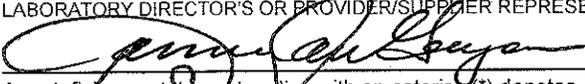


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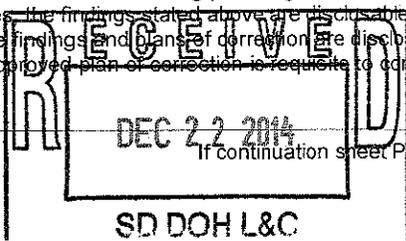
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F 000	INITIAL COMMENTS Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/24/14 through 11/26/14. Good Samaritan Society Tripp was found not in compliance with the following requirements: F280, F371, and F441.	F 000	Addendums noted with an asterisk per 11/27/15 telephone to facility administrator. SD/SDDOH/MF	
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: Surveyor: 29354	F 280	* The director of nursing will oversee the documentation of completed tasks. SD/SDDOH/MF Resident 7 will be checked and changed three times per shift as per care plan and will be documented after each occurrence. All residents with tasks on the care plan will have documented proof that each task has been done per the care plan. The DNS and Staff Development Coordinator (SDC) will provide education on 12/18/14 to Certified Nurse Assistants (CNAs) regarding the need for tasks to be done and documented as per the care plan after each occurrence. The Point of Care (POC) Reference Guide will be used during this education for the CNAs to understand the necessity for documentation. The Shift Change Steps for Nurses will also be reviewed with nurses on 01/15/15* pointing out the nurse's responsibility in reviewing POC assignment status. The DNS will also review how to create an (continued on page 2)	01/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/18/14
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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 required to continued program participation.



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F 280	<p>Continued From page 1</p> <p>Based on observation, interview, record review, and policy review, the provider failed to follow the care plan for toileting for one of one sampled resident (7) requiring total assistance. Findings include:</p> <p>1. Observation on 11/24/14 from 10:00 a.m. through 3:55 p.m. of resident 7 revealed at: *11:00 a.m. she was sitting in a wheelchair by the nurses station. *3:10 p.m. she was sitting in a wheelchair by the nurses station. *3:15 p.m. a staff member pushed her into the day room. *3:55 p.m. she was checked and changed for incontinency.</p> <p>Observation on 11/25/14 at 8:30 a.m. of resident 7 revealed: *Certified nursing assistant (CNA) A had finished with resident 7's perineum (private area) care. *Several observations from 9:55 a.m. through 11:45 a.m. revealed she remained in the day room. *At 11:55 a.m. CNA and the director of nursing (DON) checked and changed her for incontinency. *From 12:30 p.m. through 4:00 p.m. she remained in the day room.</p> <p>Review of resident 7's medical record revealed: *A 5/21/02 admission date. *Diagnosis of Alzheimer's disease. *The 10/14/14 Minimum Data Set (MDS) assessment: -Confirmed her ability was limited to making requests. -Had long and short term memory impairment. -Required total assistance with transfer and toilet</p>	F 280	<p>(continued from page 1)</p> <p>individualized toileting plan with the nurses and care team using the GSS Toileting Programs Procedure. The SDC or designee will audit POC documentation related to toileting tasks weekly for four weeks then monthly for three months for 25 percent (%) of resident records to ensure that tasks are completed as per the care plan and then documented after each occurrence. The SDC or designee will report the findings to the QAPI Committee monthly and the committee will determine if further auditing is needed. The DNS will audit care plans to assure toileting plans are appropriate and individualized monthly for three months. The DNS will report audit findings to the QAPI Committee monthly and the committee will determine if further audits are needed when the four months of audits are complete.</p> <p><i>*all observations</i></p>	

