

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1022 NORTH DAKOTA AVENUE CANTON, SD 57013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>*Addendums noted with an asterisk per 11/10/15 per telephone with facility administrator.</i></p> <p>INITIAL COMMENTS</p>			
F 278 SS=E	<p>Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/28/15 through 9/30/15. Good Samaritan Society Canton was found not in compliance with the following requirements: F278, F281, F334, and F441.</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a</p>	F 278	<p>F278-Assessment Accuracy /Coordination/Certified SS=E</p> <p>Assessment of repositioning devices</p> <p>Resident 3 was assessed to determine if she was able to remove her positioning device and was found capable of removing it independently when asked by staff. MDS coordinator noted these findings in the monthly nursing assessment documentation.</p> <p>Resident 9 was assessed to determine if she was able to remove her positioning device and was found capable of removing it independently when asked by staff. MDS coordinator noted these findings in the monthly nursing assessment documentation.</p> <p><i>*Restorative Nurse will initiate the positioning device and notify MDS coordinator. MDS coordinator will assess resident for restraints when a positioning device is initiated for a resident. The MDS coordinator will use the restraint assessment to determine if</i></p>	10/23/15

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

Myron More

TITLE

Administrator

(X8) DATE

10/23/15

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.

OCT 26 2015

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

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F 278	<p>Continued From page 1 material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Surveyor: 32355 Surveyor: 29354</p> <p>A. Based on observation, record review, interview, and policy review, the provider failed to ensure appropriate assessments had been completed for two of two sampled residents (3 and 9) who used repositioning devices. Findings include:</p> <p>1. Random observations from 4:30 p.m. through 5:45 p.m. on 9/28/15 and 9:00 a.m. through 3:30 p.m. on 9/29/15 of resident 3 revealed she had been sitting in a wheelchair (w/c) with a half-tray attached to the right side.</p> <p>Observation on 9/28/15 at 4:45 p.m. revealed resident 3 had been able to lift the half-tray upon request by the surveyor.</p> <p>Review of resident 3's medical record revealed: *An admission date of 11/14/13. *Minimum Data Set (MDS) assessments done on 11/24/14, 4/21/15, and 7/14/15 had not been coded for restraint use. *On 7/9/14 there was nursing documentation to support she required the use of a positioning device to stabilize the right side of her body. There was no documentation to support where that positioning device had been located and if she could have removed it.</p>	F 278	<p>the positioning device is a restraint and will identify in a nursing note if the resident is able to remove the positioning device on their own. A nursing assessment will be completed quarterly by a RN to identify if the resident is still able to remove the device independently so it doesn't become a restraint. Audits on all residents that have positioning devices will be completed monthly x3, quarterly x2 by QAPI coordinator or designee, and audit findings will be presented to monthly QAPI meetings for review and recommendations.</p> <p><i>*Education to staff will be provided on positioning devices and roles in the process. JH/SDDOH/EL</i></p> <p>Properly assessed for individual toileting programs</p> <p>*An initial bowel and bladder assessment will be completed upon admission by an admission nurse. MDS coordinator will determine if resident is eligible for a toileting program. If the resident does not qualify for a toileting program then the MDS coordinator will not code the MDS for the resident to be on a toileting program. The resident</p>	

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F 278	<p>Continued From page 2</p> <p>*Her 1/20/15 care plan supported the use of a "Half-tray to w/c used to maximize resident safety/positioning."</p> <p>*No further assessments or documentation after 7/9/14 to support:</p> <ul style="list-style-type: none"> -The continued use and need of a half-tray to her w/c. -She was capable of removing the half-tray without assistance by the staff. <p>Interview on 9/29/15 at 9:30 a.m. with the director of nursing (DON) confirmed resident 3 used a half-tray to assist her with positioning in the w/c. And she was capable of removing it on her own. She had not been aware the half-tray required an assessment to be completed upon any significant change in status or with her quarterly assessments per the provider's policy. She agreed without an appropriate assessment in place the half-tray would have been considered a restrictive device.</p> <p>2. Observation on 9/29/15 during the noon meal of resident 9 revealed she had been sitting at the table with a blue seat belt around her lower waist area.</p> <p>Observation on 9/29/15 at 5:10 p.m. outside the dining room door with resident 9 revealed the surveyor requested resident 9 remove the seat belt. She was unable to do that.</p> <p>Observation on 9/30/15 at 8:50 a.m. with the DON and resident 9 revealed the DON asked resident 9 to release the belt and she was able to do that.</p> <p>Review of resident 9's medical record revealed: *A diagnosis of Alzheimer's disease.</p>	F 278	<p>would need to show improvement to continue coding the MDS for a toileting program and be evaluated by Occupational therapy. Otherwise, staff will follow standard of care for toileting residents. When a change of condition MDS assessment is completed for a resident, a new bowl and bladder assessment will be completed. Audits will be completed monthly x3, quarterly x2 by QAPI coordinator or designee, and audit findings will be presented to monthly QAPI meetings for review and recommendations.</p> <p>CNA during care didn't check and change a resident when laid down before meal</p> <p>CNAs will be educated on the standard of care for toileting schedules for residents. audit will be performed biweekly x2; monthly x2 and then quarterly x1 by staff development nurse and audit findings will be presented to monthly QAPI meetings for review and recommendations.</p>	<p><i>*On bowel & bladder assessments for all new admits and significant changes.</i> <i>JK/SPDOH/EL</i></p> <p><i>JK/SPDOH/EL</i> <i>Five (5)</i> <i>*see next page</i></p>	

