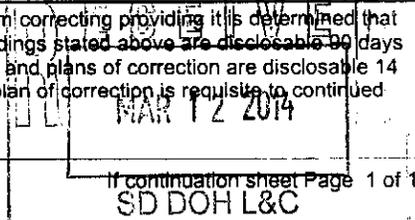
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TRIPP			STREET ADDRESS, CITY, STATE, ZIP CODE 300 N DOBSON ST TRIPP, SD 57376	
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F 000	INITIAL COMMENTS Surveyor: 12218 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/10/14 through 2/12/14. Good Samaritan Society Tripp was found not in compliance with the following requirements: F167, F221, F281, F431, and F441.	F 000	Addendums noted with an asterisk per 2/21/14 telephone to facility DON. MJH/SDDH/MF	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation and interview, the provider failed to ensure the most recent survey results were readily accessible to the residents. Findings include: 1. Observations throughout the entire survey from entrance on 2/10/14 at 1:15 p.m. through exit on 2/12/14 at 5:30 p.m. revealed: *The most recent survey results had been posted on the bulletin board outside the administrator's office.	F 167	F 167 RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE The survey results are now located at the bottom right hand corner of the bulletin board outside the Administrator/Business Office. The results are posted three feet from the ground. Administrator or designee will audit placement of the survey results once a week for four weeks then once a month for two more months. Results of the audits will be reported monthly to Quality Assurance (QA) committee. QA will determine further action. * Administrator/Business office will report audit results to the QA committee. MJH/SDDH/MF	04/03/14

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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F 167	Continued From page 1 *Those survey results had been on the top right corner of the bulletin board. *They had not been accessible to residents in wheelchairs.	F 167		
F 221 SS=E	Interview on 2/12/14 at 4:30 p.m. with the administrator confirmed the posted survey results had not been accessible to all residents. 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to assess and obtain physicians' orders for seven of seven sampled residents (1, 2, 3, 4, 6, 7, and 8) with side rails. Findings include: 1. Random observations from 2/10/14 through 2/12/14 of resident 4's bed revealed one raised half side rail attached to the upper half of her bed. Review of resident 4's medical record revealed: *There had been no assessment indicating a need for a side rail. *There had been no physician's order for a side rail. *Her revised 12/9/13 care plan: -Indicated she had been able to reposition independently in bed.	F 221	F 221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS Resident 4: Physical device and restraint assessment (PDRA) completed per Good Samaritan Society (GSS) policy. Resident 4's care plan has been amended to reflect use of quarter rails on the bed for assistance with repositioning and movement. The PDRA and care plan will be reviewed each quarter by the care team in conjunction with quarterly Minimum Data Set (MDS) assessment. Resident 6: PDRA completed per GSS policy. Resident 6's care plan has been amended to reflect use of assist bars on the bed for assistance with repositioning and movement. The PDRA and care plan will be reviewed each quarter by the care team in conjunction with quarterly MDS assessment. Resident 7: PDRA completed per GSS policy. Resident 7's care plan (continued on page 3)	04/03/14

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

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F 221	<p>Continued From page 2</p> <p>-Had not indicated she required a side rail. *Her 11/26/13 Minimum Data Set (MDS) indicated side rails had not been used.</p> <p>2. Random observations from 2/10/14 through 2/12/14 of resident 6's bed revealed two horseshoe-shaped quarter rails placed on each side at the head of her bed.</p> <p>Review of resident 6's medical record revealed: *There had been no assessment indicating the need for a side rail. *There had been no physician's order for side rails. *Her revised 11/20/13 care plan indicated she used the bed rail to reposition and turn in bed with assistance. *Her 11/18/13 MDS indicated side rails had not been used.</p> <p>3. Random observations on 2/11/14 and 2/12/14 of resident 7's bed revealed two raised half side rails to each side of the top half of her bed.</p> <p>Review of resident 7's medical record revealed: *There had been no assessment indicating the need for a side rail. *There had been no physician's order for side rails. *Her revised 6/18/13 care plan: -Indicated she required staff assistance to reposition in bed. -Had not indicated she required a side rail. *Her 12/6/13 MDS indicated side rails had not been used.</p> <p>4. Random observations on 2/11/14 and 2/12/14 of resident 8's bed revealed one raised half side rail attached to the upper half of her bed.</p>	F 221	<p>(continued from page 2)</p> <p>has been amended to reflect use of quarter rails on the bed for assistance with repositioning and movement. The PDRA and care plan will be reviewed each quarter by the care team in conjunction with the quarterly MDS assessment. Resident 8: Does not sleep in the bed. The care plan has been amended to reflect resident choice to sleep in recliner as was resident's preference when at home. The quarter rails for this bed [REDACTED] Director of Nursing Services (DNS) or designee will audit bed rail position once a week for four weeks then once a month for two months. Results of the audit will be reported monthly to QA committee. QA will make further recommendations regarding further auditing as necessary. Resident 2: PDRA completed per GSS policy. Resident 2's care plan has been amended to reflect use of assist bar on the bed for assistance with repositioning and movement. The PDRA and care plan will be reviewed each quarter by the care team in conjunction with the (continued on page 4)</p>		