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F 280	Continued From page 2 use. -Was always incontinent of bowel and bladder. -Required extensive assistance with personal hygiene. -Functional limitation in range of motion impairment on both sides of her upper extremity (shoulder, elbow, wrist, hand). -Was at risk for developing pressure ulcers (open area). -Was on a scheduled diuretic medication (used to get rid of excess water from the body). -Required a mechanical lift (equipment used to lift residents) for all transfers. -Care area assessment triggered for urinary incontinence due to total dependence with toileting and always incontinent. *The revised 9/16/14 care plan interventions stated for toilet use: check and change 3 (three) times shift and prn (when necessary). *The revised 11/25/13 care plan interventions stated for brief use: resident used medium brief for incontinence. Check 3 (three) times a shift and prn. *Review of the September 2014 through November 25, 2014 bowel and bladder flow sheets revealed she had been toileted three times: -September 1 - 30, 2014: Day shift twenty-three out of thirty days, evening shift zero out of thirty days, and night shift sixteen out of thirty days. There was no documentation for the evening shift the resident had been toileted ten out of thirty days. -October 1 - 31, 2014: Day shift twenty out of thirty-one days, evening shift two out of thirty-one days, and the night shift sixteen out of thirty-one days. -November 1 - 25, 2014: Day shift fifteen out of twenty-five days, evening shift three out of	F 280			

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F 280	Continued From page 3 twenty-four days, and the night shift ten out of twenty-four days. Interview on 11/25/14 at 2:40 p.m. with the director of nursing revealed: *The staff had not followed the care plan for toileting resident 7. *Sometimes the staff had not documented when the event had occurred. *She agreed the bowel and bladder documentation survey report had areas that were not documented on for toileting. *Her expectations were for CNAs to document when care was done. If it was not documented then it had not been done. Review of the provider's September 2012 Care Plan policy revealed: **"Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintain the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs." *The care plan "will be modified to reflect the care currently required/provided for the resident."	F 280			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The Kitchen Aid and large mixer have been cleaned. The Kitchen Aid mixer will be cleaned with hot soapy water after each use and covered with plastic covering to prevent food splatter. The plastic cover will be thrown away and replaced each time the Kitchen Aid mixer is used. The large mixer, including attachment base, will be cleaned after each use (continued on page 5)	01/15/15	

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F 371	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, measurement, and policy review, the provider failed to ensure sanitary conditions were maintained: *For the kitchen for the following: -Two of two hood panels (filters) above the stove. -Two of two fans in the walk-in refrigerator. -Two of two food mixers. -Multiple baking and steam table pans stored underneath the two-compartment sink area. -One of two freezers (dry food storage area) with a significant build-up of frost. Findings include:</p> <p>1. Observation and measuring on 11/24/14 in the kitchen from 4:55 p.m. through 6:05 p.m. revealed: *Two hood filters above the stove had a significant amount of an accumulation of grease with a moderate amount of brown and black spots. *Two fans in the walk-in refrigerator contained a moderate build-up of brown and black spots on them. *Two food mixers contained a moderate build-up of white, tan, and brown spots underneath the mixer located over the uncovered mixing bowls. *Multiple baking and steam table pans were located underneath the two compartment sink's physical air break on the drain line. *One of two freezers located in the dry food storage area had a significant build-up of one and one-fourth inch of frost when measured.</p> <p>Interview on 11/24/14 during the above listed</p>	F 371	<p>(continued from page 4) with hot soapy water. The attachments will be sent through the dish machine after each use. The large mixer will be covered with a plastic cover after cleaning to prevent settling of dust. The plastic cover will be discarded and replaced with each use. Dietary staff was educated to cleaning procedure* Dietary Manager (DM) will audit both mixers daily for one week then once a week for three more weeks to assure procedure is followed. DM will report audit findings to QAPI Committee after a total of four weeks of audits are complete. QAPI will determine if further audits or education is needed. Pots and pans that were stored under the vegetable sink have been moved to another location. ^ Freezer is on a quarterly defrost (continued on page 6)</p> <p><i>The area below the vegetable sink will not be used for storage.</i></p>	<p><i>by the dietary supervisor. 11/26/14</i></p> <p><i>11/26/14</i></p>
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F 371	<p>Continued From page 5</p> <p>times with the certified dietary manager (CDM) regarding the above listed areas in the kitchen revealed:</p> <ul style="list-style-type: none"> *The maintenance department was responsible for cleaning the hood filters above the stove and the refrigerator fans. *The CDM stated her department was responsible for cleaning the rest of the kitchen. *Dietary was responsible for cleaning the food mixers and defrosting the freezer. *She agreed the hood filters, fans, and food mixers needed cleaning. *She agreed the storage location of the baking and steam table pans underneath the sink was a potential for contamination if there had been a leak. <p>Interview on 11/25/14 at 8:15 a.m. with the maintenance supervisor regarding the above listed areas in the kitchen revealed.</p> <ul style="list-style-type: none"> *He had the hood filter cleaning on a monthly schedule. *He had the fans on a two times per month cleaning schedule. *The dietary department was responsible for cleaning the rest of the kitchen. *He agreed the hood filters and fans needed cleaning. *He agreed the storage location of the baking and steam table pans underneath the sink was a potential for contamination if there had been a leak. <p>Review on 11/25/14 of the maintenance cleaning schedule for 2014 revealed:</p> <ul style="list-style-type: none"> *The kitchen stove filters were on a monthly to three times per month schedule. -Those filters had been dated as last cleaned on 11/10/14. 	F 371	<p>(continued from page 5)</p> <p>schedule, due December 2014.</p> <p>Defrosting will be documented on a log by the person assigned to defrost the freezers. Freezer temperatures remain in acceptable range. DM will audit freezer defrost logs as well as inspect the freezer each quarter. [REDACTED] to assure frost build-up is managed and report audit findings to the QAPI Committee each quarter. QAPI will determine if further audits or education is necessary after the third quarter of audits.</p> <p>Hood panels above the dietary stove and fans in the walk-in freezer have been cleaned by Maintenance. Maintenance will clean the hood panels and fans once a month and keep a log for recording the dates these items are cleaned. DM or designee will co-sign the log ensuring cleaning is complete. Maintenance will bring this log to monthly QAPI Committee meetings for three months for the committee to review. The QAPI Committee will determine, after three months, if maintenance will be required to continue with monthly reports.</p>	