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F 278	<p>Continued From page 3</p> <p>*The MDS assessments for the 2/10/15 annual and the 7/28/15 quarterly reviews revealed: -She had a Brief Interview for Mental Status (BIMS) (testing of thought process) score of 3. That score indicated she was severely cognitively (memory, thinking, reasoning) impaired. -Section P0100 Restraints was marked "Not used." *A 4/12/14 Fax communication to the physician requesting "OK to place self-release seatbelt alarm to wheelchair d/t [due to] increased number of falls et [and] for resident safety?" Physician signed response "OK." *Nursing documentation revealed: -There was no initial assessment completed for placement of the self-release alarm belt provided by the facility. -The 11/5/14 and 1/28/15 for Physical Device and Restraint Review revealed there had been no documentation for "What is the resident's response to the use of the device?" *The care plan intervention revealed PERSONAL ALARM: w/c (wheelchair) seat alarm used to alert staff to resident's movement and to assist staff in monitoring movement. Resident able to remove independently. Date Initiated: 5/6/14. Revision on: 5/6/14.</p> <p>Interview on 9/30/15 at 10:45 a.m. with the MDS RN regarding resident 9 revealed: *The self-release seat belt had been initiated on 4/12/15. *Confirmed the nurses had not documented the response to the seat belt alarm on 11/5/14 and 1/28/15. *The restraint assessment was completed with monthly nursing documentation by the nurses. *She confirmed the resident's BIMS score was 3. The score indicated severely impaired.</p>	F 278	<p>* to determine if the residents were toileted and then documented accurately in PCC per GSS standard of care. JK/SDDot/EL</p>		

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F 278	<p>Continued From page 4</p> <p>*She had usually had resident 9 release the belt in the AM.</p> <p>Interview on 9/30/15 at 11:30 a.m. with the DON regarding resident 9 revealed her expectations would have been for quarterly restraint assessments to have been completed.</p> <p>3. Review of the provider's revised October 2013 Physical Restraints policy revealed "If the device, material or equipment is not a restraint, it must be reviewed with a significant change in condition and quarterly in conjunction with the care plan to ensure that it continues to not be a restraint for the resident."</p> <p>Surveyor: 32355</p> <p>B. Based on observation, record review, interview, and policy review, the provider failed to ensure four of eight sampled residents (3, 4, 6, and 7) were appropriately assessed for an individualized toileting plan. Findings include:</p> <p>1. Review of resident 3's medical record revealed:</p> <p>*The care plan indicated she was on a toileting schedule "Scheduled toileting in am when awake, before/after meals, HS (hours of sleep)." Date initiated was 4/28/14 and revised on 4/29/14.</p> <p>*The Bowel and Bladder documentation reports for November 2014, April 2015, and July 2015 revealed:</p> <p>-No defined times for voiding.</p> <p>-The staff documented once per shift to support if she was continent or incontinent (no control) of urine.</p> <p>*The 11/24/14 annual MDS assessment revealed she had:</p> <p>-A trial of a toileting program with no</p>	F 278		

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F 278	<p>Continued From page 5 improvement.</p> <p>-Remained on a toileting program.</p> <p>*The 4/21/15 quarterly MDS assessment revealed the same documentation at the 11/24/14 assessment.</p> <p>*The 7/14/15 quarterly MDS assessment revealed the same documentation as the above assessments except she was frequently incontinent of urine.</p> <p>*No documentation of a bowel or bladder assessment to support an individualized toileting program.</p> <p>Interview on 9/29/15 at 3:00 p.m. with the MDS assessment coordinator revealed:</p> <p>*The above documented toileting schedule for resident 3 had been a standard used for all residents who required assistance with toileting. That had been the provider's protocol for the staff to follow for toileting the residents.</p> <p>*She had considered that an individualized toileting program, because not all residents:</p> <p>-Awaken at the same time every morning.</p> <p>-Eat and finish their meals at the same time.</p> <p>-Go to bed at the same time.</p> <p>*She had not done any toileting assessments to assist the staff with following the individual voiding patterns of the residents.</p> <p>Surveyor: 29354</p> <p>2. Observation on 9/29/15 at 9:05 a.m. with certified nursing assistants (CNA) G and H during care with resident 4 following breakfast revealed:</p> <p>*They transferred resident 4 with the total mechanical lift from the wheel chair to the bed.</p> <p>*CNA H left the room.</p> <p>*CNA G repositioned resident 4 on her back in bed. She had not checked to see if resident 4 had been incontinent of urine or feces (bowel</p>	F 278		