*have been tied down
MWH/SD/14/14

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F 221	<p>Continued From page 3</p> <p>Review of resident 8's medical record revealed: *There had been no assessment indicating the need for a side rail. *There had been no physician's order for a side rail. *Her revised 10/9/13 care plan: -Indicated she had been able to reposition herself in bed. -Had not indicated she required a side rail. *Her 11/18/13 MDS indicated side rails had not been used.</p> <p>Surveyor: 29162 5. Random observations throughout the entire survey from entrance on 2/10/14 at 1:15 p.m. through exit on 2/12/14 at 5:30 p.m. of resident 2's bed revealed one raised quarter side rail attached to the upper half of his bed near his bedside stand.</p> <p>Review of resident 2's medical record revealed: *There had been no assessment indicating a need for a side rail. *There had been no physician's order for a side rail. *There had been a focus area on his care plan dated 6/14/13 that had identified -Activities of daily living as a problem. -Interventions for bed mobility had been supervision, cueing, encouragement, and</p>	F 221	<p>(continued from page 3) quarterly MDS assessment. Resident 3: PDRA completed per GSS policy. Resident 3's care plan has been amended to reflect use of quarter rails for assistance with repositioning, movement, and the resident's ability to raise and lower head of bed independently as resident desires. The PDRA and care plan will be reviewed each quarter by the care team in conjunction with the quarterly MDS assessment. Resident 1: PDRA completed per GSS policy. Resident 1's care plan has been amended to reflect use of quarter rail for assistance with repositioning and movement. Care team will audit and report completion of PDRA and care plan reviews for Residents 4, 6, 7, 8, 2, 3, and 1 at the April 2014 QA meeting. QA will determine if further auditing and reporting is necessary. The PDRA and care plan will be reviewed each quarter by the care team in conjunction with the quarterly MDS assessment. PDSA will be completed by the care team each quarter for all residents with quarter rails or assist bars on the bed. Care team will record PDSA and care plan review in a Quality of (continued on page 5)</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 4</p> <p>one-to-two person assistance to reposition and turn in bed. There had been no mention of a quarter side rail for positioning. -Interventions for transfers had been the use of "bed rails" to help with transfer. *His 12/13/13 MDS indicated "bed rails" had not been used.</p> <p>6. Random observations throughout the entire survey from entrance on 2/10/14 at 1:15 p.m. through exit on 2/12/14 at 5:30 p.m. of resident 3's bed revealed his bed had two one-half side rails attached to the upper half of his bed. One of those side rails had been on each side of his bed.</p> <p>Review of resident 3's medical record revealed: *There had been no assessment that indicated a need for a side rail. *There had been no physician's order for a side rail. *There had been a revised focus area on his care plan dated 11/14/13 that had identified: -Limited physical mobility as a problem. -Interventions for mobility had been one-to-two staff for transfers. A Hoyer lift (a device to assist with moving residents) might have been needed with two assistants. -Interventions for bed mobility had been one-to-two staff participation to reposition and turn in bed. Encourage the use of trapeze (a bar to hold on to to help move oneself) and independent bed mobility. -There had been no mention on the use of one-half side rails for mobility or positioning. *His 11/1/13 MDS indicated "bed rails" had not been used.</p>	F 221	<p>(continued from page 4)</p> <p>Life progress note for each resident during quarterly review. Care team will audit all reviews and will report on all residents reviewed as well as changes in need for quarter rails or assist bars to QA committee each month for 3 months. QA will determine if further auditing is needed.</p> <p><i>* Resident 8's bed will be switched to a bed without rails when one becomes available. Otherwise the bed rails have been tied down. MJH/SDDH/MF</i></p>		

