

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

ORIGINAL

PRINTED: 03/04/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2015
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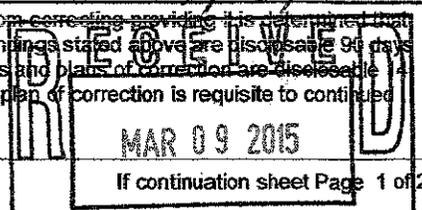
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/27/15 through 1/29/15. Good Samaritan Society Canistota was found not in compliance with the following requirement(s): F221, F226, F314, F315, F329, and F431.</p> <p>F 221 SS=D 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to complete quarterly assessments for the use of a restraint for one of one sampled resident (5). Findings include:</p> <p>1. Review of resident 5's 8/7/14 and 11/3/14 Minimum Data Set (MDS) assessments revealed she had a restraint in her chair that prevented her from rising.</p> <p>Review of resident 5's 11/14/14 care plan revealed the restraint had been her lift chair in her room. The staff elevated her legs for pain control, and she was unable to operate the controller to put the recliner down.</p> <p>Review of resident 5's medical record revealed</p>	F 000	<p>Initial Comments Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with Section 7305 of the State Operations Manual.</p> <p>F 221 Right to be free of Physical Restraints 1. For resident #5 the facility completed the Physical Device Restraint Review UDA on 2/5/2015. The team determined this to be a restraint due to resident's inability to control the lift chair independently. The</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>Dylan Spil</i>	TITLE Administrator	(X6) DATE 3/6/15
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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 disposable 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 disposable 45 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 221	Continued From page 1 she had a Physical Restraint Assessment completed on 11/21/13. There should have been four completed restraint assessments since 11/21/13, but there had only been one undated assessment done.  Interview on 1/28/15 at 9:40 a.m. with the interim director of nursing regarding resident 5 revealed: *She was able to push herself up from a sitting position. *They had used the lift chair to elevate her legs for pain control. *She was not able to use the controller to put down the recliner if she had wanted to get up. *The Physical Restraint Assessments should have been completed at least quarterly.  Review of the provider's August 2014 Restraints: Physical policy revealed the interdisciplinary team or reduction committee should have completed the Physical Device and Restraint Review quarterly.	F 221	interdisciplinary team will review this with each MDS. The care plan reflects the lift chair as a physical restraint and close observation of the resident while in the chair. 2. For all other potential residents the licensed nurse will complete the Physical Device-Restraint Assessment UDA upon admission or prior to adding or placing a physical device to determine if it is a restraint. If a restraint is determined necessary the licensed nurse will notify the physician with rationale and obtain an order. The licensed nurse will obtain permission from responsible party.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, incident report review, interview, and policy review, the provider failed to thoroughly investigate:	F 226			

2A

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28

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, incident report review, interview, and policy review, the provider failed to thoroughly investigate:	F 226	F226 Development/Implementation of Abuse and Neglect policies. 1. For resident # 14 and #15- the facility is not able to go back and correct the unwitnessed fall investigation noted in this citation. The care plans reflect the residents are at risk for falls with measurable goals and interventions.		

20

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226	<p>Continued From page 2</p> <p>*An unwitnessed fall for one of one resident (14) with multiple bruises and a skin tear to her left hand.</p> <p>*An unwitnessed fall for one of one resident (15) where he stated he had been lying on the floor for an hour.</p> <p>Findings include:</p> <p>1. Review of a 12/29/14 incident report regarding resident 14 revealed:</p> <p>*The resident's right eye had been black and blue.</p> <p>*She had bruises on her right breast and right hip along with a skin tear on her left hand.</p> <p>*She stated she had fallen last night when getting ready for bed, and she had hit her head on the sink.</p> <p>*She had gotten up by herself.</p> <p>*When asked if staff had helped her get ready for bed she replied no one had assisted her.</p> <p>*She had been oriented to person, place, situation, and time.</p> <p>Review of resident 14's 10/22/14 Minimum Data Set (MDS) assessment revealed:</p> <p>*She needed extensive assistance from one staff person with dressing, toilet use, and personal hygiene.</p> <p>*Her cognition (thinking) ability was severely impaired.</p> <p>Review of the 12/29/14 Investigation report for the above incident revealed:</p> <p>*Four staff had been listed for having had worked with resident 14 in the past seventy-two hours.</p> <p>-None of those staff had been interviewed.</p> <p>*There was no information as to why no one had assisted her with getting ready for bed when she had required extensive assistance of one staff</p>	F 226	<p>2. For all other potential residents the facility will ensure the incident report has been completed and the GSS #415 Investigation has been completed for all incidents. The administrator and interdisciplinary team will review the incident and determine the investigation to include the; who, what, where, why, how and when with a summary of conclusion.</p> <p>3. IN-SERVICE: Education will be provided by the administrator/ designee for staff to include GSS policy and procedure for Incident Reports, Investigation and reporting. The directed in-service guidelines in the 2567 with the WHO, WHAT, WHERE, HOW and WHEN with summary of conclusions will be included in the education.</p> <p>4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly x 4 weeks and monthly x 4 months. The DNS is responsible to ensure the audits will include GSS 415 investigation has been completed with use of the probe questions of WHO was involved, WHAT took place, WHEN did the</p>	2/24/15