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F 371	<p>Continued From page 6</p> <p>*The kitchen fans were on a monthly to three times per month schedule. -Those fans had been dated as last cleaned on 11/21/14.</p> <p>Review on 11/25/14 of the quarterly dietary cleaning schedule for 2014 revealed: *The upright freezer was to have been defrosted quarterly. -That freezer had been initialed as last defrosted in September 2014. *Underneath the sink and the shelves were to have been cleaned quarterly. -That area had been initialed as last cleaned in September 2014.</p> <p>Review on 11/25/14 of the six months dietary cleaning schedule for 2014 revealed: *The large mixer and stand were to have been cleaned every six months. -That mixer had been initialed as last cleaned in August 2014.</p> <p>Review on 11/25/14 of the revised May 2004 daily cleaning schedule list revealed the mixer was to have been wiped down daily.</p> <p>Interview on 11/26/14 at 8:00 a.m. with the maintenance supervisor and at 9:15 a.m. with the CDM regarding the upright freezer in the dry food storage area revealed: *Both agreed there was significant frost build-up on the inside of the freezer. *That would have made it hard to maintain the correct temperature.</p> <p>Review of the provider's revised May 2004 Cleaning Schedules policy revealed: *The director of dietary services was responsible</p>	F 371		

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F 371	Continued From page 7 for monitoring staff to ensure: -Cleaning duties were completed satisfactorily. -Within the proper timelines. Review of the provider's revised May 2004 Sanitation Pots and Pans policy revealed pans were to have been stored properly by dietary staff. Review of the provider's revised March 2009 Cleaning-Sanitation of Non-Food Contact Surfaces policy revealed: *The facility would store and prepare food under sanitary conditions at all times. *Hood filters were to have had scheduled weekly cleaning in the dishwasher or other method. *Fans were to have been cleaned weekly or as needed. *Freezers were to have been placed on a weekly cleaning schedule with any concerns reported to the director of dietary services. Review of the provider's revised May 2004 Sanitation Equipment Sanitation policy revealed: *The refrigerated units needed to have been defrosted on a scheduled basis to help maintain temperatures. *Fans were to have been kept clean. Review of the provider's revised May 2008 Sanitation Kitchen General policy revealed the provider's food preparation and serving area would have been cleaned and sanitized on a regular basis to limit contamination and prevent food-borne illness.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 8</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which 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:</p>	F 441	<p>Resident 7 will have staff provide cares who have performed proper hand washing and/or hand hygiene. All residents will receive cares by staff that follow the hand washing and hand hygiene guidelines. The DNS will provide education to all nursing staff on 12/18/14 regarding the importance of proper hand hygiene, hand washing, and glove use. The staff will review and be given the GSS #II.1.5a Guidelines and Procedure Hand Hygiene and Hand Washing.</p> <p>The SDC or designee will observe staff providing cares to assure the proper hand hygiene, hand washing technique and glove use weekly for four weeks then monthly for three months. The SDC or designee will report audit findings to the QAPI Committee monthly and the committee will determine if further auditing is needed when the four months of audits are complete</p> <p><i>* including CNAS A, B and C. SPS/SDD/HMF</i></p> <p><i>* including CNAS A, B, and C SPS/SDD/HMF</i></p>	01/15/15	