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F 278	<p>Continued From page 6 movement).</p> <p>Review of resident 4's medical record revealed: *The care plan toileting schedule: was toilet when awake in AM, before/after meals, HS. Date initiated was 5/2/14. Revision date was 2/10/15. *The following MDS assessments revealed: -4/28/25 quarterly assessment was frequently incontinent of urine and was on a toileting program. BIMS was 15. -7/7/15 significant assessment was frequently incontinent of urine and was on a toileting program. BIMS was 13. -8/12/15 significant assessment was always incontinent of urine and was on a toileting program. BIMS was 10. *She had received diuretic (promotes production of urine) medications when all three MDS assessments were done.</p> <p>Interview on 9/29/15 at 3:30 p.m. with the MDS RN regarding resident 4 revealed: *The hospice staff and she felt resident 4 was still able to use the toilet. *Her expectations would have been for resident 4 to have been toileted.</p> <p>Interview on 9/29/15 at 4:40 p.m. with the director of nursing (DON) regarding resident 4 revealed her expectations would have been for resident 4 to have been toileted.</p> <p>3. Review of resident 7's medical record revealed: *The care plan revealed she was on a toileting schedule: prompted voiding 2x (two times) per shift. The date initiated was 5/9/14. The revision date was 1/9/15. *The Bowel and Bladder documentation survey</p>	F 278		

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F 278	<p>Continued From page 7 report from July 1, 2015 through September 29, 2015 revealed: -No defined times for voiding. -No documentation if she was continent or incontinent. *The 6/16/15 quarterly Minimum Data Set (MDS) and the 7/14/15 significant change MDS assessments revealed she: -Required extensive assistance of one staff with toileting. -Was always continent of urine. -The 6/16/15 Brief Interview for Mental Status (BIMS) score was 13. -The 7/14/15 BIMS score was 10. *There was no documentation of a bowel or bladder assessment.</p> <p>Surveyor: 32332 4. Review of resident 6's medical record revealed: *The 7/20/15 care plan indicated: -She was frequently incontinent of bowel and bladder. - "Scheduled toileting when awake in AM [morning], before/after meals, HS." -Her incontinence brief was to have been checked and changed every two to three hours during the night. *A 5/7/15 progress note entry from the MDS coordinator indicated she had a prompted voiding program. *The 4/28/15 quarterly MDS assessment revealed she: -Was occasionally incontinent of urine. -Had a trial of a toileting program with no improvement. -Remained on a toileting program. *The 7/8/15 significant change MDS assessment revealed she:</p>	F 278		

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F 278	Continued From page 8 -Was occasionally incontinent of urine. -Had a trial of a toileting program with no improvement. -Remained on a toileting program. *No documentation of a bowel or bladder assessment to support an individualized toileting program. Surveyor: 32355 5. Interview on 9/30/15 at 10:45 a.m. with the MDS RN regarding toileting programs for all residents revealed: *She would look back on the resident's care plan and if they had not had a change in voiding she had not changed the care plan. *If the resident's had a change in their voiding patterns she would change the care plan. *She had not done any toileting assessments to follow the actual voiding patterns of the resident's.	F 278			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F281-Services Provided Meet Professional Standards SS=E <u>Medications</u> To ensure that we have a system in place to easily account for non-narcotic medications received from pharmacy in bubble pack form, licensed nurses will date	10/23/15	

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F 281	Continued From page 9 This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Have a system in place to easily account for non-narcotic medications requiring a physicians' prescription for one of two local pharmacy providers. *Properly care for two of two sampled residents (2 and 4) who were at risk for skin breakdown. *Ensure two of two observed residents (9 and 15) receiving nebulizer treatments (device to administer medicine as a mist) had been assessed for the ability to self-administer medications. Findings include: 1. Observation and interview on 9/30/15 at 10:15 a.m. with licensed practical nurse (LPN) B during a review of the south medication cart revealed blister-pak medication cards (cardboard punch cards used to store individual pills for each resident). Each blister sealed pill had a number beside it. Further review of the cards revealed: *The medications removed from the cards from the local pharmacy had been removed to have been given on the date relating to the number beside the medication used. *The medications removed from the cards from the consultant pharmacy had not been removed to have been given on the date relating to the number beside the medication used. Interview at that time with LPN B revealed: *The consultant pharmacy had not specified in what order the medications were to have been	F 281	medication card once the first dose is given. We will educate licensed nurses regarding this on Oct. 29 th . *On all bubble packs JK/SDDOH/EL Audits will be completed weekly x 4, monthly x 3 and quarterly x 1 by QAPI coordinator or designee and audit findings will be presented to monthly QAPI meetings for review and recommendations. Skin Break down Resident 2's chart has documentation on 9/30/15 by CDM that she was notified of the resident's skin issue and RD made recommendations on 10/1/15 for dietary needs of resident. For resident 4 we will educate all nurses that upon any findings of skin breakdown on a resident, a licensed nurse will complete the wound UDA then inform physician, dietary manager, and MDS coordinator at the time the skin breakdown is identified and document the skin issue on the care plan. Within 24 hours after the wound UDA is completed, a RN will complete a Wound RN	

