

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2015
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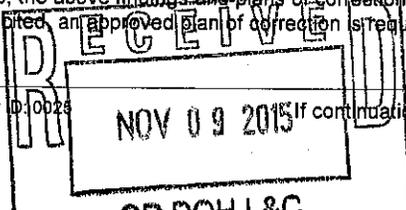
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY HOWARD	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST HAZEL AVENUE HOWARD, SD 57349
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><i>* Addendums noted with an asterisk per 11/23/15 per telephone with facility DON. KG/SDDOTTEL</i></p> <p>INITIAL COMMENTS</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 10/13/15 through 10/15/15. Good Samaritan Society Howard was found not in compliance with the following requirements: F280, F281, F309, F314, and F441.</p>	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview,</p>	F 280	<p><u>F-tag 280 Right to Participate Planning Care - Revise CP</u></p> <p>This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>For resident #6 and #8 -Clarification of <u>contradictory interventions</u> have been clarified 11/4/15. Resident requires prompting, cueing, and assistance as needed. Resident will sit at an assigned assist table for staff to observe and assist with meals and intake. Care Plan and MDS have been updated to reflect interventions. For all other potential residents the care plan and MDS <u>reflect accurate and non-conflicting interventions</u>. Residents who require prompting, cueing, and assistance as needed will be placed at an assigned</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/5/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

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F 280	<p>Continued From page 1</p> <p>and policy review, the provider failed to follow, update, and/or revise care plans for two of three sampled residents (6 and 8) who needed extensive assistance of one staff person. Findings include:</p> <p>1. Review of resident 6's 8/2/15 Minimum Data Set (MDS) assessment revealed he required extensive assistance of one staff person to eat. His thinking ability was severely impaired.</p> <p>Review of resident 6's 8/6/15 care plan revealed there were two interventions for eating that were contradictory. One stated "Resident requires hand over hand, reminding, prompting, cueing, assistance to eat." The other intervention stated "Provide supervision/observation, and assistance at meals." The second intervention had not accurately reflected the above MDS assessment.</p> <p>Observation on 10/14/15 at 7:55 a.m. of resident 6 revealed he was at the dining table for breakfast. He had scrambled eggs, bacon, an English muffin with jam, and cheerios in milk. He was attempting to eat on his own but was struggling with picking up the silverware and food. He was very shaky. He had attempted several times to pick up the English muffin but was unable to pick it up. At 8:15 a.m. an unidentified certified nursing assistant (CNA) who had been assisting another resident at the same table sat next to resident 6 and fed him two bites. He ate them very well. She then got up and returned to help the other resident. She did not return to assist resident 6. At 8:50 a.m. he was still at the table attempting to eat without assistance. He had eaten a few bites of the cheerios and drank some of his beverages.</p>	F 280	<p>assist table for staff to observe and assist as needed.</p> <p>INSERVICE- Re-education provided to nursing staff by DON on November 10th 2015. Education will include dining service with specifics to prompting, cueing, and assistance for residents who require staff to observe and assist with meals and intake.</p> <p>AUDIT- will include resident is observed and assisted by prompting, cueing, or actual assistance at meal time and with snacks. Audit of [redacted] will be completed weekly for 4 weeks and monthly for 4 months. The QAPI/DNS/designee will be responsible for audits to be completed and a monthly report of the audit findings submitted to the QAPI committee for further recommendation.</p> <p><i>*Residents who need assistance... HG/SDDU/H/EL</i></p>	12/4/15	

