

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY DE SMET</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>411 CALUMET AVENUE NW DE SMET, SD 57231</b>	
(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	<b>INITIAL COMMENTS</b>  Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/6/15 through 1/7/15. Good Samaritan Society-DeSmet was found not in compliance with the following requirements: F157, F323, F325, F371, and F441.	F 000	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 provisions of federal and state law. For the purposes of any allegations that the center is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 157 SS=D	<b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b>  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	1. Unable to go back at this point and inform physician and family about the weight loss of resident #2. 2. Resident's family members and physicians will be notified with all significant changes in the resident's physical, mental, or psychosocial status promptly. Resident and family wishes and physician orders will then be implemented. 3. All Staff will be educated on 1/28/2015 and 1/29/2015 by the DNS on the importance of prompt notification to	

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

TITLE

(X6) DATE

*Hail Blocker*

*Administrator*

*1/28/15*

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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F 157	Continued From page 1  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to notify the physician of a significant weight loss for one of two sampled residents (2). Findings include:  1. Review of resident 2's 10/22/14 Minimum Data Set (MDS) revealed she had a 10 percent (%) weight loss in the past six months. The weight loss had not been physician ordered.  Review of resident 2's monthly weight records from 1/8/14 through 12/31/14 revealed her weight: *Had been declining since 4/30/14. *On 4/30/14, 123.2 pounds (lb). *On 5/28/14, 118 lb. *On 6/25/14, 117.2 lb. *On 7/30/14, 116.4 lb. *On 8/27/14, 112.6 lb. *On 9/17/14, 109 lb. *On 10/8/14, 106.6 lb. *On 10/22/14, 106 lb. -That had been a 13.96% weight loss. *On 12/31/14, 103.2 lb.  Review of resident 2's interdisciplinary progress notes revealed: *On 10/6/14 the registered dietician had identified a 13% weight loss from six months ago. *There had been no documentation the physician	F 157	physician and family when significant changes to a resident occur. 4. The DNS or designee will audit the medical records 24 hour report and the communication link to assess for any significant changes to resident status. The audit will include the notification to family and physician. These audits will be done weekly X4 and then monthly X3. The DNS or designee will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed. 5. Date complete 1/30/2015	1/30/2015

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F 157	Continued From page 2 had been notified on 10/6/14 of the significant weight loss.  Review of the 11/19/14 physician's note regarding resident 2 revealed Remeron (antidepressant medication) had been added on 10/14/14 to assist with her weight loss.  Interview on 1/7/15 at 1:15 p.m. with the director of nursing, MDS coordinator, and the medical records staff person (she had been the dietary manager until December 2014) regarding resident 2 revealed: *They had not notified the physician on 10/6/14 of the significant weight loss. *They were not able to locate any documentation of communication with the physician regarding the weight loss except for the 11/19/14 physician's note. *On 11/19/14 her weight had been 100.4 lb.  Review of the provider's September 2012 Weight Monitoring policy revealed the center should have immediately consulted with the resident's physician when there had been a significant change in the resident's weight.	F 157			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	1. All chemicals have been secured and not accessible to residents in the bath rooms, shower room, soiled utility rooms, nursing utility room and the housekeeping carts. 2. All odor elimination sprays, all disinfecting wipes or sprays, and cleaning chemicals will be stored away from resident bathing supplies. Chemicals in housekeeping carts will		

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F 323	Continued From page 3 This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, interview, and policy review, the provider failed to ensure chemicals had been secured and were not accessible to residents for: *Two of three bath rooms (100 and 200 hallway). *One of one shower room. *One of two soiled utility rooms (200 hallway). *One of one nursing utility room. *Two of two housekeeping carts. Findings include: 1. Observation on 1/6/15 during the initial tour revealed: *The 200 hallway bath room was unlocked. Neutron NI-712 odor eliminator spray had been sitting on the toilet tank. The warning label on the can stated, "May cause skin or eye irritation. Harmful if swallowed." *The nursing utility room had the door propped open and had Clorox disinfecting wipes on the counter. *The 200 hallway soiled linen room was unlocked. TB Plus Spray, Virex 256 spray, and Neutron NI-712 spray had been stored under the sink. *The 300 hallway shower room was unlocked. Clorox disinfecting wipes and disinfectant spray had been stored on the same shelf with residents' bathing items (body wash, shampoo, and lotion). *The sink on the west side of the dining room had Brasso pot and pan cleaner and Windex stored under the sink. It had not been locked. *Disinfectant bottles and wipes had been stored on top of the housekeeping carts. Those housekeeping carts had been left in the hallways unattended where residents walked by. *Residents had access to and had been observed	F 323	be stored in a locked compartment on the cart or not placed on the cart. Chemicals stored in utility rooms will have locks on the door. 3. The Administrator, Environmental supervisor, or designee will provide education to all staff on 1/28/2015 and 1/29/2015 regarding the need to keep chemicals away from resident bathing supplies and locked so that residents are not able to access them. 4. The Administrator or designee will audit the housekeeping carts, the utility rooms, the bath and shower rooms to assure chemicals are stored away from resident bathing supplies, that all chemicals are locked in compartments on housekeeping carts or behind lock doors. These audits will be done weekly X4 and then monthly X3. The administrator or designee will report audit findings to the QAPI committee and the committee will determine if further auditing is needed. 5. Date complete 1/30/2015	1/30/2015	