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F 281	<p>Continued From page 10 removed from the cards.</p> <p>*The numbers beside the pills had not related to the date they were to have been given.</p> <p>*If two of the same pills were to have been given at the same time, both pills would have been removed from the same card without regard to the numbers.</p> <p>*When the medication card was empty the nurse would contact the consultant pharmacy for a new card.</p> <p>*Each card had a date to indicate when it had been sent from the pharmacy, but there had been no date on the card to indicate when the nurses began using that card.</p> <p>*There had been no way for the nurses to know if all the medications had been given by looking at the card.</p> <p>*LPN B stated the pharmacist could know by looking at their inventory at the pharmacy if all of the medications had been given.</p> <p>Phone interview on 9/30/15 at 1:40 p.m. with the consultant pharmacist revealed:</p> <p>*She agreed the nurses would not have been able to tell if all the medications had been given by looking at the blister-pak cards.</p> <p>*She could tell if all the medications had been given by looking at the prescription fill date on her records, and then reconciling (showing the numbers matched) against the medications left in the cards.</p> <p>*Medication cards were not routinely reconciled.</p> <p>*Each provider she served had their own system for accounting for their medications.</p> <p>*Some providers used the numbers on the cards to match the date the medication was to have been given.</p> <p>*Some providers used one card to punch out two pills at the same time, because there was not</p>	F 281	<p>assessment and review the care plan. This education will occur on Oct. 29th for all Licenses Nurses.</p> <p><i>*on all new skin issues. JH/SDDOT/EL</i></p> <p>Audits will be performed bi-weekly x4, monthly x2, quarterly x1 by QAPI coordinator or designee and audit findings will be presented to monthly QAPI meetings for review and recommendations.</p> <p><i>*Audits will be done on whether initial wound UDA was completed, that the physician dietary manager, and MDS coordinator was notified on skin issue and care plan update and that the wound RN Nebulizer assessment was completed within 24hrs after initial UDA was completed. JH/SDDOT/EL</i></p> <p>All residents, including residents 9 and 15 will be assessed for the ability to self-administer medications to determine if the residents are capable to administer their own nebulizer treatments. If the resident is able to self-administer their medication, a physician order will obtained and resident will be assessed quarterly to determine if the resident is able to continue the ability to self-administer their medications.</p> <p>If resident is deemed unable to self-administer their medications a</p>		

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F 281	<p>Continued From page 11</p> <p>enough room in the medication carts to use one card for each pill time. *She had not given recommendations to the provider for how the medications cards were to have been used.</p> <p>Interview on 9/30/15 at 1:50 p.m. with registered nurse (RN) D revealed: *She usually began giving the medications in the blister-pak cards from the provider's consultant pharmacy by using the pill with the number thirty beside it, because that was the way the narcotic medications were removed from their blister-pak cards. *Other nurses began with the pill beside the number one. *Some nurses just began by punching out a pill beside any random number. *She agreed there would have been no way of knowing if all medications had been given by looking at the consultant pharmacy blister-pak cards.</p> <p>Interview on 9/30/15 at 1:55 p.m. with the director of nursing revealed she agreed there was not a system for the nurses to easily see if all the medications had been given.</p> <p>Review of the provider's September 2012 Pharmaceutical Services policy revealed: *Services would be provided to meet the needs of each resident including procedures that would ensure the accurate dispensing and administering of all medications. *Services would be obtained to establish a system of records of all controlled medication in sufficient detail to enable accurate reconciliation.</p>	F 281	<p>licensed nurse will monitor the resident throughout the nebulizer treatments. This education will occur on Oct. 29th for all Licensed Nurses. Audits will be performed <i>*on all residents who use nebulizers.</i> bi-weekly x2, monthly x2, quarterly x1 by QAPI coordinator or designee and audit findings will be presented to monthly QAPI meetings for review and recommendations.</p> <p><i>*Audits will consist of verifying that residents have a Self-administration order. If resident doesn't have a Self-administration order, an audit will be done to observe the nurse to ensure monitoring of residents throughout their nebulizer treatments.</i></p> <p>JK/SDDO/H/EL</p>	

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F 281	<p>Continued From page 12</p> <p>Surveyor: 29354</p> <p>2. Observation on 9/29/15 at 9:05 a.m. with certified nursing assistants (CNA) G and H during care for resident 4 following breakfast revealed:</p> <p>*The CNAs transferred resident 4 with the total mechanical lift from the wheelchair to the bed.</p> <p>*CNA H left the room.</p> <p>*CNA G repositioned resident 4 on her back in bed. She had not checked to see if resident 4 had been incontinent of urine or feces (bowel movement).</p> <p>Review of resident 4's medical record revealed:</p> <p>*She had diagnoses of protein-calorie malnutrition and urinary incontinence.</p> <p>*An 8/28/15 at 22:23 [10:23 p.m.] nursing progress note "resident has 2 open areas over bony prominence [any point of the body where bone is immediately below the skin surface and greatest risk of developing a pressure ulcer] on coccyx [tailbone] measuring 2 cm [centimeter] in diameter; fax sent to physician for new orders."</p> <p>*A fax communication to the physician dated 8/28/15 at 2155 [9:55 p.m.] "Resident has two open areas over bony prominence on coccyx measuring 2 cm in diameter. Okay for the following Clean with saline pat dry, apply skin prep, cover with Hydrocolloid [specific dressing] dressing changing every 3 days and PRN [when necessary] until healed?" The physician response was dated 9/1/15 "Okay for above."</p> <p>*Review of the care plan revealed:</p> <p>-She required extensive assistance of two staff with personal hygiene, toilet use, and bed mobility.</p> <p>-She was on a toileting schedule: Scheduled toileting when awake in AM, before/after meals, HS (at bedtime.)</p> <p>-"The resident has potential for pressure ulcer</p>	F 281			