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F 226	<p>Continued From page 3</p> <p>person. *There was no information regarding the last time she had been assisted to the bathroom. *There was no documentation in regards to a determination of how she had gotten the bruises and the skin tear.</p> <p>2. Review of a 12/24/14 incident report regarding resident 15 revealed: *He had been found laying on the floor in his room. *He stated he had been lying there for an hour. *He had attempted to get undressed and had fallen onto his bottom and lower back. *He had been oriented to person, place, situation, and time. *No injuries had been noted.</p> <p>Review of resident 15's 12/2/14 MDS assessment revealed: *He needed extensive assistance from one staff person with dressing, toilet use, and personal hygiene. *He had no identified cognition problems.</p> <p>Review of the 12/24/14 Investigation report for the above incident revealed: *Eight staff had been listed for having had worked with resident 15 in the past seventy-two hours. -None of those staff had been interviewed. *The report had been completed at 1:00 a.m. *There was no information as to why staff had not been assisting him with getting undressed when he needed extensive assistance from one staff person. *There was no information regarding the last time he had been assisted to the bathroom.</p> <p>3. Interview on 1/28/15 at 2:15 p.m. with the</p>	F 226	<p>event occur, WHERE did the event occur, WHY did the incident occur, HOW did the incident occur a conclusion summary and if necessary the debriefing for root cause and PDSA with team. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root cause.</p>		

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F 226	Continued From page 4 interim director of nursing regarding investigations for the incidents mentioned above revealed: *They had not interviewed staff regarding the above incidents. *She agreed they had not thoroughly investigated the situations to prove there had been no neglect. *There had been no other documentation in the residents' medical records.  Review of the provider's September 2013 Abuse and Neglect policy (II.A.1) revealed "Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law."  Review of the provider's June 2014 Abuse and Neglect policy (II.A.1a) revealed: *The investigation team would review incidents no later than the next working day following the incident. *The investigation team would determine whether further investigation was needed. *The investigation might include interviewing staff, residents, or other witnesses about the incident. *The investigation would have been documented on the Investigation form 415.	F 226			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314	F 314 Treatment/Services to prevent/Heal pressure ulcers 1. For resident # 7- Resident has a pressure relieving mattress and gel cushion placed in the wheelchair. The care plan reflects frequent		

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F 314	<p>Continued From page 5 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Educate staff on how to identify a pressure ulcer and appropriately assess, monitor, and intervene for two of two residents (7 and 8) with pressure ulcers obtained after admission into the facility. *Appropriately assess or put interventions in place for two of two sampled residents (4 and 12) who were at risk for developing pressure ulcers. Findings include:</p> <p>1: Observation and interview on 1/27/15 p.m. at 2:00 p.m. with resident 8 revealed she: *Was in a wheelchair. *Was overweight. *Was dependent on staff for transfers from one surface to another. *Had a pressure ulcer on her bottom for "about a month or so." *Stated occasionally the pressure ulcer on her bottom had caused her pain. *Had no pressure relieving mattress on her bed or pressure relieving cushion in her wheelchair.</p> <p>Review of the resident 8's medical record revealed: *She was admitted on 3/11/13. *She had diagnoses of a brain injury, epilepsy, a blood clot, a history of a pressure ulcer, obesity, and bipolar disorder (psychiatric disorder).</p>	F 314	<p>re-positioning by staff. The wound data collection tool-UDA will be completed daily by the licensed nurse. The wound RN assessment UDA will be completed weekly. The wound RN will complete measurements and document progression weekly and notify physician when needed. For resident # 8-Resident has a pressure relieving mattress and gel cushion in chair. The care plan reflects frequent re-positioning by staff. The wound data collection tool UDA will be completed daily by the licensed nurse. The wound RN assessment UDA will be completed weekly and include measurement and notification to the physician when needed. For resident # 4-Resident has a pressure relieving mattress and gel cushion in chair. The physician has documented this is a chronic wound that will like not completely resolve. The care plan reflects frequent re-positioning. The wound data collection tool UDA will be completed daily by the licensed nurse and the wound RN assessment UDA will be completed by the RN weekly and include measurements</p>	