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F 441	<p>Continued From page 9 Surveyor: 29354</p> <p>Based on observation, interview, and policy review, the provider failed to ensure hand hygiene was performed for one of one resident (7) observed during personal care by three of three observed certified nursing assistants (CNA) (A, B, and C). Findings include:</p> <p>1. Observation on 11/24/14 from 3:55 p.m. through 4:10 p.m. of CNAs A and B during personal care for resident 7 revealed: *Without performing hand hygiene they put on gloves and transferred resident 7 with a mechanical lift (equipment used to lift residents) into bed. *They removed resident 7's slacks. *CNA A: -Took several wet wipes and cleaned resident 7's perineum area (private area). She discarded the used wipes into the trash bag. *CNAs A and B removed their gloves and pulled resident 7's slacks up. *CNAs A and B placed the Hoyer sling (sling used during transfer) under resident 7 and transferred her with the mechanical lift into the wheelchair. *CNA A pushed her into the hallway and placed a blanket on her. *CNA B straightened the bed linen and removed the soiled garbage bag. *Both CNAs washed their hands at this time.</p> <p>Observation on 11/25/14 at 8:30 a.m. in resident 7's room of CNA A revealed: *She had completed perineum care with the resident. She discarded the used wet wipes in the garbage bag and then: -Removed her gloves. -Applied a new brief.</p>	F 441		

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F 441	<p>Continued From page 10</p> <ul style="list-style-type: none"> -Pulled up the residents slacks. -Put the Hoyer sling under the resident. -Put her shoes on. <p>*At 8:35 a.m. CNA C entered the room and without performing hand hygiene assisted CNA A with transferring the resident into the wheelchair. *CNAs A and C washed their hands.</p> <p>Interview on 11/25/14 at 2:45 p.m. with the director of nursing revealed hand hygiene should have been done:</p> <ul style="list-style-type: none"> *Before and after direct care for a resident. *After touching the resident. *After removal of gloves. <p>Review of the provider's revised June 2014 Hand Hygiene and Handwashing policy revealed hand hygiene should have been done:</p> <ul style="list-style-type: none"> *Before having direct contact with residents. *After having direct contact with a resident's skin. *After having contact with body fluids. *After touching equipment or furniture near the resident. *After removing gloves. <p>Review of the provider's revised November 2013 Perineal Care procedure revealed "Perform hand hygiene and put on gloves. (If additional supplies are needed during perineal care, remember to remove soiled gloves, wash hands or use hand sanitizer before touching objects in environment. Re-glove to resume perineal care.)"</p>	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435091	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2014
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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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/25/14. 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 K062 and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 062 SS=D	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: 32334 Based on observation, record review, and interview, the provider failed to ensure the automatic sprinkler system was continuously maintained in reliable operating condition and inspected and tested annually and quarterly in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include: 1. Observation at 11:15 a.m. on 11/25/14	K 062	K 062 NFPA 101 LIFE SAFETY CODE STANDARD AUTOMATIC SPINKLER SYSTEM QUARTERLY FLOW TESTING The fourth quarter testing was completed on 12/18/14 by Building Sprinkler and the test was positive. The quarterly flow testing will take place four times under the direction of the Maintenance Supervisor reported to the Administrator and QAPI Committee at their quarterly meeting. Any adjustments or changes will be recorded at that meeting.	01/15/15

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

TITLE

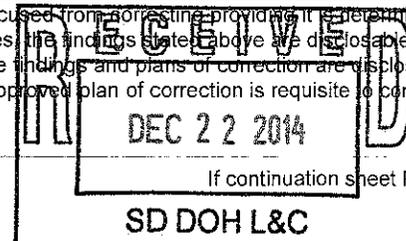
(X6) DATE

[Signature]