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F 280	<p>Continued From page 2</p> <p>Observation on 10/14/15 from 11:52 a.m. through 12:30 p.m. of resident 6 revealed he was in the dining room for lunch. He had been served spaghetti. There had been one staff person at the table to assist two other residents. He pushed away from the table and did not want to eat. The CNA at the table had not attempted to get him to return to eat.</p> <p>Observation on 10/14/15 from 5:45 p.m. through 6:40 p.m. of resident 6 revealed he was in the dining room for supper. He had been pushed up to the table and stated "Back me out I don't want anything." He continued to attempt to give his food away to another resident at the table. CNA B had been at the table assisting two other residents. She had not spoken to resident 6 during that timeframe. He was attempting to drink his beverages. He was able to drink a few sips of his beverages but had not eaten anything.</p> <p>During the above observations the staff had not provided extensive assistance of one person as indicated on the 8/2/15 MDS.</p> <p>Interview on 10/14/15 from 4:00 p.m. through 4:45 p.m. with the director of nursing (DON) regarding resident 6 revealed the MDS assessment was accurate. He should have had staff assisting him with his meals. She stated he was admitted on 7/27/15 and had been at a table with no staff assistance. They noticed he was not eating very well and had moved him to a table with staff assistance for that reason. He had weight loss but they had added a supplement to his diet. The supplement had helped with the weight loss.</p> <p>2. Review of resident 8's 8/27/15 MDS</p>	F 280		
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F 280	<p>Continued From page 3</p> <p>assessment revealed he required extensive assistance of one staff person to eat.</p> <p>Review of resident 8's 8/27/15 care plan revealed there were two interventions for eating. One intervention had been "Resident is able to hold cup, feed self, eat finger foods, etc [and so forth]...independently, needs cueing and assist at times." The second intervention stated "Provide supervision/observation, assistance at meals. Assist with set up help and remind resident to eat slowly." Those interventions had not accurately reflected the above MDS assessment.</p> <p>Observation on 10/14/15 at 7:55 a.m. and at 11:52 a.m. revealed resident 8 had one staff person assisting him with his meals.</p> <p>Observation on 10/14/15 at 5:45 p.m. of resident 8 revealed he did not have a staff person assisting him with his meal. He was able to eat with his fingers but ate in a hurry.</p> <p>Interview on 10/14/15 at 6:15 p.m. with CNA B regarding resident 8 revealed he did not need staff assistance and ate on his own.</p> <p>Interview on 10/15/15 at 3:30 p.m. with the DON regarding resident 8 revealed he sometimes could eat on his own, but staff should still have been there to assist him.</p> <p>3. Review of the provider's August 2015 Comprehensive Care Plan and Care Conferences policy revealed the care plan should have been "driven by identified resident issues/conditions and their unique characteristics, strengths, and needs." The interventions should have been individualized and realistic. They</p>	F 280		

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F 280 F 281 SS=D	<p>Continued From page 4 should have identified specifically what staff would do for the resident.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to obtain a physician's order for a pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to tissue) treatment for one of two sampled residents (6) with a pressure ulcer. Findings include:</p> <p>1. Review of resident 6's medical record revealed he developed a pressure ulcer to his left buttock on 10/11/15. There had been a fax sent to the physician on 10/11/15 requesting treatment. The physician had not answered the fax regarding the treatment. On 10/11/15 staff had applied a DuoDerm (specific type) dressing without a physician's order.</p> <p>Interview on 10/14/15 at 9:00 a.m. with licensed practical nurse D regarding resident 6 revealed they were still waiting on the physician's order for the type of pressure ulcer treatment to use.</p> <p>Interview and record review on 10/14/15 from 4:00 p.m. through 4:45 p.m. with the director of nursing regarding resident 6 revealed staff had not received a physician's order for the DuoDerm</p>	F 280 F 281	<p><u>F-tag 281</u> <u>Professional Standards</u> This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility state that with respect to:</p> <p>For resident #6 and all other potential residents orders will be obtained from the physician prior to any treatment. Orders will include specific product use and directions. Physician will be notified first via fax, or by telephone for a timely response to initiate the treatment. INSERVICE- Re-education licensed nurses per GSS policy and procedure for obtaining physician orders. Education will be provided by the DON 11/5/15 at 2pm.</p> <p>AUDIT- To include orders obtained prior to starting or changing treatment. The order will include type of product direction and use. The</p>	
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F 281	Continued From page 5 dressing treatment for the pressure ulcer. They should have called the on-call physician on 10/11/15 to get the order. She thought DuoDerm might have been on the standing orders signed by the physician. Review of the standing orders for resident 6 revealed it was not part of those orders. Review of the provider's July 2015 Physician/Practitioner Orders policy revealed "Orders must be obtained for wound care including product to be used, when to change and when to reassess."	F 281	QAPI/DNS/designee will be responsible to complete audits on all residents currently with wounds to determine physician orders were obtained and to include product use and direction. The DNS/designee will be responsible to submit a monthly report of the audit findings to the QAPI committee for further recommendation.	12/4/15	
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to assess, develop, and implement interventions for pain management for one of one sampled resident (6) with uncontrolled pain during the residents' care. Findings include: 1. Observation on 10/14/15 at 4:30 p.m. revealed CNAs B and C went into resident 6's room and closed the door.	F 309	<i>*Audits will be completed weekly for 4 weeks and monthly for 4 months. HG/SDDOH/EL</i> <u>F-Tag 309</u> <u>Provide care/Services for Highest Well Being</u> This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to: For resident #6, on October 29, 2015- Tramadol was increased to 100mg TID scheduled and will be tapered per physician direction as the fentanyl		