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F 221	<p>Continued From page 5</p> <p>Surveyor: 12218 7. Observation throughout the survey from 2/10/14 at 1:15 p.m. through 2/12/14 at 5:00 p.m. of resident 1's bed revealed: *It had a half side rail with a triangular control device between the upper and lower bars. *The half rail was attached along the side of the upper half of the bed next to the resident's head. *The half side rail was always up when the resident was in bed and when she was not in bed.</p> <p>Review of resident 1's medical record revealed: *There had been no assessment completed/documented as to the need for a side rail on the bed. *There had been no physician's order for a side rail. *Her significant change MDSs on 9/17/13 and on 12/31/13 indicated "bed rails" had not been used. *Her 1/15/14 revised care plan had no mention of the need for side rails or "bed rails."</p> <p>Surveyor: 32332 8. Interview on 2/11/12 at 4:00 p.m. with the MDS coordinator revealed: *The side rails were used to hold the bed controls. *She had not considered the side rails to be restraints. *She had not coded them as restraints on the MDS. *They had not needed to be on the care plan.</p> <p>Interview on 2/12/14 at 8:55 a.m. with the director of nursing (DON) revealed: *The side rails were used to hold the bed controls.</p>	F 221		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 221	<p>Continued From page 6</p> <p>*She had not considered the rails to be restraints, therefore: -The residents had not been assessed for the medical necessity of a restraint prior to using the side rails. -The physicians had not been contacted for an order to use the rails. -The residents had not needed a medical condition for use of the side rails. -The side rails had not been care planned. -They had not been coded as a side rail on the MDS.</p> <p>Review of the provider's January 2014 Policy and Procedure for Bed Rails/Side Rails revealed: *Residents were to have been assessed for the appropriateness of side rails. *A physician's order that included the medical symptom for use was required for a bed rail/side rail. *Bed rail/side rail usage would occur only when medical necessity for side rails had been documented, and after the bed had been assessed for entrapment risk.</p> <p>Review of the provider's August, 2013 Physical Restraint policy revealed: *Any time a device was placed adjacent to the resident's body, a determination would have been made as to whether it was or could have been a restraint for that individual. *If the device was not a restraint for that resident steps that were taken to make that decision were to have been documented in the interdisciplinary progress notes. *If the device was not a restraint it was to have been reviewed when there had been a condition change and quarterly in conjunction with the care plan to ensure it continued to have not been</p>	F 221		

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F 221	Continued From page 7 considered a restraint.	F 221			
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to contact the physician for orders to increase the oxygen flow for one of nine sampled residents (6). Findings include:</p> <p>1. Random observations on 2/10/14 through 2/12/14 of resident 6 in her room and in the dining room revealed resident 6 receiving oxygen by nasal cannula. At each observation the oxygen concentrators liter flow had been set at four liters (L).</p> <p>Review of resident 6's medical record revealed: *A 10/22/13 physician's order for oxygen at two liters continuous on her February 2014 medication administration/treatment record. *A 2/3/14 physician's order upon return from a hospitalization for oxygen at two liters continuous. *A 2/9/14 Clinical Monitoring - Respiratory Status note indicated oxygen use of 4 L. *Daily Skilled Notes on 2/10/14 through 2/12/14 had indicated oxygen use but had not indicated the liter flow used.</p> <p>Interview on 2/12/14 at 10:20 a.m. with registered nurse A revealed:</p>	F 281	<p>F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>Resident 6's oxygen (O2) order was changed on 02/12/14 to "O2 per nasal canula to keep saturation above 90 percent (%)". All staff in-service presented on 02/25/14, reviewed oxygen safety as well as physician's order requirement. Nurse's meeting held 02/27/14, reviewed GSS policy regarding O2 therapy and physician's written order regarding O2 therapy. DNS or designee will audit 5% of residents who require O2 therapy to ensure O2 concentrator and/or canister regulator is set at correct liter flow according to the resident's current physician's order weekly for four weeks, then monthly for two months. DNS or designee will report results of audits to QA committee, QA will determine further audits or action as necessary.</p>	04/03/14	