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F 314	<p>Continued From page 6</p> <p>*She was diagnosed with a new pressure ulcer on 12/14/14.</p> <p>*Her care plan revealed:</p> <ul style="list-style-type: none"> <li>-She required the use of a stand-aide and assist of two staff for transferring from one surface to another.</li> <li>-Staff were to avoid positioning her on her left side because of her pressure ulcer on her left buttock.</li> <li>-Nursing staff were to "assess/record/monitor wound healing daily with a weekly registered nurse (RN) assessment. Report improvements and declines to the healthcare provider."</li> <li>-No other interventions were documented on the care plan to prevent her current pressure ulcer from worsening or from her developing new pressure ulcers.</li> </ul> <p>*Her Braden score (used to identify residents at risk for skin breakdown) revealed:</p> <ul style="list-style-type: none"> <li>-A score of 14. That placed her at moderate risk.</li> </ul> <p>*Interventions for a score of moderate risk (shown in the provider's Braden scale form) that were to have been used were:</p> <ul style="list-style-type: none"> <li>-"Frequent turn with a repositioning schedule.</li> <li>-Pressure reduction support.</li> <li>-Maximal remobilization.</li> <li>-Protect heels.</li> <li>-Manage moisture and nutrition.</li> <li>-Manage friction and sheer (movement of the body that may cause skin to develop pressure ulcers)."</li> </ul> <p>*Her current medication administration record (MAR) revealed a DuoDerm dressing (a protective dressing for wounds). Apply to left buttock every three days.</p> <p>Observation and interview on 1/28/15 at 9:00 a.m. of RN B providing wound care to resident 8 revealed:</p>	F 314	<p>and notification to the physician when needed.</p> <p>For resident # 12-Resident has pressure relieving mattress and gel cushion in chair.</p> <p>2. For all other potential residents the wound data collection tool UDA will be completed daily by all of the licensed nurses on any resident who has a wound, this would include all wounds except rashes, bruises and skin tears.</p> <p>The wound data collection tool will be completed daily by the all of the licensed nurses and the wound RN assessment will be completed weekly by the RN with measurements and notification to the physician when needed. It was determined to establish a wound team to do wound rounds weekly which will include assessment, measurement and monitoring of the wound progression. This will be completed the day prior to physician rounding so the physician has the availability to also assess the wound or change treatments. The wound team will also work with staff on prevention, appropriate cushions and re-positioning interventions.</p>		

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F 314	<p>Continued From page 7</p> <p>*The resident had just finished toileting.</p> <p>*She observed one new pressure ulcer area making a total of two pressure ulcers. RN B was not aware of the second pressure ulcer area before that day.</p> <p>*RN B had not measured those areas but had approximated their size to have been 3 centimeters (cm) by 2 cm and 3 cm by 1 cm.</p> <p>*She staged them (used to describe severity of ulcers on a scale from one to four with four being the worst) as a stage II (a blistered area only effecting the outermost layer of the skin) pressure ulcer.</p> <p>*The resident's skin on her lower buttocks had a gray bruised color (the beginning stages of possible deep tissue injury).</p> <p>Interview later that day at 4:00 p.m. with RNs A and B regarding resident 8's pressure ulcers revealed:</p> <p>*The wound was noted in the documentation as a pressure ulcer.</p> <p>*They had not documented size of the pressure ulcer except when it had first appeared on 12/14/14 as they understood it (the pressure ulcer) was just a blister. "We only document if it is listed as a pressure ulcer."</p> <p>*Neither RN were able to describe what a pressure ulcer was when asked.</p> <p>*When asked about what the significance of the gray bruised color may be, they were unsure.</p> <p>*They had not reported any pressure ulcer treatment progress or decline to the physician. They "don't have to report it if we think its not a pressure ulcer."</p> <p>Review of resident 8's Wound Data Collection and Wound RN assessments revealed:</p> <p>*The wound was first discovered on 12/14/14.</p>	F 314	<p>3. IN-SERVICE: Education will be provided by the DNS/Staff Development Nurse to nursing staff. In house education completed by 2/24/15. The education will include GSS policy and procedure for Skin and Wound Management, Wound data collection completion, the Wound RN assessment and implementing the Wound Team. The facility will also bring in a Wound Care Specialist from American Medical Technologies to provide education to all nurses the week of March 16th.</p> <p>4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly x 4 weeks and monthly x 4 months. The audit will include completion of wound data collection tool UDA daily by the licensed nurse, Wound RN Assessment UDA weekly by the RN to include measurements and wound progression with physician notification, Care plan updates with interventions and re-positioning and pressure relieving devices. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations and identifying root causes.</p>	2/24/15	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2015</b>
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F 314	<p>Continued From page 8</p> <p>*At that time it had measured 1 cm by 0.5 cm with a depth of 0.1 cm.</p> <p>*A note was placed in the assessment by the nurse that stated "protective ointment applied, will fax MD (medical doctor) to notify for further treatment."</p> <p>*Further assessments dated 1/5/15, 1/12/15, and 1/19/15, revealed the resident's wound was described as a pressure ulcer. No measurements were documented by nursing staff from 12/14/14 through 1/28/15.</p> <p>2. Observation on 1/27/15 at 10:15 a.m. of resident 7 in the dining room revealed:</p> <p>*The resident was in a wheelchair.</p> <p>*She was being fed by an unidentified staff member.</p> <p>*She was unable to speak.</p> <p>Review of resident 7's medical record revealed:</p> <p>*She was admitted on 6/1/12.</p> <p>*She had diagnoses of Alzheimer's, adult failure to thrive, and a history of an open wound to her buttocks.</p> <p>*Her most recent ulcer was found on 10/18/14.</p> <p>*Her care plan revealed:</p> <p>-She required two staff members for assistance with turning and repositioning.</p> <p>-"Total assistance for personal hygiene care."</p> <p>-A "gel mattress overlay to bed."</p> <p>-"Turn and reposition in bed to offload pressure on a bony prominence."</p> <p>*There was no gel mattress overlay found on her bed.</p> <p>*There was no documentation in reference to how often she needed to be turned or repositioned by staff.</p> <p>*Her Braden score on 1/17/15 revealed:</p> <p>-It was 12. She was at high risk for the</p>	F 314		