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F 309	<p>Continued From page 6</p> <p>At the above time while in the hallway by resident 6's room he could be heard for a full minute (was timed). He was crying out and yelling "that hurts" and "stop" multiple times along with moaning.</p> <p>After knocking on his door permission was gained to enter his room. Observation revealed: *The above CNA's were wiping his bottom to change his briefs in order to transfer him into his wheelchair. *He continued to moan and cry out and was grimacing while they continued with his care. *He stopped once they were done, and he was up in his chair.</p> <p>Interview immediately after the above observation with licensed practical nurse (LPN) D regarding resident 6 revealed: *She was in the hallway outside of the resident's room passing medications. *He had received his scheduled pain medication half an hour before the care started. *He received an extra as-needed (PRN) dose of pain medication that morning before his morning care to help with pain. *He had not received a PRN dose for his recent care to help with his pain.</p> <p>Interview five minutes later with resident 6 revealed when asked "Do you hurt?", he replied "My behind hurts the worse."</p> <p>Interview the same day at 5:00 p.m. with CNA C regarding resident 6 revealed: *"He always screams like that." *When asked what she would do to help with his pain she replied "I'm not sure what he gets for pain."</p>	F 309	<p>becomes effective.</p> <p>On November 2nd 2015 Fentanyl 12mcg patch was ordered. Pain Assessment / PAINAD will be completed weekly and PRN for 4 weeks to monitor effectiveness of new pain medication and management. The resident has PRN Ativan ordered, which can be offered to the resident to reduce anxiety and behaviors in regards to personal cares.</p> <p>Care plan was updated to reflect resident at moderate / high risk for pain. Interventions to include non-pharmacological interventions to include back massage, warm/cool packs to specific areas.</p> <p>For all other potential residents Pain Data/Assessments will be completed upon admission/ readmission/quarterly and with a change in condition. Residents at high risk for pain will be monitored weekly for pain management until stable and as interdisciplinary team deems stable.</p> <p>INSERVICE : Re-education provided to licensed nurses by the DON on November 5- 2015, 2pm. Education will include GSS Policy and Procedure for pain assessment and management. The education will include care plan updates and use of Pain Assessment / PAINAD.</p>	