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F 323	Continued From page 4 near all of the above areas. There were cognitively impaired residents in the facility that could have entered the above areas.  Observation on 1/7/15 at 8:00 a.m. revealed the above previously observed chemicals were still in the same unsecured locations. A housekeeping cart in the 100 hallway had a bucket with mop heads and an unidentified solution stored on the bottom of the cart. That cart was unattended in a hallway where residents walked by.  Interview on 1/7/14 at 10:00 a.m. with the director of nursing (DON) revealed housekeeping had been responsible for chemical storage. She would have expected chemicals to be inaccessible to residents or kept in a locked area.  The September 2012 revised housekeeping and laundry departments safety rules policy stated chemicals were not to be left unattended in any area to which residents have access. They should have been stored in a locked area.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	1. REsident #2 has had interventions added to their diet and their care plan per direction from the RD and her physician. R Resident #2 remains on the Nutrition at Risk committee and documentation is being done monthly by the RD. 2. All residnets with weight loss will be added to the Nutrition at Risk committee and followed monthly by the RD and the dietary manager. Physician will be notified promptly by staff	

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F 325	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to implement interventions to prevent unwanted weight loss for one of two sampled residents (2) with weight loss. Findings include:</p> <p>1. Review of resident 2's 10/22/14 Minimum Data Set (MDS) assessment revealed she had a 10 percent (%) weight loss in the past six months. The weight loss had not been physician ordered.</p> <p>Review of resident 2's monthly weight records from 1/8/14 through 12/31/14 revealed her weight: *Had been declining since 4/30/14. *On 4/30/14, 123.2 pounds (lb). *On 10/22/14, 106 lb. -That had been a 13.96% weight loss. *On 12/31/14, 103.2 lb.</p> <p>Review of resident 2's 10/23/14 Mini-Nutritional Assessment revealed she had been at risk for malnutrition.</p> <p>Review of resident 2's 10/23/14 Dietary Profile revealed: *She had a regular diet. *She had a recent decline in intake for meals. *She was to be given a minimum of 1500 cc (30 cc equals one ounce of fluid) beverages per day with meals. *The following were interventions listed in the profile that could have been applied but had not been: -A nutritional supplement.</p>	F 325	<p>of the weight loss and orders will be initiated. Family members will be notified promptly and asked about past food likes/dislikes. All interventions will be added to the diet card and the care plan. If deemed necessary fluid intakes will be monitored, food intakes will be monitored with each meal. The pharmacy consultant will be asked to provide a medication review to rule out possible medication interactions that could impair appetite or cause weight loss.</p> <p>3. The DNS and RD will provide education to all staff on 1/28/2015 and 1/29/2015 regarding interventions that should be done to prevent weight loss and the importance of prompt notification to the dietary manager and nursing supervisor when declines in appetite or fluid intake are seen. Several examples of interventions will be shared with staff that could possibly assist the resident with improved meal intakes.</p> <p>4. The DNS or designee will audit the at risk residents plus 10% of other residents to assure meal intakes are monitored with each meal. Audit will also include weekly weight monitoring, the monthly RD</p>		

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F 325	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>-An individual snack schedule.</li> <li>-Adjust dining services to encourage improved intake.</li> <li>-Adjust dining services to honor resident choice.</li> <li>-Close monitoring of resident's weight (update care plan).</li> <li>-Refer to nutrition risk committee.</li> <li>-Refer to registered dietitian (RD).</li> <li>-Update care plan.</li> </ul> <p>Review of resident 2's interdisciplinary progress notes from 7/28/14 through 12/30/14 revealed:</p> <ul style="list-style-type: none"> <li>*On 10/6/14 the RD had identified a 13% weight loss from six months ago.</li> <li>*There had been no documentation the physician had been notified on 10/6/14 of the significant weight loss.</li> <li>*She had not been started on the nutritional intervention program (fortified foods) until sometime in November (no date indicated).</li> <li>*There had been no documentation the interdisciplinary team had discussed the weight loss and developed interventions.</li> <li>*She had been started on Remeron on 10/14/14 for "anorexia/lack of appetite related to weight loss."</li> <li>*On 12/1/14 the RD had wrote the dietary department had attempted giving her a dietary supplement, but she had not liked it.</li> <li>-There was no documentation when that had been attempted.</li> <li>*There had been no other interventions documented.</li> <li>*On 12/1/14 they had a conversation with the family about putting her on hospice services due to her weight loss. The family had declined and had not thought she was in need of those services at that time.</li> </ul>	F 325	<p>documentation that the physician and family had been notified, and that the pharmacy consultant had been asked to review for medication interaction. In addition the diet card and care plan will be audited to assure all interventions have been added. Audits will be done weekly X4 and then monthly X3, the DNS or designee will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>5. Date complete 1/30/2015</p>	1/30/2015	