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

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F 314	<p>Continued From page 9</p> <p>development of pressure ulcers.</p> <p>-Interventions for a score of high risk (shown in the provider's Braden scale form) that were to have been used were:</p> <p>-"Frequent turn with a planned repositioning schedule.</p> <p>-Pressure reduction support.</p> <p>-Maximal remobilization.</p> <p>-Protect heels.</p> <p>-Manage moisture and nutrition.</p> <p>-Manage friction and shear."</p> <p>Observation on 1/28/15 at 9:25 a.m. of RN B providing wound care to resident 7 revealed:</p> <p>*She had a pressure ulcer on her left lower buttocks. Skin surrounding the ulcer was pink in color.</p> <p>*RN B had not measured the area but had approximated it's size to have been measured 1.5 cm by 1 cm, a Stage II pressure ulcer.</p> <p>3. Observation on 1/28/15 at 9:45 a.m. of RN B providing wound care to resident 4 revealed:</p> <p>*There were numerous open areas on his buttocks that were bright red in color.</p> <p>*Surrounding that area of skin on his lower buttocks was a gray bruised color (the beginning stages of possible deep tissue injury).</p> <p>*RN B remarked although he had open areas before "they weren't this bad yesterday. We use vinegar soaks on his bottom twice a day."</p> <p>*She then applied a barrier cream to his buttocks.</p> <p>Review of resident 4's medical record revealed he:</p> <p>*Was admitted on 9/7/06.</p> <p>*Had diagnoses of dementia (mental confusion), contact dermatitis and eczema (skin conditions) hypoxemia (low levels of oxygen in blood).</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>*Had orders for vinegar soaks twice daily related to eczema.</li> <li>*Had a physician's order for Ketoconazole cream (an anti-fungal cream) to his coccyx (tailbone) area twice daily.</li> <li>*Required the assistance of two staff for transfers between bed and his wheelchair with the use of a stand-aide.</li> <li>*Had areas of concern on his care plan that included:               <ul style="list-style-type: none"> <li>-Provide a pressure relieving mattress.</li> <li>-Notify nurse immediately of new areas of skin breakdown.</li> <li>-Encourage reposition or offload (relieve pressure) every shift.</li> <li>-Use stand aide for transfers and Hoyer [total assist lift] for bath and weights."</li> </ul> </li> <li>*Scored a 17 on his Braden scale. That placed him at mild risk for developing pressure ulcers.</li> <li>*Interventions for a score of mild risk (shown in the provider's Braden scale form) that were to have been used were:               <ul style="list-style-type: none"> <li>-Frequent turn (example every two hours).</li> <li>-Pressure reduction support.</li> <li>-Maximal remobilization.</li> <li>-Protect heels.</li> <li>-Manage moisture and nutrition.</li> <li>-Manage friction and sheer."</li> </ul> </li> </ul> <p>Review of resident 4's interagency orders from his re-admission back to the facility from a brief hospital stay dated 4/24/14 revealed:</p> <ul style="list-style-type: none"> <li>*"He was at risk for skin breakdown.</li> <li>*Nurses were to assess bony prominences.</li> <li>*Turn and reposition the resident every two hours.</li> <li>*Protect his skin, keep it clean and dry.</li> <li>*Use a moisture barrier for incontinence.</li> <li>*Use a specialty bed or air mattress per facility protocol."</li> </ul>	F 314			