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F 309	<p>Continued From page 7</p> <p>Review of resident 6's medical records revealed: *He was admitted on 7/27/15. *His diagnoses included dementia (a progressive decline in mental ability), pain, and a pressure ulcer on his bottom. *His last nursing pain assessment was on 8/29/15. *He received a scheduled pain medication three times a day. That was changed from PRN on 10/5/15 due to a pharmacist recommendation. *No further assessments had been found to evaluate the effectiveness of his pain medication.</p> <p>Review of resident 6's 8/2/15 Minimum Data Set assessment regarding pain revealed he: *Received scheduled and PRN pain medication and a non-medical intervention for pain. *Showed pain non-verbally, vocally, and by expression. *Had pain three to four days of the week.</p> <p>Review of resident 6's 10/14/15 care plan revealed: *"The resident has potential for pain/discomfort..." *"Minimize potential of resident behavior problems by modifying pain before cares are given." *"Attempt non-pharmacological [medication related] interventions: distraction." *"Notify health care provider if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain." *No specific plan for interventions except for "distraction."</p> <p>Interview on 10/15/15 at 10:45 a.m. with the director of nursing services regarding resident 6</p>	F 309	<p>AUDITS: To be completed weekly for four weeks and monthly for four months. Audit include pain assessment was completed weekly for four weeks to determine effectiveness of new pain medications. Audit to include any use of PRN Ativan for anxiety prior to cares and if the PRN Ativan was used, did it effectively reduce anxiety related to peri-care and ADL'S. The audits to be completed by QAPI/DNS/or designee. The DNS/designee is responsible to monitor the audits and submit a monthly report of the audit findings to the QAPI committee for further recommendations.</p>	<p> *12/4/15 KG/SDD/WEL</p>
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F 309	Continued From page 8 revealed: *She confirmed his PRN pain medication was changed to scheduled due to the pharmacist noting the resident was receiving the PRN frequently. No other interventions had been done. *There were no other pain assessments since 8/29/15. *She thought the above observation of the resident's behavior had "a lot to do with his dementia." *She agreed residents with dementia could have pain. *She agreed he had no updated assessments to adequately evaluate and treat his pain during care. Review of the provider's September 2012 Pain Management policy revealed all residents would receive interdisciplinary consultations on assistance in managing pain. The registered nurse would review response to medication intervention and work closely with the physician to assist in the individualized pain measurement plan. Review of the provider's September 2015 Pain Data Collection and Assessment procedure revealed: **"Purpose: to determine what pain relief interventions that are specific to the resident can be used and established to aide in maintaining a comfortable level of function and quality of life." **Residents identified to be at high risk for pain will be reviewed weekly by the RN [registered nurse] who will also work with the medical provider to update the individualized pain management plan."	F 309			
F 314	483.25(c) TREATMENT/SVCS TO	F 314			

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F 314 SS=G	<p>Continued From page 9</p> <p>PREVENT/HEAL PRESSURE SORES</p> <p>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 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: 32335 Based on observation, record review, interview, and policy review, the provider failed to implement and follow interventions for one of one sampled resident (6) who developed two pressure ulcers (a skin injury caused by unrelieved pressure that resulted in damage to tissue) after admission to the facility. Findings include:</p> <p>1. Review of resident 6's medical record revealed: *He had been admitted on 7/27/15. *He developed a pressure ulcer to his right heel on 8/22/15. -That pressure ulcer was not yet healed. *He developed a pressure ulcer to his left buttock on 10/11/15.</p> <p>Review of resident 6's 7/27/15 Braden Scale for Predicting Pressure Sore Risk assessment revealed: *He had a score of twelve that meant he was at high risk for developing pressure ulcers.</p>	F 314	<p><u>F tag 314 Treatment/Svcs to prevent/heal pressure sores</u> This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>For resident # 6 -updated care plan to reflect specific interventions pressure relieving mattress while in bed, pressure relieving cushion in chair. Interventions to include turn/reposition/change at least every 2-3 hours. Continue with supplement administered during medication pass and additional protein at each meal per dietician. Orders obtained for air mattress and ROHO cushion specific to pressure ulcer. Physical Therapy evaluated and reviewed pressure relieving cushion for effectiveness and recommended ROHO cushion. The care plan has been updated to reflect changes. Resident</p>		