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F 325	<p>Continued From page 7</p> <p>Review of resident 2's 10/29/14 care plan revealed the interventions for her "nutritional problem" were:            **Resident is able to make choices at Buffet and eat independently."            **Remains on Nutrition Intervention Program and the Nutrition Risk List for monthly RD [registered dietitian] review."            **Observe and record intake at each meal."            *None of her food preferences had been documented.            *There had been no other interventions on the care plan for her weight loss.</p> <p>Interview on 1/6/15 at 11:45 a.m. with registered nurse F revealed resident 2 was not being monitored for weight loss. The family had been concerned, but they were not "officially" monitoring her for it.</p> <p>Observation on 1/6/15 at 1:55 p.m. of resident 2 revealed she was in her room resting in the recliner. At 3:30 p.m. she had been at Bingo. She was playing independently and was marking her card after the numbers had been called. Interview at 4:45 p.m. with her revealed she was friendly and talkative. She used a walker to get around and enjoyed Bingo but did not "win big." She had been waiting to walk down to the dining room for supper. She thought the food was okay, had no complaints on it, but she stated "You can not like everything."</p> <p>Observation on 1/6/15 at 5:35 p.m. of resident 2 in the dining room revealed she:            *Had been served a cheese sandwich, cream of potato soup, a bowl of cooked rhubarb, water, and tomato juice.            *She ate independently and ate 75% to 100% of</p>	F 325			

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F 325	<p>Continued From page 8 her meal.</p> <p>Interview and diet card review on 1/6/15 at 5:45 p.m. with the dietary manager regarding resident 2 revealed: *If a resident was on the nutritional intervention program it meant they received fortified foods or more calories. *The fact she was to receive fortified foods at all meals had not been added to the resident's diet card. -She was not aware that it should have been put on the diet card. *She had not given resident 2 any added calories or fortified foods that evening.</p> <p>Observation on 1/7/15 at 9:15 a.m. of resident 2 revealed she had been served french toast, two strips of bacon, coffee, water, and a dark juice. Interview on 1/7/15 at 9:20 a.m. with cook C revealed she had not provided resident 2 with any extra calories that morning. She had not followed the nutritional intervention program.</p> <p>Interview on 1/7/15 at 1:15 p.m. with the director of nursing, MDS coordinator, and the medical records staff person (she had been the dietary manager until December 2014) regarding resident 2 revealed: *They had not notified the physician on 10/6/14 of her weight loss. *They had not followed the nutritional intervention program to make sure she was getting extra calories. *They had not been monitoring her fluid intake. *They had not followed the provider's February 2013 Interventions for Nutritional Risk of Residents policy.</p>	F 325			

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F 325	Continued From page 9 Review of the provider's February 2013 Interventions for Nutritional Risk of Residents policy included the following interventions that should have been attempted when there was a significant weight loss: *Interventions would have been added to the care plan. *The RD was to calculate resident's need for additional vitamins and/or fluid. *Use a therapeutic diet to encourage intake. *Fortified or high calorie/high protein diet. *Snacks between meals. *Beverage cart between meals. *Substitutions per individual preference. *Offer finger foods. *Provide smaller more frequent meals. *Observe residents during meals. *Restorative dining program. *Adaptive equipment. *Proper positioning. *Cueing/Encouragement at meals and snacks. *Provision of feeding assistance. *Counseling regarding psychosocial needs. *Weekly weight. *Pharmacy consult for review of medications.	F 325		
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. Unable to go back and change the sanitizing solution. The blue and brown ice packs were removed from the freezer compartment of the refrigerator next to the activity area. 2. All contact surfaces used for food preparation will be cleaned using a 2 step process, first cleaned using the proper sanitizing solution and then rinsing. All wiped cloths will remain in the sanitizing	