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F 281	Continued From page 8 *The resident had been experiencing more shortness of breath over the last three to four days. *Staff had been increasing the oxygen liter flow when resident 6 had complained of shortness of breath. *The physician had not been contacted for orders to increase the oxygen flow. *She should have contacted the physician to obtain orders to increase the liter flow. Interview on 2/12/14 at 1:50 p.m. with the director of nursing revealed her expectation would have been the nurse would have contacted the physician for orders prior to changing the oxygen liter flow. Review of the provider's September 2012 Oxygen Administration policy revealed: *Oxygen administration would be carried out only with a physician's order. *The nurse would be responsible for the correct administration. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, Mo., 2005 revealed on page 418: *The physician was responsible for directing medical treatment. *Nurses were obligated to follow the physician's orders. *The nurse was to keep the physician informed of the resident's condition.	F 281			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	F 431 DRUG RECORDS, LABEL/STORE DRUGS AND BIOLOGICALS The expired as necessary (PRN) (continued on page 10)	04/03/14	

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F 431	<p>Continued From page 9</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on medication review and interview, the provider failed to ensure repackaged as-needed (PRN) medications were maintained within their one-year expiration date for 4 of 11 sampled</p>	F 431	<p>(continued from page 9)</p> <p>medications for residents 1, 6, 11, and 12 were removed from the medication cart on 02/12/14 and returned to the appropriate pharmacy for destruction. All nurses educated on 02/27/14 to repackaged medications expiration date of one year from the repackaged or date filled on the pharmacy label. Nurses educated to remove expired medications and destroy accordingly. DNS met with pharmacy consultant on 02/28/14, both reviewed regulation. DNS or designee will audit all PRN medications for expiration weekly for 4 weeks, then monthly there after. The DNS or designee will report all audit findings at monthly QA meetings, QA will determine further audits or actions.</p>	

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F 431	<p>Continued From page 10</p> <p>residents (1, 6, 11, and 12) in 1 of 1 medication cart containing PRN medications. Findings include:</p> <p>1. Review of PRN medications on the day shift medication cart on 2/12/14 at 10:55 a.m. revealed PRN medications repackaged into blister sealed (pre-formed single-dose plastic packaging) cards:</p> <p>*Resident 1's blister pack of docusate/senna (to soften stools): -Had been dispensed from the pharmacy on 1/23/12. -The expiration date was May 2014.</p> <p>*Resident 6's blister pack of meclizine (for dizziness): -Had been dispensed from the pharmacy on 6/27/12. -The expiration date was July 2014.</p> <p>*Resident 11's blister pack of docusate/senna: -Had been dispensed from the pharmacy on 12/16/11. -The expiration date was May 2014.</p> <p>*Resident 12's blister pack of meclizine: -Had been dispensed from the pharmacy on 1/21/13. -The expiration date was September 2017.</p> <p>Interview at that time with licensed practical nurse B revealed: *She was in charge of monitoring medications for their expirations. *The pharmacist had instructed her to use the expiration date on the packaging for monitoring. *She had not known the blister pack medications would expire one year after the pharmacist had dispensed them.</p>	F 431		

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

PRINTED: 02/24/2014
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2014
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F 431	Continued From page 11 Phone interview on 2/12/14 at 1:15 p.m. with the consultant pharmacist revealed: "If I had known about the one-year expiration rule, I had forgotten about it." Interview on 2/12/14 at 1:50 p.m. with the director of nursing revealed she had not been aware the blister packaged medications had expired one year after the pharmacist packaged them.	F 431		
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	F 441	F 441 INFECTION CONTROL PREVENT SPREAD, LINENS RN A and all nurses were re-educated to GSS wound care policy and procedure on 02/27/14, which includes when hand hygiene should take place as well as when to use barriers for clean items. DNS or designee will audit 5% of all wound care or dressing changes weekly for four weeks then 5% of all wound care/dressing changes monthly for two months. DNS or designee will report results of audits monthly to QA committee. QA will determine further need for auditing.	04/03/14

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F 441	<p>Continued From page 12</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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> <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: Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to ensure sanitary technique was used by registered nurse (RN) A during one of four sampled resident's (5) observed dressing change. Findings include:</p> <p>1. Observation on 2/12/14 at 2:30 p.m. of RN A while she changed residents 5's dressing revealed she entered the resident's room and: *Laid the dressing supplies directly on the resident's bedside stand. *Did not wash her hands. *Changed her gloves four times. Did not sanitize her hands between any of those glove changes. *Measured one wound on the resident's bottom and then used that same tool to measure a different wound on the resident's bottom. *Removed her gloves. Did not sanitize her hands after she had removed those gloves. *Laid that same measuring tool on the resident's hand and wrote on the tool with a black marker.</p>	F 441			