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F 314	<p>Continued From page 10</p> <p>*The intervention guide included the following interventions:</p> <ul style="list-style-type: none"> -Frequent turning with a planned schedule. -Supplement with small shifts in position. -Pressure reduction support surface (chair or bed). -Use foam wedge for 30 degree lateral (on side) positioning. -Maximal remobilization (as much movement as possible). -Protect heels. -Manage moisture. -Manage nutrition. -Manage friction and shear (rubbing against a surface that would cause a skin injury). <p>Review of resident 6's 8/2/15 Minimum Data Set (MDS) assessment revealed:</p> <ul style="list-style-type: none"> *His thinking ability was severely impaired. *He was at risk for development of pressure ulcers. *Interventions that had been checked as being applied included: -Pressure relieving device in his chair. -Pressure relieving device in his bed. -Turning/Repositioning program. -Nutrition or hydration intervention. -Ulcer care. -Nonsurgical dressing, other than feet. -Ointments/medications, other than feet. *He required extensive assistance of one staff person to eat. <p>Review of resident 6's 8/6/15 care plan revealed:</p> <ul style="list-style-type: none"> *A focus area stated "The resident has pressure unstageable PU [pressure ulcer] on right heel R/T [related to] altered mental status, dehydration, disease process, immobility, incontinence [loss of bowel and bladder control], and poor nutrition." 	F 314	<p>right heel currently resolved with heel protectors in place at all times. The intervention is to provide ^{*prompting, cueing} supervision, observation, and assistance at all meals. MDS corrected to accurately code assistance.</p> <p>For all other potential residents, Braden scales will be completed weekly for 4 weeks upon admission and re-admission to the center. Braden scales will be completed with a significant change in condition and quarterly. Residents identified at risk for potential pressure ulcers will have pressure relieving mattress and cushions. Skin ^{*and other interventions recommended by the Braden Instruction.} observations will be completed weekly for all residents with a Braden Scale of 18 or less. Care plan will reflect focus measurable goals, and specific interventions for prevention and management of pressure ulcers.</p> <p>INSERVICE- Re-education provided to licensed nurses by the DON on November 5th, 2015 at 2pm. Education to include GSS policy and procedure for prevention and management of wound care. This education to include care plan updates. Completion of wound data collection tools daily with pressure ulcers and a Wound RN assessment weekly with notification to the physician as to progress/treatment of wound. Wound</p>	<p><i>*prompting, cueing</i> <i>KG/SDDOT/EL</i></p> <p><i>*and other interventions recommended by the Braden Instruction.</i> <i>KG/SDDOT/EL</i></p>
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F 314	<p>Continued From page 11</p> <p>*Interventions had included:</p> <ul style="list-style-type: none"> -Heel protectors started on 8/23/15. That had been after the development of the pressure ulcer to his heel. -"Resident has air mattress on bed and cushion in wheelchair for pressure relief." An order for the air mattress and heel protectors had been obtained on 8/21/15. *A focus area of limited physical mobility with an intervention to turn and reposition every two hours. *A focus area for nutrition with an intervention of "Offer additional 1-2 oz [ounce] of protein each meal. Offer 2 cal [protein supplement] BID [two times per day] due to open areas." That had been initiated on 9/14/15. That had been after the development of the pressure ulcer to the heel. *There were two interventions for eating that were contradictory. -One stated "Resident requires hand over hand, reminding, prompting, cueing, assistance to eat." -The other intervention stated "Provide supervision/observation, and assistance at meals." -This second intervention had not accurately reflected the MDS assessment. <p>Observations on 10/14/15 throughout the day revealed staff had not provided extensive assistance of one person to resident 6 during meal times. Refer to F280.</p> <p>Observations on 10/14/15 from 7:55 a.m. through 12:30 p.m. of resident 6 revealed:</p> <ul style="list-style-type: none"> *At 7:55 a.m. he had been in the dining room in his wheelchair (w/c). *At 8:50 a.m. he was still at the table in the dining room in his w/c. *At 9:15 a.m. he had been taken in his w/c into 	F 314	<p>measurements will be completed weekly. Orders will be obtained prior to any treatment of the wound.</p> <p>AUDITS- The QAPI/DNS/or designee will assure and monitor the air mattress is inflated at all times, and the ROHO cushion is placed and appropriately inflated at all times. Turning, repositioning, and changing will be monitored every 2-3 hours. Heel protectors will be worn at all times. Monitor orders are obtained prior to treatment. Monitor resident for assistance at all meals. [redacted] be completed by QAPI/DNS/or designee weekly x 4 weeks and monthly x 4 months. The DNS/designee is responsible to monitor the audits and submit a monthly report of the audit findings to the QAPI committee for further recommendations.</p> <p>*Audits for random residents will... hg/SDDO/HEL</p>	12/4/15	