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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 371	Continued From page 10  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, testing, interview, product information review, and policy review, the provider failed to ensure sanitation in the following areas: *In the kitchen of the wiping cloths used during one of two meal preparation observations. *In one of one residents' refrigerator (dining room) foods stored with non-food items (residents' ice packs). Findings include:  1. Observation on 1/6/15 at 4:20 p.m. in the kitchen revealed dietary assistant A wiping a food production counter with a cloth she had taken from a white bucket located on a food production counter.  Observation and testing of the liquid in the above bucket on that counter revealed: *There was one wet cloth in the opaque (not clear), soapy liquid. *The liquid in the bucket using an EcoLab chlorine test paper revealed the liquid in that bucket was at zero parts per million (ppm). *That test revealed no sanitizer in the sanitizing bucket. *The liquid in that bucket with a wiping cloth in it needed to be at a minimum concentration of 50 ppm.  Interview on 1/6/15 at 4:25 p.m. with the dietary manager (DM) regarding the above bucket of liquid revealed: *The wiping cloths in that bucket were used to wipe down the food counters, equipment, and the steam table.	F 371	solution until used. Sanitizing solution will be checked frequently with a test kit and the solution will be changed when sanitizing solution becomes depleted or when the water is visibly soiled. Non-food items will not be stored with food items. 3. The dietary manager will educate dietary staff on 1/28/2015 and 1/29/2015 referencing the Good Samaritan Society's procedure Sanitizing Solutions reviewing the 2 step process in cleaning direct contact surfaces in food preparation areas. The DNS will educate staff on 1/28/2015 and 1/29/2015 related to the storage on non-food items with food items. 4. The dietary manager will audit sanitizing solution is correct and effective for sanitation. Audit will include the cleaning cloth being stored in the solution when not in use, how often the solution is checked and changed, and if the 2 step process is followed. The Activity director or designee will check the refrigerator near the activity area to assure non-food items are not being stored with food items. These audits will be done weekly X4 and then monthly X3 with the activity director and		

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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F 371	<p>Continued From page 11</p> <p>*That same bucket was not used in the dining room as Oasis 146 Multi-Quat (quatarnary) Sanitizer was only used for sanitizing the tables and chairs.</p> <p>*The bucket's liquid had not been changed since around 9:00 a.m. that morning.</p> <p>*She agreed the sanitizing liquid needed to have been changed more frequently.</p> <p>*She confirmed that same bucket's liquid was not sanitizing at a level of zero ppm.</p> <p>Observation and testing at the same time as the above in the kitchen revealed a second sanitizing bucket located in the one-compartment sink next to a food counter. Testing of the liquid in that bucket revealed:</p> <p>*There was one wet cloth in the opaque, soapy liquid.</p> <p>*The liquid in the bucket using a EcoLab Chlorine test paper tested at zero ppm.</p> <p>*That test revealed no sanitizer in the sanitizing bucket.</p> <p>*The liquid in that bucket with a wiping cloth in it needed to be at a minimum concentration of 50 ppm.</p> <p>Interview and testing at the same time as the above in the kitchen with the DM regarding the above bucket located in the one-compartment sink revealed:</p> <p>*That bucket had "just been made" (with soap, Clorox, and water).</p> <p>*The Clorox out of the container used in preparing the bucket was tested using a EcoLab chlorine test paper, and the result was zero ppm.</p> <p>*That container containing the Clorox bleach was:</p> <ul style="list-style-type: none"> <li>-Not an original Clorox bleach container.</li> <li>-The bleach had been transferred into a thirty-two ounce squeeze-type container.</li> </ul>	F 371	<p>dietary manager reporting audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> <p>5. Date Complete 1/30/2015</p>	1/30/15	

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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F 371	<p>Continued From page 12</p> <p>-That container had been labeled with an attached photocopy of the product information. *The liquid from that container was tested using a EcoLab chlorine test paper, and the result was zero ppm. *The DM stated that Quat would be used as a sanitizer on the kitchen work counters, equipment, and the steam table until that could be corrected to ensure proper sanitizing in the kitchen areas.</p> <p>Observation and testing with a chlorine test strip on 1/7/15 at 7:14 a.m. in the kitchen revealed the bucket located in the one-compartment sink next to a food counter area was at 200 ppm.</p> <p>Interview on 1/7/15 at the same time as the above with cook C and at 8:15 a.m. with cook B revealed there was no documentation kept on the sanitizing levels of the buckets containing the wiping cloths used in the kitchen.</p> <p>Observation and testing with a chlorine test strip on 1/7/14 at 9:30 a.m. in the kitchen revealed the bucket located on the food production counter and the bucket located in the one-compartment sink next to a food counter area were at 200 ppm.</p> <p>Review of the Clorox product information sheet for sanitizing solutions for food contact surface and food equipment revealed: *The bleach solution used for sanitizing must not exceed 200 ppm available chlorine. *Use chlorine test strips to ensure efficacy (the power to produce an effect). *Clean and rinse the area. *Wipe the area with the sanitizing solution. *Treated surfaces must remain wet for a least two minutes.</p>	F 371		

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 371	<p>Continued From page 13</p> <p>Interview on 1/7/15 with the DM regarding the above sanitizing buckets with the wiping cloths revealed she:</p> <ul style="list-style-type: none"> <li>*Agreed both the liquid in the sanitizing buckets and the wiping cloths coming out of the buckets needed to have been at a higher ppm for proper sanitizing.</li> <li>*Stated the buckets that contained the wet cloths were used to wipe down the work counters, equipment, and the steam table in the kitchen.</li> <li>*Agreed the sanitizer had not been sanitizing properly.</li> <li>*Confirmed there was no documentation of checking the ppm of the sanitizer.</li> <li>*She was unsure of how long that had been occurring, and the sanitizer had not been working properly.</li> </ul> <p>Review of the provider's February 2013 Sanitizing Solutions policy revealed:</p> <ul style="list-style-type: none"> <li>*The purpose was to promote the effective use of sanitizing solutions on direct contact surfaces used for food preparation.</li> <li>*Chemicals were to have been mixed in the recommended concentration of levels for maximum efficiency.</li> <li>*Manufacturer's information were to have been referred to for proper concentrations measured in ppm.</li> <li>*The solution concentrations were to have been checked frequently with a test kit.</li> <li>*The sanitizing solution was to have been changed when it had become depleted or when the water was visibly dirty.</li> <li>*Monitor to ensure all products had been correctly labeled and dated when opened.</li> </ul> <p>Review of the provider's Cleaning-Sanitation of</p>	F 371		