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

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F 314	<p>Continued From page 11</p> <p>4. Observation and interview on 1/28/15 at 1:30 p.m. and again on 1/29/15 at 9:00 a.m. with resident 12 revealed she:</p> <ul style="list-style-type: none"> <li>*Had been able to use her arms but was paralyzed (unable to move) from the lower chest/high waist down to her feet.</li> <li>*Had been a resident at the facility for "a long time."</li> <li>*Would get tired easily as she had a tracheostomy (opening in her neck used to breath), was overweight, and was limited in upper body muscle strength.</li> <li>*Was unable to reposition herself and required assistance from staff to do so.</li> <li>*Would be able to feel the urge to pass urine but was unable to hold it. She "usually" needed her sheets changed due to wetness from urine incontinence.</li> </ul> <p>Review of resident 12's medical record revealed:</p> <ul style="list-style-type: none"> <li>*She had been admitted on 2/8/96.</li> <li>*Diagnoses of diabetes with neurological (sensory limitations in extremities complications, acute respiratory failure, schizophrenia (mental illness), and paraplegia (paralysis to the lower half of the body).</li> <li>*Her care plan included: <ul style="list-style-type: none"> <li>- "Two staff person assist with a Hoyer lift to transfer."</li> <li>- "Requires complete assist with personal hygiene care."</li> <li>- "Encourage resident to reposition or assist to reposition frequently when in bed."</li> </ul> </li> <li>*Her Braden score dated 11/10/14 was 18. That showed mild risk.</li> </ul> <p>Interview and medical record review on 1/29/15 at 9:25 a.m. with the Minimum Data Set (MDS)</p>	F 314			

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

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FORM APPROVED  
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F 314	<p>Continued From page 12</p> <p>coordinator regarding the accuracy of resident 12's Braden score revealed:</p> <p>*Under the category of sensory she had listed a number 4 which indicated no impairment.</p> <p>*She agreed that was inaccurate and should have been a number 2, very limited (sensory impairment that limited the ability to feel pain or discomfort in one half of the body.)</p> <p>*She had scored her as a number 4 under moisture as rarely moist.</p> <p>*She agreed that was inaccurate as the resident was incontinent of urine and should have been scored a number 3 for occasionally moist.</p> <p>*Under mobility she had scored the resident as a number 3 which was slightly limited.</p> <p>*She agreed the resident was dependent on staff for repositioning and at best would score a number 2 with limited mobility with ability to make slight changes in body position.</p> <p>*She agreed the resident should have accurately been assessed at a score of 13 or 14 which would have placed her at moderate risk.</p> <p>5. Interview and policy review on 1/29/15 at 10:00 a.m. with the interim director of nursing (DON) and the administrator regarding the above residents revealed:</p> <p>*There had been no formal position for a wound care nurse at the facility.</p> <p>*The DON had not seen the pressure ulcers on residents 7 and 8.</p> <p>*She had been the wound care nurse at another facility she was currently serving at.</p> <p>*It had been her expectation staff would have followed policy and procedures related to pressure ulcers.</p> <p>*The nurses were given education on pressure ulcer policies since the prior survey in July 2014.</p> <p>*It had been the administrator's expectation that</p>	F 314		

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

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FORM APPROVED  
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F 314	<p>Continued From page 13</p> <p>nursing staff would identify, report, monitor, and intervene with regard to pressure ulcers, and pressure ulcer prevention for those at risk. *It was the DON's expectation nursing staff were to report progress or decline of any wound treatment to the physician after two weeks of treatment.</p> <p>Review of the educational inservice on 8/22/14 through 8/26/14 revealed the purpose was to update and educate staff on policies and procedures relating to wound care and the update to the care plan. RN B was not listed on the staff identifier to have attended that inservice training. RN A was in attendance.</p> <p>Review of the provider's updated June 2014 Skin Assessment and Pressure Ulcer policy revealed: *"Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan. *Developing an individualized repositioning schedule is recommended based on observations to the resident's skin. *Any resident at risk will be placed on a pressure redistribution surface. *The RN should record the type of wound and the degree of tissue damage on the wound RN assessment. The nurse records the location, type, and measurements on the wound data collection form. *The interdisciplinary team should determine any modifications that are necessary to the resident's plan of care. *When a pressure ulcer is present, daily monitoring should include the following: -An evaluation of the ulcer. -The status of the surrounding area of the ulcer. -The presence of possible complications.</p>	F 314		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	Continued From page 14 -Whether pain is present. -The ulcer should show signs of improvement within two to four weeks. -At a minimum the pressure ulcer should be evaluated at least weekly and documented on the Wound RN Assessment form. This should include measurements, characteristics, pain, current treatments. *If the ulcer is not showing any signs of healing, the interdisciplinary team and the physician should make modifications to the treatment plan. *Consider a referral to a wound care specialist and a discussion with the medical director."  Review of the provider's updated June 2014 Pressure Ulcer Practice Guidelines revealed: *"If the pressure ulcer does not show some evidence of progress toward healing after fourteen days, the pressure ulcer/wound and the resident's overall condition should be re-evaluated. *Suspected deep tissue injury may be purple localized area of discolored intact skin due to damage of the underlying soft tissue from pressure and/or sheer. Evolution may be rapid."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 No Catheter/prevent UTI 1. For resident # 4- the catheter was discontinued due to a urinary stricture. The resident was subsequently hospitalized and catheter was placed for the stricture. 2. For all other potential residents the facility will ensure the medical diagnosis meets the need for an indwelling catheter and continual	