Administrator

12/8/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

PRINTED: 12/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435091	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/25/2014	
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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K 062	<p>Continued From page 1</p> <p>revealed a wet system riser in the janitor's room of the 300 wing. That riser supplied a wet pipe system protecting an adjacent storage room in the 300 wing. Record review of the inspection tags hanging on that riser revealed that riser had not been inspected since 6/10/13. A quarterly flow test should have been conducted for the waterflow sensor tied to that riser. An annual inspection of the supervisory control valves and backflow prevention should have been conducted.</p> <p>Further observation at the same time revealed the inspector test connection installed to test the waterflow alarm did not terminate in an orifice that would give a flow equivalent to one of the sprinklers with the smallest orifice installed on that wet system. The inspector test connection installed was a 3/4 inch ball valve with 3/4 inch copper drain pipe.</p> <p>Interview with the maintenance supervisor at the time of the observation revealed he was unaware that riser was not being inspected annually. He was also unaware a quarterly flow test was not being conducted. He indicated he was not aware that inspector test connection was of the required size. Review of the provider's sprinkler inspection records revealed a quarterly flow test had been conducted on the main sprinkler riser, but Building Sprinkler Inc. had missed the secondary sprinkler riser.</p>	K 062		
K 144 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>	K 144		

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K 144	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to replace the generator battery per NFPA 99 guidelines. Specific gravity testing for the generator battery had not been done since the battery was installed. Findings include: 1. Observation at 12:15 p.m. on 11/25/14 revealed the generator battery was dated as being replaced on 8/16/11. Generator batteries should be scheduled for replacement every twenty-four to thirty months. Approximately thirty-nine months had lapsed since the last battery had been installed. Weekly specific gravity tests are required to be performed. Interview with the maintenance supervisor at the time of the observation revealed he was unaware that battery should have been replaced, and that specific gravity testing was required.	K 144	K 144. NFPA 101 LIFE SAFETY CODE STANDARD GENERATOR BATTERY REPLACEMENT Battery was replaced on November 28, 2014. Replacement schedule will be maintained by the Maintenance Supervisor and reported to the QAPI every twenty four – thirty six months.	01/15/15

ORIGINAL

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/26/2014
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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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S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/24/14 through 11/26/14. Good Samaritan Society Tripp was found not in compliance with the following requirements: S294, S301 and S398.	S 000	Addendums noted with an asterisk per 11/15 telephone to facility administrator. SBJ/DDH/ME	
S 294	44:04:07:04 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and record review, the provider failed to have the registered dietitian (RD) review the menu changes on a	S 294		

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

TITLE

Administrator

(X6) DATE

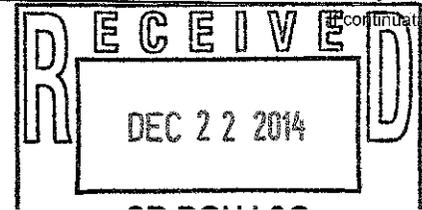
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STATE FORM

6899

30XE11

Continuation sheet 1 of 5



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2014
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S 294	<p>Continued From page 1</p> <p>monthly basis. Findings include:</p> <p>1. Observation on 11/24/14 at 5:35 p.m. at the evening meal revealed: *Pudding tart was the dessert on the written menu. *Chocolate pudding was served instead of the pudding tart.</p> <p>Review of the provider's menu substitution log book revealed: *Written food substitutions had not been recorded since 6/20/11. *The RD had not reviewed and approved menu changes monthly.</p> <p>Interview on 11/25/14 at 9:30 a.m. with the certified dietary manager (CDM) and cook D revealed: *The RD had not been reviewing the menu changes on at least a monthly basis. *Menu changes had not been recorded since 6/20/11. *They both stated the entrees on the written menu were changed as frequently as five times per month. *They both stated the desserts were changed very frequently at several times per week.</p> <p>Observation on 11/25/14 at 12:46 p.m. at the noon meal revealed: *Pork loin, parsley buttered potatoes, buttered broccoli, and fruited jello were listed on the written menu. *Kielbasa (a type of sausage), mashed potatoes, sauerkraut, and apricot cobbler were served.</p> <p>Interview on 11/26/14 at 9:15 a.m. with the CDM revealed: *Menu changes were not being written down for</p>	S 294	<p>Menu changes/substitution log is now up to date. Registered Dietitian (RD) and DM will ensure log is reviewed and signed off by RD monthly. DM will bring the menu changes/substitutions log to each monthly QAPI Committee meeting for three months for review by committee members. QAPI will determine after three months if DM will need to continue to bring the log to the meeting for review.</p> <p><i>* The DM will review the log daily to see that it is being utilized appropriately showing date, what was being substituted, what the substitution was, and the reason for the change.</i> SBKDDHMF</p>	01/15/15
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South Dakota Department of Health