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 371	<p>Continued From page 14</p> <p>Non-Food Contact Surfaces revealed: *The provider would have stored, prepared, distributed, and served food under sanitary conditions at all times *Cleaning and sanitizing surfaces was a two-step process. *Surfaces first must have been cleaned and rinsed before being sanitized. *Wiping cloths were to have remained in sanitizing solution until used. *Sanitizing solutions were to have been checked with test strips for proper solution strength.</p> <p>2. Observation on 1/6/15 from 11:02 a.m. through 11:37 a.m. during the initial tour of the kitchen and dining room areas revealed: *A refrigeration unit for resident use in the dining room next to the activity office. *In that refrigerator's freezer non-food items were being stored with food items. *The items consisted of the following: -Two small-sized blue ice packs located in an open plastic container marked with a resident's name. *The same freezer area contained ice cubes in a bag, sherbet, and lefsa (a type of Norwegian bread).</p> <p>Observation on 1/7/15 at 8:35 a.m. of that same refrigeration unit in the dining room as the above revealed: *One large-sized brown ice pack marked with a resident's name in a plastic bag. *That ice pack was laying under two packages of lefsa next to a carton of sherbet.</p> <p>Interview on 1/7/15 at 8:37 a.m. with licensed practical nurse E regarding the ice packs in the residents' refrigeration unit in the dining room</p>	F 371			

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 371	<p>Continued From page 15 revealed:</p> <ul style="list-style-type: none"> <li>*The large-sized brown ice pack stored in the freezer was a resident's ice pack.</li> <li>*That ice pack had been used for the resident's pain.</li> <li>*She was unsure what the small-sized ice packs were used for.</li> <li>*She agreed the food and non-food items should not have been stored together.</li> </ul> <p>Interview on 1/7/15 at 9:45 a.m. with the activity director regarding the ice packs in the residents' refrigeration unit in the dining room revealed:</p> <ul style="list-style-type: none"> <li>*The small-sized ice packs were marked with a resident's name that had not been in the facility for about two years.</li> <li>*She agreed the food and non-food items should not have been stored together.</li> </ul> <p>Interview on 1/7/15 at 9:08 a.m. with the director of nursing regarding the ice packs in the residents' refrigerator unit in the dining room revealed:</p> <ul style="list-style-type: none"> <li>*The large-sized ice packs had been used for a resident's care and treatment by the resident.</li> <li>*The small-sized ice packs were marked with a resident's name that had not been at the facility for some time.</li> <li>*She agreed the food and non-food items should not have been stored together.</li> </ul> <p>Interview on 1/07/15 at 3:00 p.m. with the DM regarding the ice packs in the residents' refrigerator unit in the dining room revealed:</p> <ul style="list-style-type: none"> <li>*Dietary did not use the ice packs.</li> <li>*The ice packs had been used for residents' care.</li> <li>*She agreed the food and non-food items should not have been stored together.</li> </ul>	F 371			

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F 371	Continued From page 16 Review of the provider's September 2012 Cold Application policy for resident care revealed the purpose was to: *Prevent or reduce edema (swelling). *Reduce inflammation. *Relieve pain. *Control bleeding. *Reusable cold packs were to have been placed back in the freezer. *Disposable cold packs were to have been discarded.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	1. The razors for residents were cleaned and returned to their room. A new hose for air mattress has been ordered and will discard the duct tape. Unable to change the length of time RN #D washed her hands or turned off the taps. 2. All residents personal razors will be cleaned after use and stored in their rooms. Duct Tape or any other type of adhesive will not be used on any equipment; repairs will be made to equipment so that repair maintains the ability to clean the surfaces. All staff will follow hand hygiene and hand washing procedure by washing their hands for at least 20 seconds and turning off the taps using paper towels		