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F 315	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and record review, the provider failed to: *Have an appropriate diagnosis for the insertion (to put in) of urinary catheter (tube inserted into the bladder through the urethra). *Have supporting documentation for the continued use of a urinary catheter for one of one sampled resident (4). Findings include:</p> <p>1. Observation on 1/28/15 at 9:45 a.m. of resident 4 revealed *He had a urinary catheter. *He had numerous open areas on his buttocks.</p> <p>Review of resident 4's medical record revealed: *He was admitted on 9/7/06. *He had a physician's order dated 8/13/14 to insert a urinary catheter for a diagnosis of skin breakdown on his buttock area that was not thought to be pressure related. *He had been re-evaluated by the physician on 12/10/14. In the physician's notes it had been documented "chronic indwelling Foley (typer of catheter) catheter for skin issues." *He had a history of chronic diarrhea. *His ulcers had not healed after the insertion of the Foley catheter on 8/13/14.</p> <p>Interview and policy review on 1/29/15 at 10:00 a.m. with the director of nursing (DON) regarding the above resident's urinary catheter revealed: *The DON stated the urinary catheter was placed in an effort to heal his buttock wounds. *She agreed they had not healed in the presence</p>	F 315	<p>use of a catheter.</p> <p>3. IN-SERVICE: Education will be provided by the DNS/Staff Development Nurse for the nursing staff with GSS policy and procedure for catheter appropriate use of indwelling catheter with medical diagnosis.</p> <p>4. AUDITS: The DNS/QAPI Nurse/designee will complete audits weekly x 4 weeks and monthly x 4 months. Audit to include appropriate medical diagnosis which supports the need for an indwelling catheter. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations.</p>	2/24/15

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F 315	Continued From page 16 of the urinary catheter. *There was no medical diagnosis to support the continued use of the urinary catheter.	F 315			
F 329 SS=D	<b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, and interview, the provider failed to: *Have an appropriate diagnosis, identify	F 329	F 329 Drug regimen is free of un-necessary drugs. 1. For resident #1 the Seroquel had been discontinued. Policy and procedure followed before implementing new order on 2/26/15. AIMS was performed on 2/25/15 before starting Seroquel. Daily behavior charting is being completed for day and night shift for 4 weeks. The care plan reflects individualized behaviors and interventions. Resident #10 has expired. 2. For all other potential residents the facility will ensure an appropriate diagnosis and individualized behaviors meet the need for antipsychotic medication use. Non-pharmacological interventions will be attempted prior to medication use. The nursing staff will observe behaviors and notify the physician of behaviors and rationale for medication need. The AIMS will be completed prior to administering the medication. Documentation will		

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F 329	<p>Continued From page 17</p> <p>appropriate behaviors, and complete the Antipsychotic Assessment prior to starting her on Seroquel (an antipsychotic medication which can alter behaviors and the thought process) for one of one sampled resident (1) admitted in the past six months.</p> <p>*Document and monitor individualized behaviors for one of one sampled resident (10) on psychotropic medications (any medication capable of affecting the mind, emotions, and behaviors).</p> <p>Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She had an admission date of 7/28/14. *Her diagnoses upon admission were: -Acute confusional state. -Urinary tract infection. -Vulnerable elderly person. -Hypertension. -Depression. -Breast Cancer. -Post Menopausal. *On 7/30/14 (two days after her admission) there was physician's order for the following: -"Please add dementia for diagnosis." -"Seroquel 25 mg [milligram] tablet 1/2 tab PO [orally] every hs [bedtime] for dementia with psychotic features." *There had been no documented behaviors listed on that physician order regarding the need for the Seroquel.</p> <p>Review of resident 1's interdisciplinary notes from 7/28/14 through 8/27/14 revealed: *On 7/28/14 she was "alert to self with confusion," was unsure why she was in the facility, and made statements of leaving. A Wanderguard (a device</p>	F 329	<p>be completed to support appropriate diagnosis for the medication and if the medication has been discontinued for a specific reason. The care plan will reflect the individualized behaviors, the medication regimen and the interventions. The medications will be reviewed collaboratively with the nursing department, pharmacist and physician.</p> <p>3. IN-SERVICE: Education will be provided by the DNS/Staff Development Nurse for the nursing department. The education will include the GSS policy and procedure for psychotropic mediations, psychopharmacological medications and sedative/hypnotics, completion of the AIMS, documentation requirements and care planning.</p> <p>4. AUDITS: The DNS/QAPI Nurse/designee will complete the audits weekly x 4 weeks and monthly x 4 months. Audits will include accurate diagnosis for use of the psychotropic medications. Individualized behaviors are monitored with use of the psychotropic medications and AIMS has been completed prior to administering the medication. The</p>	2/24/15