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F 441	<p>Continued From page 13</p> <p>*Carried the used measuring tool to the treatment cart with ungloved hands.</p> <p>*Left the resident's room without washing her hands.</p> <p>Interview on 2/12/14 at 3:10 p.m. with the director of nursing revealed she would have expected RN A to have:</p> <p>*Sanitized her hands after she had removed her soiled gloves and before she had put clean gloves.</p> <p>*Used a separate measuring tool for each wound.</p> <p>*Washed her hands before she had changed the resident's dressing.</p> <p>*Washed her hands when she had been done with the dressing change.</p> <p>Review of the provider's revised November 2013 Wound Dressing Change policy revealed:</p> <p>*A field for the clean dressing was to have been created.</p> <p>*Hand hygiene was to have been completed after removing gloves.</p>	F 441		

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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 2/12/14. Good Samaritan Society Tripp was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies at K029, K038, K046, K062, and K074 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 3/10/14 telephone to facility administrator. CH/SDMH/MF	
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 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the separation of hazardous areas from other areas. One randomly observed corridor door for the 300 wing shower room used	K 029	K 029 HAZARDOUS AREAS SEPARATED FROM OTHER AREAS. The area on the 300 wing room currently used as storage is now separated from other areas as a result of the installation of a door closer and latch. The closer was installed on 2/14/14. The safety person will inspect weekly times four for three months and report monthly to the Administrator and Quality Assurance committee meeting to determine if further action is needed.	04/03/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Handwritten Signature]

Administrator

3/1/14

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.

MAR 12 2014

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K 029	Continued From page 1 for general storage was not equipped with a closer. Findings include: 1. Observation at 11:45 a.m. on 2/12/14 revealed the former shower room in the 300 wing was being used for general storage. The room was over 100 square feet in area. The corridor door was not equipped with a closer. Interview with the maintenance supervisor at the time of the observation confirmed those findings. The deficiency affected one of several hazardous areas in the building required to be provided with self-closing doors to the corridor. 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: 18087 Based on observation, testing, and interview, the provider failed to ensure five of ten exits were readily accessible at all times (main entrance; dining room, two areas; lounge; and receiving). Findings include: 1. Observation beginning at 10:00 a.m. on 2/12/14 revealed five of ten building exits (main entrance; dining room, two areas; lounge; and receiving), were equipped with Locknetics brand magnets. The doors were also equipped with a device that would magnetically lock the door	K 029		
K 038 SS=E		K 038	K 038 EGREES COMPONENT OF BUILDING EXITS. The exit door contractor has been contacted and will be providing a proposal/plan for the correction of this requirement. We have been placed on list with A.B.C. Security System for replacement  <i>*The safety person will monitor the project and will report the completion date to the QA committee.</i> CH/SDDH/MF	04/03/14

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K 038	Continued From page 2 when a resident with a wander management device (Watchmate) came in close proximity to the exit. A keypad was mounted adjacent to the doors that would unlock the magnet. Interview with the maintenance supervisor at the time of the observations confirmed those findings. 2. Testing of the door magnets at the time of the observations with the maintenance supervisor (equipped with a Watchmate device) revealed the door magnets were not the delayed egress type. Interview with the maintenance supervisor at the time of the observations confirmed those findings. Access-control locks are not acceptable for use in a path of egress unless they meet the exceptions in the Life Safety Code 101, 2000 Edition, Chapter 7.2.1.6.2. Posting the code to unlock the magnet with the keypad does not meet the standard. The deficiency affected a single component of egress requirements for numerous building exits.	K 038		
K 046 SS=D	Ref: 2000 NFPA 101 Section 19.2, 7.2.1.6.2 NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install emergency power system as required. Findings include: 1. Observation at 10:45 a.m. on 2/12/14 revealed	K 046	K 046 EMERGENCY GENERATOR REQUIRED EMERGENCY STOP STATION Electrician has been contacted on March 3, 2014 to arrange for the installation of remote emergency switch to stop the generator in the event of emergency. Electrician is the building on March 10, 2014 to establish plan of installation. Parts on order and will be installed as soon as part arrive.	04/03/14