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435074</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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F 441	<p>Continued From page 17 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, record review, interview, and policy review, the provider failed to ensure appropriate infection control practices were maintained for: *One of one observed resident's (12) electric razors. *Tubing on one of one observed resident's (3) pressure relieving air mattress system. *One of three observed registered nurses (RN) during handwashing. Findings include:</p> <p>1. Observation on 1/6/15 during the initial tour revealed two electric razors in the cabinet above the sink in the 200 hallway bath room. Both razors had been labeled with resident 12's name. Removal of the head of each of the razors revealed they had a large amount of hair inside.</p>	F 441	<p>paper towels to prevent further contamination to hands. 3. The DNS will educate all staff on 1/28/2015 and 1/29/2015 regarding infection control practices and the cleaning and storage of resident's personal equipment, maintaining equipment in a way that allows the continued ability to clean surfaces, and proper hand hygiene and hand washing with reference to the GSS II.F.2- Infection Control Guidelines/Procedure Hand Hygiene and Hand Washing. 4. The DNS or designee will audit the storage and cleaning of resident's personal equipment the audit will also include checking medical equipment to assure all are maintained well and have cleanable surfaces. Hand washing and hand hygiene practices will be observed by the DNS or designee on all staff to assure guidelines and procedures are followed. These audits will be done weekly X4 and then monthly X3 and will be reported to the QAPI committee monthly by the DNS or designee. The committee will determine if further auditing is needed. 5. Date complete is 2/6/2015</p>	2/6/15	

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 441	<p>Continued From page 18</p> <p>Observation on 1/7/14 at 8:00 a.m. in the 200 hallway bathroom revealed the above razors had not been cleaned.</p> <p>Interview on 1/7/15 at 10:00 a.m. with the director of nursing (DON) revealed resident razors should have been in the resident's room. The night shift certified nursing assistants (CNA) had been responsible for cleaning razors. She confirmed resident 12's razors should have been cleaned by the above second observation.</p> <p>2. Observation on 1/6/14 of resident 3's dressing change revealed a pressure relieving air mattress in use. The tubing used to fill the mattress with air had duct tape holding it together. Observation on 1/7/14 at 9:50 a.m. revealed the tubing was still wrapped in duct tape making it an uncleanable surface.</p> <p>Interview on 1/7/14 at 10:15 a.m. with the DON revealed she had been unaware the tubing had duct tape on it. She confirmed it needed to be removed. Surveyor: 28057</p> <p>3. Observation on 1/7/15 at 10:50 a.m. revealed registered nurse (RN) D had administered medications by gastric tube to resident 13. During that medication administration she had washed her hands four times. Every time she had washed her hands for ten seconds or less and had turned the faucet off with her bare hands instead of using a paper towel. That had caused her hands to be contaminated from the soiled faucet handles.</p> <p>Interview at that same above time with RN D confirmed she should have washed her hands longer and used a paper towel to turn off the</p>	F 441			

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 441	Continued From page 19 faucet.  Interview on 1/7/15 at 4:55 p.m. with the DON confirmed RN D should have washed her hands for at least twenty seconds and used a paper towel to turn off the faucet.  Review of the provider's revised November 2014 Hand Hygiene and Handwashing policy revealed hands were to be washed for at least twenty seconds, and the faucet turned off with a paper towel.	F 441			

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

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PRINTED: 01/14/2015  
FORM APPROVED  
OMB NO. 0938-0391

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/07/15. Good Samaritan Society DeSmet (Building 01) was found not 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 upon correction of the deficiencies identified at K038 and K062 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: *Neil Blocker* TITLE: *Administrator* (X6) DATE: *1/28/15*

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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>435074</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b>  B. WING _____	DATE SURVEY COMPLETE:  <b>1/7/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY DE SMET</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>411 CALUMET AVENUE NW DE SMET, SD</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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**K 038**      **NFPA 101 LIFE SAFETY CODE STANDARD**

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1

This STANDARD is not met as evidenced by:  
Surveyor: 18087

Based on observation and interview, the provider failed to ensure one set of randomly observed marked exits (200 wing cross-corridor doors from the rehabilitation (rehab) suites area) were readily accessible at all times. A set of cross-corridor doors was equipped with a magnet lock and was not equipped with delayed egress signage. Findings include:

1. Observation at 4:45 p.m. on 1/07/15 revealed the cross-corridor doors from the rehab suites area (former secure wing) had a magnet lock exiting into the main building at resident rooms 212 and 215. There was not a sign on the door indicating the magnet lock was a delayed egress style lock. Those cross-corridor doors provided the second means of egress from the rehab suites area. Interview with the environmental services supervisor at the time of the observation confirmed that finding. He stated new delayed egress signs had been installed in 2014.

**K 062**      **NFPA 101 LIFE SAFETY CODE STANDARD**

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

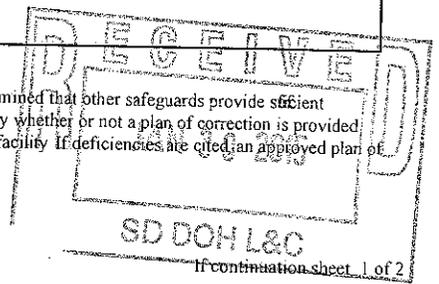
This STANDARD is not met as evidenced by:  
Surveyor: 18087

Based on observation and interview, the provider failed to maintain the automatic sprinkler system in reliable operating condition for two randomly observed sprinklers (200 wing corridor) that had plastic caps on them. Findings include:

1. Observation at 5:30 p.m. on 1/07/15 revealed two sprinklers in corridor alcoves (between resident rooms 202 and 204 and between resident rooms 206 and 208) had plastic caps on them. Interview with the environmental services supervisor at the time of the observations confirmed those conditions. He revealed the building had become completely sprinklered in 2013, and the caps must have been overlooked for removal by the installer.