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F 281	Continued From page 13 development R/T [related to] poor intake, immobility, weakness, end of life condition." Provide pressure reduction mattress, and heel boots on when in bed. There was no documentation of a pressure ulcer on the care plan. *The 9/7/15 Wound Care sheet revealed: -Site: the left upper buttocks (two round fleshy parts that form the lower rear areas of the body's trunk). -Type: Incontinence open area. -Treatment: Duoderm (specific dressing change) every 3 (three) days and PRN. -Measurements: 100% epithelia (skin that forms a thin protective layer on exposed body surface), blanching red areas. -Comments: Duoderm until redness is gone. *Review of the medication administration records from August 1, 2015 through September 29, 2015 revealed: -August 1 to 31, 2015: House supplement 2.0 three times a day for weight loss, poor appetite. That had been started on 9/5/15. Calmoseptine ointment apply to buttocks topically every shift for incontinent episodes related to rash and other nonspecific skin eruption until healed. There was no documentation to use tegaderm to the coccyx or buttock area. -September 1 to 29, 2015 revealed the hydrocolloid (a specific dressing type) dressing had been started on 9/1/15. There was no documentation a tegaderm had been used. *Review of nursing progress notes revealed on: -8/31/15 at 13:20 [1:20 p.m.] "Resident has 1 [one] superficial open area remaining to upper buttock. Area is breaking down due to incontinence. Duoderm was placed and awaiting physician response to fax." -9/1/15 at 10:15 [10:15 a.m.] "Fax order received	F 281			

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F 281	<p>Continued From page 14</p> <p>for the following: Hydrocolloid dressing to coccyx, cleanse with saline, pat dry, apply skin prep, cover with hydrocolloid dressing changing every 3 days and PRN until healed."</p> <p>-9/14/15 at 13:12 [1:12 p.m.] "Resident left upper buttocks areas has 100% epithelia. Pink scar tissue remains due to frequent open areas to bottom."</p> <p>-9/18/15 at 23:00 [11:00 p.m.] "She is prone to skin breakdown especially to coccyx."</p> <p>*Review of the 8/28/15 registered dietitian (RD) notes had not addressed any skin issues. There was no further documentation from the registered dietitian or the certified dietary manager (CDM).</p> <p>*A 9/5/15 physician's order to increase house supplement from two ounces, three times a day to three ounces, three times a day due to weight loss.</p> <p>The Braden Scale for Predicting Pressure Sore Risk assessments revealed on the following dates:</p> <p>*4/20/15 a score of 16 indicating a low risk.</p> <p>*7/16/15 a score of 14 indicating a moderate risk.</p> <p>*9/24/15 a score of 13 indicating a moderate risk.</p> <p>Review of the following Minimum Data Set (MDS) assessments revealed on the following dates:</p> <p>*4/28/15 quarterly MDS and the 7/7/15 significant change MDS she was at risk for skin breakdown, was frequently incontinent of urine, and area for pressure reducing device for bed was marked "no."</p> <p>*8/12/15 significant change MDS assessment she was at risk for skin breakdown, was always incontinent of urine, and area for pressure reducing device for bed was marked "no."</p> <p>Interview with the CDM on 9/30/15 at 8:10 a.m. regarding resident 4 revealed:</p>	F 281			

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F 281	<p>Continued From page 15</p> <p>*The house supplement had been increased to three times a day for weight loss not for skin issues.</p> <p>*She had not been informed resident 4 had a pressure ulcer (open area over a bony prominence).</p> <p>Interview on 9/29/15 at 3:30 p.m. with the MDS registered nurse (RN) revealed the care plan should have indicated information on any type of pressure ulcer.</p> <p>Interview on 9/29/15 at 4:40 p.m. with the director of nursing revealed:</p> <p>*She would have expected the care plan to be updated within a week for any type of pressure ulcer or skin/wound concern.</p> <p>*She would have expected the CDM to have been notified as soon as possible regarding any type of skin breakdown.</p> <p>Interview on 9/30/15 at 1:10 p.m. with the wound care registered nurse D regarding resident 4 revealed:</p> <p>*She was the nurse who assessed and documented all wounds.</p> <p>*She had not felt the area was a pressure ulcer.</p> <p>*The resident had a decline in her health and was now on hospice services.</p> <p>*She was incontinent of urine and bowel movements.</p> <p>*She had been trying to educate the nursing staff on the difference between the coccyx and the sacrum areas.</p> <p>*If an open area was not a pressure ulcer it was not documented on the care plan. The care plan would list areas as potential for skin or open area breakdown.</p> <p>*She documented weekly on the electronic</p>	F 281		

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F 281	<p>Continued From page 16</p> <p>medical record regarding open areas and pressure ulcers.</p> <p>*She had not "called" the area a pressure ulcer. She had considered it an open area on the left upper buttock due to incontinence.</p> <p>*Her training and education as a skin/wound nurse included:</p> <ul style="list-style-type: none"> -Four to six hours of education at a seminar in the past. -She had worked two years as a wound nurse in a larger facility. <p>*She only documented what she had found or had seen.</p> <p>*She considered an open area over a bony prominence a pressure ulcer.</p> <p>*The dietary department had been informed of the resident's open area on 9/7/15.</p> <p>Observation and interview on 9/30/15 at 1:40 p.m. with licensed practical nurse (LPN) B regarding resident 4's open area revealed:</p> <p>*She could not remember exactly where the open areas had been on the resident but were above her tail bone.</p> <p>*Further review revealed LPN B pointed to the area approximately three inches above the resident's tail bone and directly over the spinal area.</p> <p>Interview on 9/30/15 at 3:10 p.m. with the MDS RN revealed all mattresses were considered pressure relieving. An air overlay had been placed on residents' beds who were at risk for skin break down or had current skin break down. There was a certain weight limit for placement of the air overlays. She was not sure of the weight limit but would get back to the surveyor with the policy.</p>	F 281			