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K 046	Continued From page 3 the emergency generator supply power for emergency lighting did not have the required emergency stop station located outside of the room housing the prime mover or located elsewhere on the premises where the prime mover was located outside the building as required. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator. Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3; 1999 NFPA 110 3-5.5.6	K 046	*The emergency stop switch will be installed close to the nurses station. The safety person will monitor the installation and will report the completion date to the QA committee. CH/SDOHH/MF		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had the required quarterly flow testing performed during the previous five months (September 2013 through January 2014). Record review of the previous years (2013) fire sprinkler system inspections revealed quarterly flow testing documentation was not available. Findings include: 1. Review of the provider's automatic sprinkler system inspection reports for 2013 revealed quarterly flow testing documentation was not	K 062	K062 AUTOMATIC SPRINKLER SYSTEM QUARTERLY FLOW TESTING The quarterly flow testing will take place quarterly times four under the direction of the Maintenance Supervisor reported to the Administrator and QA at their quarterly meeting. Any adjustments or changes will be recorded at that meeting	04/03/14	

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K 062	Continued From page 4 available. Interview with the maintenance director at the time of the record review indicated he was unaware of the quarterly flow testing requirements. He further revealed he had not been provided with a copy of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems from the sprinkler installer. The deficiency affected a single component of the building's required maintenance and testing regarding the automatic fire sprinkler system.	K 062			
K 074 SS=D	Ref: 2000 NFPA 101 Section 19.3.5, NFPA 25 NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3	K 074	K 074 FLAME RESISTANT QUALITIES OF DRAPERIES AND CURTAINS The draperies and curtains in the dining room, therapy room, staff lounge and conference have been removed, washed and treated with the approved retardant material by the Safety person. Retardant treatment record will be maintained by Safety person and reported to the Administrator and QA Committee quarterly times two.	04/03/14	

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K 074	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to verify the required flame resistant qualities of draperies and curtains in four of four common areas (dining room, therapy, lounge, and conference room). Findings Include:</p> <p>1. Observation at 10:30 a.m. on 2/12/14 of draperies and curtains in the dining room, therapy room, lounge, and conference room revealed no factory installed tags stating the items were flame resistant in accordance with National Fire Protection Association (NFPA) 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. Interview with the maintenance supervisor at 10:30 a.m. on 2/12/14 revealed the draperies and curtains had not been treated with an approved fire retardant material.</p> <p>The deficiency affected a single component of the building's required criteria regarding furnishings, bedding, and decorations.</p> <p>Ref: 2000 NFPA 101 Section 19.7.5.1, 10.3.1</p>	K 074		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TRIPP	STREET ADDRESS, CITY, STATE, ZIP CODE 330 N DOBSON ST P.O. BOX 370 TRIPP, SD 57376
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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/10/14 through 2/12/14. Good Samaritan Society Tripp was found not in compliance with the following requirement: S206.	S 000	Addendums noted with an asterisk per 2/25/14 telephone to facility DON. MJH/sddoh/mf	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	S 206 PERSONNEL TRAINING Dietary Manager (DM) met with all dietary staff on 02/25/14 and provided education regarding awareness of resident's eating requirements, socialization, assist with encouragement, substitutions to be offered, feeding precautions to prevent choking, need to reheat food, types of fluid requirements, awareness of changes in eating abilities, and need for repositioning and assistive devices. All staff in-service scheduled for 04/01/14 to be presented by Registered Dietitian/Dietary Consultant and will cover above listed topics. Staff Development Coordinator will add this requirement to list of yearly required in-service topics. *one will report her list to the QA committee. MJH/sddoh/mf	04/03/14

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

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 206	<p>Continued From Page 1</p> <p>This Rule is not met as evidenced by: Surveyor: 12218 Based on record review and interview, the provider failed to ensure all required in-service training sessions each year were offered to all the staff. Findings include:</p> <p>1. Review of the annual required in-service agendas for all personnel for 2013 revealed: *Dining assistance needs of residents had not been presented. *Dining assistance included observation and awareness of resident eating requirements, socialization, assistance with encouragement, substitutions to be offered, feeding precautions to prevent choking, the need to reheat food, types of fluid requirements, changes in eating abilities, and need for repositioning and assistive devices.</p> <p>Interview on 2/12/14 at 11:45 a.m. with the certified dietary manager revealed: *She was unaware the dining assistance category was an additional topic to be covered. *She knew the consultant registered dietitian (RD) had given an in-service on nutrition and hydration.</p> <p>Interview on 2/12/14 at 3:00 p.m. with the staff development coordinator revealed: *She knew the RD had given an all-staff in-service on nutrition and hydration in 2013. *She was unaware the dining assistance was an additional category of training that needed to be included in the in-service to all staff.</p>	S 206		