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

The above isolated deficiencies pose no actual harm to the residents



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND Nfs	PROVIDER #  <b>435074</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE:  <b>1/7/2015</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>K 062</b>	Continued From Page 1
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10614	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/07/2015
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NAME OF PROVIDER OR SUPPLIER  
**GOOD SAMARITAN SOCIETY DE SMET**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**411 CALUMET AVE NW  
DE SMET, SD 57231**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000 Initial Comments

Surveyor: 18087  
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/06/15 through 1/07/15. Good Samaritan Society DeSmet was found not in compliance with the following requirements: S166 and S294.

S 000 Addendums noted with an asterisk per 01/15 telephone to facility administrator. KJSD/DMF

S 166 44:04:02:17(1-10) OCCUPANT PROTECTION

The facility must take at least the following precautions:  
 (1) Develop and implement a written and scheduled preventive maintenance program;  
 (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents;  
 (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit;  
 (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities;  
 (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks;  
 (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;

S 166

1. The three exit doors (main entrance, employee entrance and activities door) have alarms turned on and will remain alarmed unless monitored by staff directly.  
 2. Entrance doors will be unlocked during normal business hours but alarmed so staff can monitor for who is coming into and exiting the building. The center is equipped with cameras at those three exit doors that do allow staff to monitor so when an alarm is triggered staff will need to verify who is coming in or who has exited the building. Further need for an electronic key-pad lock, or swipe-card controlled lock so alarms are not creating an unpleasant environment for our residents will be reviewed for future installation. In order to be in compliance with S166 alarms will be on so that any one coming in and going out will sound an alarm.

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

TITLE

(X6) DATE

*Gail Blocker*

*Administrator*

DEC 4 2015  
JAN 30 2015  
SD DOH L&C

If continuation sheet 1 of 6

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10614</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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S 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32573 A. Based on observation, interview, and policy review, the provider failed to have three of eight exit doors (main entrance, employee entrance, and the activities door) monitored by staff or alarmed at all times. Findings include:</p> <p>1. Observation from 1/6/15 at 10:45 a.m. to 1/7/15 at 7:15 a.m. revealed the main entrance door had been unlocked and unalarmed every time the survey team entered or exited the facility. Random observations throughout the survey revealed the nurses' station near the main entrance door had not been staffed. There had been no one watching that door.</p> <p>Observation on 1/6/14 at approximately 2:30 p.m when the survey team returned to the facility from lunch revealed a resident going outside to smoke through the unalarmed and unlocked main entrance door. The nurses' station had not been attended.</p>	S 166	<p>3. All staff will be in-serviced on the need for all exit doors to be alarmed 1/28/2015 and 1/29/2015. Procedures for Entrance/Exit doors Alarms will be reviewed and posted. Signs have been posted on each affected exit door notifying public entering and exiting that an alarm will sound and staff will have to manually check and shut off alarm.</p> <p>4. Enviromental Services will monitor the alarms to ensure they are working correctly and report findings to the QAPI committee X4 weekly and X3 monthly. QAPI committee will decide if further auditing is needed or if a performance improvement team needs to be formed. Administrator and/or Enviromental Services Director will continue to search a different option that will allow the safety of residents but not create a loud and unpleasant enviroment with more than necessary alarms sounding.</p> <p>5. Date complete 2/26/2015</p>	2/26/2015
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South Dakota Department of Health

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S 166	<p>Continued From page 2</p> <p>Interview on 1/7/15 at 2:25 p.m. with the director of nursing revealed the three exit doors stated above were not alarmed or locked during normal staffing hours (about 5:30 a.m. until 7:30 p.m.). Live feed video cameras (cameras that do not record over time) were in use at each of those doors. The monitor was at the nurses' station. She had not expected the videos to be monitored at all times, because the staff were usually aware of residents whereabouts. She confirmed if the video was not continuously monitored residents could exit the facility without anyone knowing.</p> <p>Review of the 3/1/09 Entrance/Exit Door Alarms policy revealed doors continuously monitored or monitored by security cameras would have the alarms disabled during daylight hours year round. All other doors should be alarmed or locked at all times. During bad or cold weather all doors should have been alarmed at all times.</p> <p>Surveyor: 18087 B. Based on observation and interview, the provider failed to equip overhead light fixtures in one of one tub room (200 wing) with shatterproof lamps. Findings include:</p> <p>1. Observation at 5:15 p.m. on 1/07/15 in the 200 wing tub room revealed two overhead heat lamps without covers. Further observation revealed the lamps were not shatterproof.</p> <p>Interview with the environmental services supervisor at the time of the observation revealed he was unaware the heat lamps were not shatterproof.</p>	S 166	<p>1. The two overhead heat lamps in the 200 wing tub room have been replaced with shatter-proof bulbs.</p> <p>2. Enviromental service director will monitor designated or required areas needing a lens cover or shatter-proof lamp for appropriate lens cover or shatter-proof lamp.</p> <p>3. Enviromental services and all staff will be educated on 1/28 and 1/29/2015 for awareness of need for shatter-proof lamps or lens covers.</p>	
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South Dakota Department of Health