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F 281	<p>Continued From page 17</p> <p>Interview on 9/30/15 at 4:10 p.m. with the staff development nurse and infection control LPN C regarding the air overlay for resident 4's bed revealed:</p> <ul style="list-style-type: none"> *The resident had: <ul style="list-style-type: none"> -Refused the air overlay for the mattress. -Pulled it off the bed. *There was no documentation to support the above. *There was no policy or procedure for the use of an air overlay on the mattress. <p>Surveyor: 32355</p> <p>3. Review of resident 2's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 9/10/15. *Diagnoses of a right hip fracture with surgical replacement. *A stage II pressure ulcer (injury to skin usually from pressure and frequently over a bony area) had been observed on her coccyx on 9/22/15. *The physician was notified of the open area on 9/22/15 with orders received to treat the wound with a duoderm (non-medicated protective dressing). <p>Review of the resident 2's care plan revealed:</p> <ul style="list-style-type: none"> *On 9/23/15 it had been updated to reflect: <ul style="list-style-type: none"> -A focus area "The resident has potential for pressure ulcer development R/T [related to] immobility due to [d/t] fx [fracture] HIP, PVD [peripheral vascular disease]." -A goal "Resident will have intact skin, free of redness, blisters or discoloration by/through review date." -Interventions for repositioning. *On 9/28/15 a wheelchair cushion and mattress air overlay had been added to her interventions. *On 9/23/15 and 9/28/15 there had been no 	F 281			

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F 281	<p>Continued From page 18</p> <p>documentation to support a stage II pressure ulcer had been observed on the resident's coccyx as of 9/22/15.</p> <p>*No documentation to support the certified dietary manager (CDM) had been notified of the pressure ulcer.</p> <p>Review of resident 2's 9/22/15 through 9/30/15 nursing and dietary manager's progress notes revealed:</p> <p>*On 9/22/15 the charge nurse: -Observed an open area to the resident's coccyx. -Notified the wound nurse and the primary physician about the open wound. -No documentation to support the dietary department had been notified.</p> <p>*On 9/25/15 the dietician had reviewed the resident's chart. There had been no documentation to support the notification/knowledge of an open area to the resident's coccyx.</p> <p>*On 9/30/15 the dietary manager had received recommendations from the dietician to increase the resident's protein intake d/t the pressure ulcer.</p> <p>Interview on 9/30/15 at 8:10 a.m. with the CDM regarding resident 2 revealed: *She had not been notified of the pressure ulcer to the resident's coccyx until 9/29/15. *She had emailed the dietician on 9/30/15 for recommendations on the pressure ulcer. *She agreed she had not been notified of the pressure ulcer in a timely manner. *She would have expected to have been notified of the pressure ulcer within a day or two of the observation.</p> <p>Interview on 9/30/15 at 2:00 p.m. with RN D</p>	F 281			

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F 281	Continued From page 19 revealed: *She had been the wound nurse for the provider. *She worked as a wound nurse once a week on Mondays. *She would have measured, treated, and documented on the wounds every Monday. *She would have worked on wounds during the week as time allowed from her other duties. *She had been the only RN in the facility who could stage a wound or identify it as a pressure ulcer. *Her and a physician had been the only staff members who could identify a wound as a pressure ulcer and do the staging of that wound. *The charge nurses had the capability of: -Documenting what they had observed of a wound but no staging. -Putting interventions in place to prevent a pressure ulcer from occurring or worsening. -Notifying the physician for a diagnosis and treatment order. -Notifying the CDM. *The charge nurses did not have the capability to update the residents' care plans to support an open area. She would have updated the care plan. *The care plans would not have identified any open area, only the interventions for prevention. *She agreed the care plans were used to take care of the residents by the staff. She further explained the care plans would not have been updated to support any open wounds only the interventions. *She would not have expected resident 2's care plan to identify an open wound to her coccyx. *She agreed the CDM had not been notified of resident 2's pressure ulcer in a timely manner. She had stated "The other nurses can inform the dietary department. I am not sure why they	F 281		

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F 281	<p>Continued From page 20 didn't."</p> <p>Interview on 9/30/15 at 2:30 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *She had been informed the RNs who could stage a wound or identify a wound as a pressure ulcer were the wound nurse and a physician. The wound nurse had further training in that area. *She had considered RN D a wound nurse no matter what day of the week she worked. Not just on Mondays. *She would have expected resident 2's care plan to have been updated to reflect an open area to her coccyx not just the interventions to prevent a wound. *She agreed any nurse could have updated the care plan. *She was not aware the CDM had not been notified of the pressure ulcer to resident 2's coccyx. *She agreed the CDM and dietician had not been informed of the pressure ulcer to resident 2's coccyx in a timely manner. *She would have expected the wound nurse to follow-up with the CDM to ensure proper notification of that wound. <p>4. The provider did not have a job description for a wound nurse when it had been requested during the survey.</p> <p>Review of the provider's September 2012 Pressure Ulcer policy revealed:</p> <ul style="list-style-type: none"> *Purpose: "To provide appropriate assessment and prevention of pressure ulcers as well as treatment when necessary." **"A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new 	F 281			