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>		
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F 329	<p>Continued From page 18</p> <p>used for wander management) had been placed on her wrist.</p> <p>*On 7/29/14 she was "alert to self with confusion" and spent the "shift wandering into others rooms looking for her bed." She had attempted to exit a door but was "easily re-directed back to her room."</p> <p>*On 7/30/14 she was "confused at times" and "pleasant with staff."</p> <p>*There were no other behaviors noted in the documentation.</p> <p>*From 8/1/14 through 8/27/14 it had been documented twenty-nine times she had wandered.</p> <p>*There had been no documentation of attempts to help the resident adjust to her new surroundings.</p> <p>Review of the Initial Antipsychotic Medication Assessment form revealed:</p> <p>*It had been completed on 8/1/14 after the Seroquel had been started.</p> <p>*The medication being considered had been Seroquel 12.5 mg at bedtime.</p> <p>*The specific diagnosis requiring the antipsychotic was dementia.</p> <p>*Symptoms or Behaviors being treated were "wanting to go home, wandering into other residents rooms."</p> <p>*How the behaviors interfered with care stated "resident enters others rooms, which angers other residents."</p> <p>*Reassurance had been the only behavioral intervention attempted.</p> <p>Review of the pharmacy reports revealed Seroquel had been discontinued on 1/14/15 with no reason documented.</p> <p>Interview on 1/28/15 at 2:15 p.m. with the interim</p>	F 329	<p>care plan reflects the individualized behaviors and interventions.</p> <p>The DNS/QAPI Nurse/designee is responsible for completing the audits and submitting the findings to the QAPI committee for further recommendation and identifying root cause.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>		
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F 329	<p>Continued From page 19</p> <p>director of nursing (DON) revealed: *The Initial Antipsychotic Medication Assessment should have been completed prior to the start of Seroquel. *She would have expected staff to observe the resident's behaviors for at least one week before starting new medication. *Wandering would not have been a reason to start resident 1 on Seroquel.</p> <p>Review of Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., Lexi-Comp Inc., Ohio, 2011, p. 1509, revealed: **"Elderly patients with dementia-related psychosis treated with antipsychotics are at an increased risk of death compared to placebo." **"Quetiapine [Seroquel] is not approved for the treatment of dementia-related psychosis."</p> <p>2. Interview on 1/28/15 at 4:00 p.m. with certified nursing assistant C revealed resident 10 was in his room in his underwear. She stated she had just found him in the hallway like that and had re-directed him back to his room. She stated that was one of his behaviors he demonstrated. He liked to undress and walk around the facility.</p> <p>Review of resident 10's January 2015 medication administration record revealed he was receiving the following psychotropic medications: *Clozapine (antipsychotic) 400 mg at 7:00 p.m. *Diazepam (antianxiety) 10 mg at 6:30 p.m. and 5 mg in the morning. *Lorazepam (antianxiety) 1 mg at 2:00 p.m. and 0.5 mg as needed. *Trazodone HCl (antidepressant) 200 mg at 7:00 p.m. *Zoloft (antidepressant) 100 mg in the morning.</p>	F 329			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>		
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F 329	<p>Continued From page 20</p> <p>Review of resident 10's 10/13/14 care plan revealed his targeted behaviors related to schizophrenia, bipolar disorder, anxiety, and depression were:</p> <ul style="list-style-type: none"> <li>*Pacing without regards for safety.</li> <li>*Repetitive questions.</li> <li>*Inappropriate dressing.</li> <li>*Disruptive behaviors during activities.</li> </ul> <p>Review of resident 10's behavioral documentation revealed those individualized behaviors listed above were not being documented or monitored.</p> <p>Interview on 1/29/15 at 9:15 a.m. and at 9:30 a.m. with the interim DON and the social services designee regarding resident 10 revealed:</p> <ul style="list-style-type: none"> <li>*They had not been monitoring those individualized behaviors to determine if the psychotropic medications had been effective.</li> <li>*They were unable to determine how to input the individualized behaviors into the computer system for monitoring purposes.</li> </ul> <p>A policy on behavioral documentation had been requested from the interim DON but had not been provided by the time the team exited on 1/29/15 at 11:45 a.m.</p>	F 329			
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p>	F 431	<p>F 431</p> <p>Drug Records/label and Storage</p> <ol style="list-style-type: none"> <li>1. The medication refrigerator was defrosted and adjusted to the correct temperature range. The medication refrigerator temperatures are checked daily.</li> <li>2. The updated log that is used states the acceptable temperature range of</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>		
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F 431	<p>Continued From page 21</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, temperature log review, and policy review, the provider failed to consistently maintain appropriate medication refrigerator temperatures for one of one medication refrigerators. Findings include:</p> <p>1. Observation and interview on 1/28/15 at 8:00 a.m. with registered nurse (RN) B in the medication room revealed: *Temperature recorded on the medication</p>	F 431	<p>of 36 – 46 degrees Fahrenheit. A back up thermometer is placed to re-check temperatures if out of acceptable range. The nurse will notify maintenance department if the temperatures are not in range or if adjusting the temperature controls of the refrigerator do not correct the temps.</p> <p>3. IN-SERVICE: The nursing staff has been educated by DNS as to the updated log and the acceptable temperature ranges.</p> <p>4. AUDITS: The DNS/QAPI Nurse/designee will complete the audits weekly x 4 weeks and monthly x 4 months. The audit will include temperatures meet the acceptable temperature ranges and if the refrigerator was adjusted and the temperatures corrected. The DNS/QAPI Nurse/designee is responsible to submit the audit findings to the QAPI committee for further recommendations.</p>	2/24/15	