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F 314	<p>Continued From page 12</p> <p>the dayroom to watch a movie. *At 9:50 a.m. he remained in the dayroom in his w/c. *At 10:30 a.m. he was still in the dayroom in his w/c. *At 10:40 a.m. he was still in the dayroom in his w/c. *At 11:30 a.m. he had been moved in his w/c to the front lobby to wait for lunch. *At 11:52 a.m. he was moved to his table and served food. *At 12:30 p.m. he was still in the dining room. *He had not been repositioned during the above observations.</p> <p>Review of resident 6's medical record revealed he developed a pressure ulcer to his left buttock on 10/11/15. There had been a fax sent to the physician on 10/11/15 requesting treatment. The physician had not answered the fax regarding the treatment. On 10/11/15 staff had applied DuoDerm (specific type) dressing without a physician's order.</p> <p>Interview on 10/14/15 at 9:00 a.m. with licensed practical nurse D regarding resident 6 revealed they were still waiting on the physician's order for the type of pressure ulcer treatment to use.</p> <p>Interview and record review on 10/14/15 from 4:00 p.m. through 4:45 p.m. with the director of nursing (DON) regarding resident 6 revealed: *Staff had not received a physician's order for the DuoDerm treatment for the pressure ulcer on his left buttock. *They should have called the on-call physician on 10/11/15 to get the order. *She thought DuoDerm might have been on the standing orders signed by the physician. Review</p>	F 314		
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F 314	<p>Continued From page 13</p> <p>of the standing orders for resident 6 revealed it was not part of those orders.</p> <p>*The MDS assessment was accurate, and he should have had staff assisting him with his meals.</p> <p>*She stated he was admitted on 7/27/15 and had been at a table with no staff assistance. They noticed he was not eating very well and moved him to a table with staff assistance for that reason.</p> <p>*He had a weight loss during that period of time and that was when they added the supplement.</p> <p>*She had not implemented a repositioning schedule for resident 6.</p> <p>*The orders for the heel protector and air mattress had been obtained after the development of the first pressure ulcer.</p> <p>*She could not recall if there had been an air mattress on his bed prior to the 8/21/15 physician's order.</p> <p>*They had not implemented the interventions suggested prior to the development of the first pressure ulcer.</p> <p>Interview on 10/15/15 at 12:30 p.m. with the DON revealed she had reviewed the pressure ulcer information for resident 6. She had found on 9/24/15 they had changed the treatment to the heel. There had not been any other changes.</p> <p>Review of the provider's July 2015 Physician/Practitioner Orders policy revealed "Orders must be obtained for wound care including product to be used, when to change and when to reassess."</p> <p>Review of the provider's September 2012 Pressure Ulcer policy revealed the center would use prevention and assessment interventions to</p>	F 314		

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F 314	Continued From page 14	F 314	<u>F tag-441 Infection Control, Prevent Spread, Linens</u>	
F 441 SS=E	<p>ensure that a resident who entered the facility without a pressure ulcer would not develop a pressure ulcer.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and</p>	F 441	<p>This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p> <p>Education to be provided to all nursing staff by the DNS and Infection Control nurse on November 10, 2015 regarding the whirlpool manufacturing directions for disinfecting the tub/shower chair between residents. Instructions include  Staff educated and audit developed to follow whirlpool manufacturing.</p> <p>AUDIT: to include following manufacturing instructions to disinfect the whirlpool. Audit to include that staff are following the disinfectant instructions</p>	

Handwritten notes:
 The manufacturer's step-by-step process for disinfecting the tub.
 K&S/DOW/KEL
 EL

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F 441	<p>Continued From page 15</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and manufacturer's information review, the provider failed to ensure proper disinfection was done for one of one whirlpool bathtub on the 200 wing by one of one bath aide (A). Findings include:</p> <p>1. Observation and interview on 10/14/15 at 9:10 a.m. of bath aide A cleaning the residents' Cascade whirlpool bathtub revealed she: *Had been in that position for a year. *Had rinsed the inside of the tub and placed the drain plug over the drain. *Pushed the button to add the disinfectant to the bathtub. *Added water until it was three-fourths full and started the air jets. *Scrubbed the interior surfaces then turned off the air jets. *Drained the bathtub then rinsed it with water. *Would leave the disinfectant on "for a minute or so" before rinsing.</p> <p>Review of the undated Cascade whirlpool tub cleaning information revealed: *Release the disinfectant button after you see solution coming out of all the air jets and you have one to one and one half gallons of disinfectant solution in the foot well of the tub." -There was no mention of adding water to the bathtub and disinfectant solution as was done above.</p>	F 441	<p>provided by the manufacturer. Audits will be completed weekly x 4 and monthly x 4 months. The audit findings will be submitted to QAPI committee monthly for further recommendations.</p>	10/14/15	