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S 294	Continued From page 2 the RD's review and approval. *She agreed the menu substitution log had "not been kept up." *She confirmed the menu changes were not being approved by the RD on at least a monthly basis. Review of the provider's revised March 2009 Menus Substitution Lists policy revealed: *Temporary and permanent changes to the menu cycle would have been documented with the: -Date. -Changed from. -Changed to. -Reason for change. -Initials of the person making the substitution on the day of use. *Permanent menu substitutions would have been approved by the RD. *The RD was to have reviewed and initialed the substitutions with each visit as needed.	S 294		
S 301	44:04:07:16 Required dietary inservice training The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing inservice training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rules of South Dakota is not	S 301	All nursing and activities staff as well as all dietary staff will be considered and identified as persons who handle food. All staff members in these departments will be required to complete the Good Samaritan Society Learning Center Module Safe Food Handling – Fundamentals, which incorporates proper food handling and preparation, leftover food handling, and time and temperature control education for food preparation and service. This (continued on page 4)	01/15/15

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S 301	<p>Continued From page 3</p> <p>met as evidenced by: Surveyor: 32331</p> <p>Based on record review, interview, and policy review, the provider failed to ensure three of nine required annual in-service training sessions (food handling and preparation techniques, leftover food handling policies, and time and temperature controls for food preparation and service) were offered for all food-handling staff yearly. Findings include:</p> <p>1. Record review of the required in-service training sessions from the 2014 Staff Development Schedule for all food handling staff revealed: *Those staff had received no annual training on the following: -Food handling and preparation techniques. -Leftover food handling policies. -Time and temperature controls for food preparation and service.</p> <p>Interview on 11/25/14 at 9:30 a.m. with the certified dietary manager and at 1:30 p.m. with the staff development coordinator, and on 11/26/14 at 8:05 a.m. with the director of nursing regarding required annual in-service training sessions for all food handlers revealed: *Food handling staff were identified as dietary, nursing, and activities. *There had not been an in-service on food handling and preparation techniques, leftover food handling policies, and time and temperature controls for food preparation and service for nursing and activities staff. *They had not known that all food handling staff were to have received that annual in-service training.</p> <p>Review of the provider's revised March 2009</p>	S 301	<p>(continued from page 3)</p> <p>Learning Center Module will be completed by 12/24/14 by all nursing and activity personnel. This module will become required annual training for all dietary, nursing, and activity personnel and will be placed on the yearly schedule of required in-service topics for 2015. The Registered Dietitian will also provide in-service education to nursing and activity staff regarding proper food handling, preparation, leftover food handling, and time and temperature controls by 1/15/15. The 2015 Required In-Service Topics Schedule is in progress, and not finalized at this time.</p> <p>*and will be overseen by the head of staff development. SB/SDDH/ME</p> <p>*Staff development will report education, in-service information, and education to the QA committee at the monthly meeting for review. QA will determine if further education is necessary. SB/SDDH/ME</p>	
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South Dakota Department of Health

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S 301	Continued From page 4 In-Service Education policy revealed the director of dietary services or designee were to have ensured education was provided for dietary staff and other staff as needed.	S 301		
S 398	44:04:13:35 Vacuum Breakers Antisiphon devices or backflow preventers must be installed on hose bibs and on all fixtures to which hoses or tubing can be attached such as laboratory and janitors' sinks, bedpan flushing attachments, handheld showers...Antisiphon devices or backflow preventers must be installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to install vacuum breakers on the hand-held hose of the resident shower stall in one randomly observed location (Bath 100). Findings include: 1. Observation at 2:15 p.m. on 11/25/14 revealed the hand-held hose for the resident shower in bath 100 was not equipped with a vacuum breaker creating a potential cross-contamination issue with the potable water system. Interview with the maintenance supervisor at the time of the observations confirmed that condition. He indicated he was not aware that handheld hose required a vacuum breaker.	S 398	Hand held hose for the resident shower in bath area is now equipped with a vacuum breaker. This was completed on 11/27/14. There are no other hand held shower hoses of this nature in the facility.	01/15/15