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

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY CANISTOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012		
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F 431	<p>Continued From page 22</p> <p>refrigerator log for January 1 through 27, 2015 had nine days logged by nursing staff that temperatures were at or below freezing.</p> <p>*Those days temperatures were recorded as follows:</p> <ul style="list-style-type: none"> <li>-January 4, 32 degrees F.</li> <li>-January 5, 32 degrees F.</li> <li>-January 13, 28 degrees F.</li> <li>-January 14, 28 degrees F.</li> <li>-January 15, 31 degrees F.</li> <li>-January 16, 31 degrees F.</li> <li>-January 19, 22 degrees F.</li> <li>-January 20, 30 degrees F.</li> <li>-January 26, 32 degrees F.</li> </ul> <p>*RN B stated she "thought the temperatures were okay because the (log) sheet says 'Refrigerators must be 41 degrees or below'."</p> <p>Review of the medications contained in the refrigerator revealed numerous stock insulins including Levemir, Novalog, and Lantus.</p> <p>Interview with the director of nursing (DON) later at 8:30 a.m. regarding the medication refrigerator log revealed:</p> <ul style="list-style-type: none"> <li>*She had been unaware of the below freezing temperatures that had been logged.</li> <li>*She would report to the consulting pharmacy for instructions regarding the medication in the refrigerator during the above temperature recordings.</li> </ul> <p>Interview later that same day with the DON at 3:30 p.m. regarding the medication refrigerator revealed the consultant pharmacist had advised them to discard all insulin medication contained in the refrigerator as it was ineffective. It was unknown if any of the insulin stored in the refrigerator had been removed and used for a</p>	F 431		

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

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>		
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F 431	Continued From page 23 resident.  Review of the provider's September 2012 Aquisition, Recieving, Dispensing and Storage of Medications policy revealed refrigerators holding medications (such as insulin) "will be kept between 36 degrees F and 46 degress F."	F 431		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/27/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>
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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/27/15. Good Samaritan Society Canistota was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/27/15 upon correction of the deficiencies identified below.  Please mark an "F" in the completion date column of those deficiencies identified as meeting the FSES to indicate the provider ' s commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers provide a minimum clear width of 32 inches (81cm) for swinging or horizontal doors. Vision panels are of fire-rated glazing or wired glass panels and steel frames. 19.3.7.5, 19.3.7.7  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on measurement and document review, the provider failed to maintain at least 32 inches of clear width for smoke barrier doors in the 100 and 200 wings. Findings include:	K 028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dylan Spul* TITLE *Administrator* (X6) DATE *2/18/15*

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.

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

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K 028	Continued From page 1 1. Measurement at 10:00 a.m. on 1/27/15 revealed the cross-corridor doors to the 100 wing measured 31 inches of clear width. Further measurement revealed the cross-corridor doors to the 200 wing adjacent to the nurses station measured 30 inches of clear width. Review of the previous life safety code survey confirmed those findings.  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028			
K 032 SS=C	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have a conforming exit. Findings include:  1. Observation at 10:30 a.m. on 1/27/15 revealed there was no conforming exit provided from the basement mechanical room. The only exit was a stair enclosure that discharged into the vestibule corridor system on the main level. Review of previous survey data also identified that condition.	K 032			

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY CANISTOTA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WEST MAIN ST CANISTOTA, SD 57012</b>
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K 032	Continued From page 2  The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 032		
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## South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2015
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOOD SAMARITAN SOCIETY CANISTOTA

700 W MAIN STREET  
CANISTOTA, SD 57012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments  Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/27/15 through 1/29/15. Good Samaritan Society Canistota was found in compliance.	S 000		

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



TITLE

Administrator

(X6) DATE

2/18/15