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S 294	Continued From page 3	S 294	S166 continued	
S 294	44:04:07:04 Written Menus	S 294	4. Enviromental service director or designee will inspect all designated or required areas for compliance by February 26, 2015 then every 6 months. Audits will include monitoring for the appropriate lens cover and/or shatter-proof bulbs being used for resident safety. Findings of audits will be reported to Safety Committee with results being shared with QAPI committee. 5. Date Complete 2/26/2015	
	<p>Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council. Tenth Edition, 1989. Records of menus as served must be filed and retained for 30 days.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to have the registered dietitian (RD) review the menu changes on a monthly basis. Findings include:</p> <p>1. Observation on 1/6/15 at 5:00 p.m. at the evening meal revealed: *A banana was to have been served on the written menu. *The evening alternate menu had included a fruit to have been served. *An assortment of desserts were served instead of the banana or fruit that included:</p>		<p>S 294 1. Unable to go back at this point and inform dietitian of menu changes and/or substitutions of written menus. 2. Menus will meet the nutritional needs of the residents, be prepared in advance, and be followed. Temporary and permanent changes to the menu cycle will be documented with the date, changed to, reason for change and the inititals of the person making the substitution on the day of use. Permanent menu changes (substitutions) will be approved by the registered dietitian (RD). As much as possible, the menu will be served as posted/planned. 3. Dietary manager or designee will in-service dietary staff on 1/28/2015 and 1/29/2015 on</p>	

South Dakota Department of Health

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S 294	<p>Continued From page 4</p> <p>*Fruit crisp. -Fruit crisp had been on the written noon meal menu on 1/6/15.</p> <p>*Whipped jello. -Whipped jello had been on the noon meal menu on 1/5/15.</p> <p>*Rhubarb sauce. -Rhubarb sauce had been on the evening meal menu on 1/4/15.</p> <p>*Cheesecake.</p> <p>Interview on 1/6/15 at 5:40 p.m. with the dietary manager (DM) regarding not serving the bananas revealed: *They were currently out of bananas. *The menu had been changed, and it had not been documented on the menu or on a log for the dietitian to have approved it.</p> <p>Interview on 1/7/15 at 7:30 a.m. with cook C regarding changes to the written menu revealed: *Changes were not being documented. **"Changes were within the same food groups and we know what to do." *The RD had never required the cooks to document changes from the written menu.</p> <p>Group interview on 1/7/15 from 10:07 a.m. through 10:45 a.m. revealed: *Seven residents were in attendance. *One anonymous resident stated there was "too much of the same food served all the time." *Three other anonymous residents agreed that there was not always variety at meals.</p> <p>Interview on 1/7/15 at 3:00 p.m. with the DM regarding changes to the written menu and menu substitutions revealed: *The cheesecake served on 1/6/15 at the evening meal had been a change from the strawberry</p>	S 294	<p>the appropriate policy and procedure regarding menu substitutions and will be instructed to use the menu substitution log, to document either on the menu or on the menu substitution log changes made to menu, and RD to review and initial the substitutions with each visit as needed.</p> <p>4. The dietary manager or appropriate designee will audit for appropriate menu substitutions to ensure that follow up occurs with RD. These audits will be done weekly X4 and than monthly X3 and the dietary manager or designee will report audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> <p><i>[Redacted]</i></p> <p><i>KG/ODDH/MF</i></p>	<p><i>x 01/30/15</i> <i>KG/ODDH/MF</i></p>

South Dakota Department of Health

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S 294	<p>Continued From page 5</p> <p>angel dessert on 1/4/15 at the noon meal. -That above menu change had not been documented. *The cheesecake, jello whip, rhubarb sauce, and fruit crisp served at the evening meal on 1/6/15 had been recently served to the residents. *Those same dessert items had been leftovers from resident meals from 1/4/15 through 1/6/15. *Changes to the written menu were not being documented on the menu or on a log for the RD to review and approve the changes on at least a monthly basis. *Menu changes were not being approved by the RD on at least a monthly basis.</p> <p>Review of the provider's February 2013 Menus Substitution Lists policy revealed: *Temporary and permanent changes to the menu cycle would have been documented with the: -Date. -Changed from. -Changed to. -Reason for change. -Initials of the person making the substitution on the day of use. *Permanent menu substitutions would have been approved by the RD. *All substitutions would have been recorded on the menu or on the menu substitution log. *The RD was to have reviewed and initialed the substitutions with each visit as needed.</p>	S 294		