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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) COMPLETION DATE	
F 281	<p>Continued From page 21</p> <p>pressure ulcers from developing." *"Residents will receive appropriate assessments and services to promote and maintain skin integrity."</p> <p>Review of the provider's September 2012 Care Plan policy revealed: *"Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." *"Care plans also will be reviewed, evaluated and updated when there is a significant change in the resident's condition and/or in accordance with state guidelines. The plan of care will be modified to reflect the care currently required/provided for the resident."</p> <p>Surveyor: 32332 5. Observation on 9/29/15 from 1:34 p.m. through 1:53 p.m. of LPN B administering a nebulizer (medication delivered by inhaling a mist into the lungs) treatment to resident 15 revealed: *Place the medication into the nebulizer chamber and applied the mask to the resident's face, then instructed the resident she would return in a few minutes and left the room. *Returned to the room at 1:38 p.m., 1:40 p.m., and 1:53 p.m. *Removed the nebulizer mask at 1:53 p.m. and turned off the machine.</p> <p>6. Interview on 9/30/15 at 10:30 a.m. with LPN B regarding resident 15's nebulizer treatments revealed: *The resident did not have a physician's order for medication self-administration. *Nursing staff used masks to administer nebulizer treatments to all residents except for resident 16.</p>	F 281			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1022 NORTH DAKOTA AVENUE CANTON, SD 57013		
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F 281	<p>Continued From page 22</p> <p>*Resident 16 required a hand-held inhalation system, so the staff were required to stay with her during her nebulizer treatments.</p> <p>*Those residents who did not use the hand-held systems were not self-administering the medication, because the masks would remain on their face during the treatment.</p> <p>Interview on 9/30/15 at 1:55 p.m. with the DON revealed:</p> <p>* LPN B had not been following the provider's policy for medication self-administration.</p> <p>*Residents using nebulizer masks were to have been assessed for their ability to safely self-administer medications if they had been left alone.</p> <p>Review of resident 15's medical record revealed there was no physician's order indicating she could self-administer medications.</p> <p>2. Observation on 9/30/15 at 3:45 p.m. revealed resident 9 sitting alone in her room in the 300 hall, receiving medication through a nebulizer mask.</p> <p>Observation and interview at 3:46 p.m. with RN D at the medication cart in the 200 hall revealed:</p> <p>*She had left resident 9 in her room with the nebulizer treatment running.</p> <p>*Because she used a mask she would not be self-administering the medication.</p> <p>*There was no physician's order indicating she could self-administer medication.</p> <p>Review of the provider's July 2014 Resident Self-Administration of Medication Policy revealed:</p> <p>*The purpose was to determine if the resident could safely self-administer medication.</p>	F 281		

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F 281	Continued From page 23 *Staff were to have completed a resident self-administration of medication user-defined assessment to determine if the resident could safely administer medications. *The interdisciplinary team's determination that the resident could safely self-administer medications was to have been documented in the medical record. *A physician's order was to have been obtained prior to the resident self-administering medications. *The care plan would indicate details of how the resident was to self-administer the medication. *The resident's ability to continue to safely self-administer medication was to have been reviewed periodically during the care planning process.	F 281		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334	<p>F334- Influenza and pneumococcal Immunizations SS=D</p> <p>Resident 2's representative will get a copy of the CDC statement and will determine if they want to have the pneumococcal vaccination.</p> <p>Resident 11's representative will get a copy of the CDC statement and HIM will determine if they want to have the PCV13.</p> <p>Resident 12's chart was updated 10/9/2015 to note that the resident had the pneumococcal vaccine on 3/2/2015. The chart was also update on 10/9/15 that resident 12 refused PCV 13.</p> <p>All residents need to be offered the Flu vaccinations Oct 1st through March 31st.</p>	10/23/15

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F 334	<p>Continued From page 24</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal</p>	F 334	<p>Upon admission, HIM will determine if resident has received flu vaccine and pneumococcal vaccine. If resident doesn't have the vaccinations, HIM will mail out the CDC statements to legal representative and resident and determine if resident wants to have the vaccination. HIM will then get physician orders to give the vaccination to resident and HIM will have the consent or decline noted by the resident or legal representative.</p> <p>Audits will be conducted on new admitted residents, monthly x3, then quarterly x2 by infection control nurse with audit findings presented to monthly QAPI meetings for review and recommendations.</p>		

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F 334	<p>Continued From page 25</p> <p>immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy review, the provider failed to ensure 3 of 12 sampled residents (2, 11, and 12) had received the pneumococcal vaccination (vaccine to prevent pneumonia) upon admission to the facility which could result in the increased risk of contracting pneumonia. Findings include:</p> <p>1a. Review of resident 2's medical record revealed she had: *An admission date of 9/10/15. *A 9/10/15 physician's order to "Administer pneumococcal vaccine if eligible." *No documentation to support she received or declined a pneumococcal vaccination from the provider after she had been admitted.</p> <p>b. Review of resident 12's medical record revealed she had: *An admission date of 7/20/15. *A 7/20/15 physician's order to "Administer pneumococcal vaccine if eligible." *No documentation to support she received or declined a pneumococcal vaccination from the provider after she had been admitted.</p> <p>c. Interview on 9/30/15 at 10:55 a.m. with the infection control and licensed practice nurse (LPN) C revealed:</p>	F 334		