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F 441	<p>Continued From page 16</p> <p>*"...Thoroughly scrub all interior surfaces of the tub and chair with the disinfectant solution. Let disinfectant stay on the surface for 10 minutes." *Remove the plug from the drain." *"Rinse the tub's interior surfaces thoroughly with the shower sprayer." *"Press and hold the Rinse button located on the control panel until clear water runs from all the air jets. Then release the Rinse button." *"Finish rinsing the interior surfaces of the tub with the shower sprayer." *"Start the air blower by pushing the Aqua-Aire button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system."</p> <p>Interview on 10/15/15 at 12:00 noon with the infection control nurse revealed she agreed bath aide A should not have added water to the disinfectant, did not leave it on long enough to properly disinfect the bathtub, nor ran the jets at the correct time to clean and remove the solution.</p>	F 441			

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K 000	INITIAL COMMENTS Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/19/15. Good Samaritan Society Howard 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 10/22/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for 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: 25107 Based on measurement and document review, the provider failed to maintain proper exit access door widths for two of two randomly observed sets of cross-corridor doors (north and east of the nurses station). Findings include:	K 028		F

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

[Handwritten Signature]

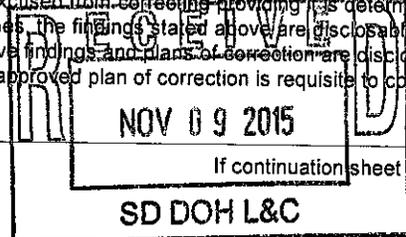
TITLE

Administrator

(X6) DATE

11/5/15

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.



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K 028	Continued From page 1 1. Measurement at 2:00 p.m. on 10/19/15 revealed each leaf in the pair of one hour fire rated cross-corridor doors to the north of the nurses station measured 30 inches in clear width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed that condition was part of the original construction. Measurement at 2:15 p.m. on 10/19/15 revealed each leaf in the pair of one hour fire rated cross-corridor doors to the east of the nurses station measured 31.5 inches in width. That clear opening width did not provide the minimum requirement of 32 inches. Review of the previous survey report confirmed that condition was part of the original construction. 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	NFPA 101 LIFE SAFETY CODE STANDARD 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: 25107 Based on observation and document review, the provider failed to ensure at least two conforming	K 032		F

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY HOWARD			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WEST HAZEL AVENUE HOWARD, SD 57349		
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K 032	Continued From page 2 exits existed from each floor of the building. The basement did not have a conforming exit. Findings include: 1. Observation at 1:00 p.m. on 10/19/15 revealed the basement did not have a conforming exit. The primary exit was the basement stairway that discharged onto the main level corridor system. The second exit was through a window to an area well equipped with a fixed ladder. Review of the previous survey report confirmed the condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 032			

ORIGINAL

PRINTED: 10/28/2015
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10631	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/15/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY HOWARD	STREET ADDRESS, CITY, STATE, ZIP CODE 300 W HAZEL AVE HOWARD, SD 57349
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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) COMPLETE DATE
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/13/15 through 10/15/15. Good Samaritan Society Howard was found in compliance.</p>	S 000		

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

[Handwritten Signature]

TITLE

Administrator

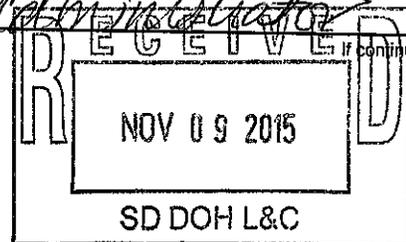
(X6) DATE

11/5/15

STATE FORM

6889

6WRQ11



If continuation sheet 1 of 1