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F 334	<p>Continued From page 26</p> <p>*She had:</p> <p>*Confirmed the above resident's had not received a pneumococcal vaccination upon admission.</p> <p>*A list of resident's who were eligible to receive the pneumococcal vaccination.</p> <p>*Recently started to review that list.</p> <p>Interview on 9/30/15 at 10:58 a.m. with the director of nursing (DON) revealed:</p> <p>*She confirmed the above residents had not received or declined a pneumococcal vaccination upon admission.</p> <p>*The admission nurse was responsible for ensuring the residents had received a pneumococcal vaccination upon admission.</p> <p>*A part of the infection control nurse's responsibilities was to follow-up on the residents' immunizations.</p> <p>Surveyor: 32332</p> <p>2. Review of resident 11's medical record revealed she had:</p> <p>*An admission date of 6/2/15.</p> <p>*A 6/2/15 physician's order to "Administer pneumococcal vaccine if eligible."</p> <p>*No documentation to support she had received (or declined) a pneumococcal vaccination after she had been admitted.</p> <p>Interview on 9/30/15 at 9:40 a.m. with the infection control nurse revealed:</p> <p>*She had confirmed resident 11 had not received the pneumococcal vaccine.</p> <p>*The staff were obtaining a list of residents who had not yet received the vaccination.</p> <p>*When the list was completed all those residents would receive the vaccination.</p> <p>*She had been told by the pharmacy the</p>	F 334		

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F 334	Continued From page 27 pneumococcal vaccine could only have been purchased in multi-dose vials. *It would have been too expensive to order the vaccine for one resident at a time, because the provider would have to dispose of the remaining doses if they had not been used in a timely manner. *The provider's standing policy had been for the resident to receive the vaccine on admission if they chose to have it. Review of the provider's revised February 2015 Immunizations for Residents procedure revealed the resident's current immunization status for pneumococcal vaccination should have been assessed.	F 334		
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	F 441	F441-Infection control, Prevent spread, Linens SS=D Education provided to CNA member F and all other CNAs to provide proper hygiene and hand washing as well as glove use during personal cares. A mandatory CNA meeting will be held on October 28th and 29th. Audits will be performed bi-weekly x2 monthly x2 quarterly x1 by QAPI coordinator or designee and audit findings will be presented to monthly QAPI meetings for review and recommendations. *See next page	10/23/15 JK/SDDOH/EL *AVE (5) JK/SDDOH/EL *on residents *to include resident #2. *to include resident #2 JK/SDDOH/EL *to include resident #2 JK/SDDOH/EL

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F 441	<p>Continued From page 28</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</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: 32355 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for one of three sampled residents (2) who was received personal care by one of three observed certified nursing assistants (CNA) (F). Findings include:</p> <p>1. Observation on 9/29/15 at 1:15 p.m. of CNA F during personal care for resident 2 revealed: *The resident had been in her room sitting in her wheelchair (w/c). *With clean gloves she had: -Placed a gait belt (type of belt put on the resident to assist with transfers) on the resident and assisted her into the bathroom. -Pulled down her pants and disposable brief, and sat her on the toilet. -Turned on the water faucet by touching the dirty</p>	F 441	<p>*Audits will be completed to ensure proper handwashing and glove use during personal cares on residents and proper linen handling is used.</p> <p>JK/SDDOHT/EL</p>		

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F 441	<p>Continued From page 29</p> <p>handles.</p> <p>-Wet two clean washcloths under the running water.</p> <p>-Turned the water faucet off by touching the dirty handles.</p> <p>-Cleansed the resident's perineal (personal) area and bottom with disposable wet wipes after she had finished going to the bathroom.</p> <p>-Pulled on her disposable brief and pants, and sat her down in the w/c.</p> <p>*With those soiled gloves CNA F had:</p> <p>-Turned on the water faucet, wet a clean washcloth, and put soap inside of the wet washcloth.</p> <p>-Gave that washcloth to the resident to wash her hands.</p> <p>-Assisted the resident to lay down in her bed.</p> <p>-Removed her gloves.</p> <p>-Retrieved a blanket from the bed and covered the resident with it.</p> <p>*CNA F had not removed her gloves or sanitized her hands during the entire process of assisting the resident with personal care.</p> <p>Interview on 9/29/15 at 1:30 p.m. with CNA F confirmed she had assisted resident 2 with personal care in an unsanitary (clean) manner.</p> <p>Interview on 9/29/15 at 4:30 p.m. with the director of nursing confirmed the above care had been performed by the CNA in an unsanitary manner. She would have expected the CNA to remove her gloves and wash her hands after performing a task that had soiled her gloves. She agreed there had been the potential of cross-contamination of bacteria to be transmitted from one resident to another.</p> <p>Review of the provider's November 2014 Hand</p>	F 441		

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F 441	Continued From page 30 Hygiene and Handwashing policy revealed no procedure in place for the staff to follow while assisting the residents with personal care.	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/29/15. Good Samaritan Society Canton was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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

Myra Mork

TITLE

Administrator

(X6) DATE

10/23/15

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.

OCT 26 2015

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10604	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/30/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1022 N DAKOTA AVENUE CANTON, SD 57013
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S 000	<p>Initial Comments</p> <p>Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/28/15 through 9/30/15. Good Samaritan Society Canton was found in compliance.</p>	S 000		

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

Myron More

TITLE

Administrator

(X6) DATE

10/23/15