

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

**ORIGINAL**

PRINTED: 01/20/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</b>
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F 000	INITIAL COMMENTS  Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/5/15 through 1/7/15. Good Samaritan Society Lennox was found not in compliance with the following requirements: F281, F309, F425, and F441.	F 000	Addendums noted with an asterisk per 2/5/15 telephone to facility WON. DKSDOH/MF	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and procedure review, the provider failed to: *Obtain interdepartmental team reviews and approval, and physician's orders for self-administration of medications for 1 of 10 randomly observed residents (15). *Ensure reweighs were completed when a weight change of more than three pounds occurred for 3 of 12 sampled residents (1, 5, and 8). Findings include:  1. Observation on 1/6/15 at 9:05 a.m. with unlicensed assistive personnel (UAP) G and the infection control nurse regarding resident 15's medication administration revealed: *UAP G prepared medications for administration and set the medication cup in front of the resident seated at the breakfast table. She walked away saying "She does self-administration of	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Loyle M. Anderson</i>	TITLE <i>Administrato</i>	(X6) DATE <i>1-29-15</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.

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F 281	<p>Continued From page 1 medications."</p> <p>*Upon request to see the physician's order and assessment for self-administration of medication the infection control nurse was unable to locate the order or the assessment in the computer system.</p> <p>Interview on 1/6/15 at 9:36 a.m. with the Minimum Data Set (MDS) coordinator revealed she could not find a current physician's order for self-administration of medications for resident 15.</p> <p>Further interview on 1/7/15 at 11:35 a.m. with MDS coordinator revealed: *There was no interdisciplinary team assessment of the resident's ability to self-administer medications. *She reviewed a resident's ability to self-administer medications quarterly during medication administration.</p> <p>Interview on 1/7/15 at 2:30 p.m. with the director of nursing (DON) revealed: *He agreed there was no current physician's order for self-administration of medications by resident 15. *There was no form to assess a resident's ability to self-administer medications once medications were set-up. A nurse assessed the resident's ability to self-administer medications quarterly during medication administration.</p> <p>Review of the provider's November 2014 Administration of Medication procedure revealed: *The resident had the right to self-administer medications if the interdisciplinary team determined the practice was safe for the individual resident and others. *If the resident had not been assessed for safety of self-administration, and there was not a</p>	F 281	<p>An order for self-medication was obtained for resident 15 on 1-6-14. All residents have been reviewed for self-administration orders. 2 members of the care plan team will assess residents upon admit and quarterly for self-administration of medications after set up. DON will in-service all staff on 2-4-15 that all residents will be assessed and have orders obtained if they are to self-administer after set up. Don or designee will audit for orders and assessment 2 residents 1 time per week times 4 weeks, then 2 residents monthly times 3, then as determined by the QAPI committee. All findings will be reported to the QAPI committee by the DON or designee for further recommendations</p>	<p><i>*monthly</i> <i>DHSSDH/INF</i> <b>2-5-15</b></p>

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F 281	<p>Continued From page 2</p> <p>physician's order to leave the medication with the resident, the person administering the medication was to have stayed with the resident until the medication was taken.</p> <p>Review of the provider's July 2014 Resident Self-Administration of Medication procedure revealed:</p> <p>*The interdisciplinary team was to determine if a resident was able to self-administer medications. *A physician's order must be obtained prior to the resident self-administering medications.</p> <p>2. Review of resident 1's complete medical record revealed:</p> <p>*Admitted on 4/4/13. *Diagnoses included pressure ulcers (red or opened areas on the skin due to unrelieved pressure), edema (build up of fluid within body), and congestive heart failure (build up of fluid within cardiovascular [heart and circulatory] system). *Resident refused meals at times. *No physician's order for when to weigh the resident. *Monitoring weight loss was documented on the plan of care as started on 6/16/14 without direction as to how often to weigh the resident. *Weight summary from 7/24/14 through 1/7/15 revealed: -July, one weight. -August, four weights. -September, three weights. -October, two weights. -November, three weights. -December, four weights. *Six of those seventeen weights showed a weight change of more than three pounds and had not had a reweight done.</p>	F 281	<p><i>* for all residents including residents 1, B and B DK/SDDH/MF</i></p> <p>Bath Aides will weigh residents weekly. Weights are recorded on the kiosk and weight book. If the bath aide notes a three pound variance a re-weight will occur and be reported to the charge nurse. The charge nurse will notify the dietary manager of the results through GSS#196 Nutritional Risk Notification. The dietary manager or designee with audit weights on 2 residents 1 time per week for 4weeks then 2 residents monthly times 3, then as determined by the QAPI committee. All findings will be reported to the QAPI committee by the dietary manager or designee. <i>*monthly DK/SDDH/MF 2-5-15</i></p>	

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F 281	<p>Continued From page 3</p> <p>-One weight change was a twenty pound difference.</p> <p>3. Review of resident 5's complete medical record revealed: *Admitted on 9/16/13. *Diagnoses included dementia (confusion) and nutritional deficiency. *No physician's order for when to weigh the resident. *Weekly weights were documented as an intervention on the plan of care as started on 3/7/14. *Weight summary revealed: -During the forty-two week period from 3/7/14 until 1/7/15 thirty-two weights were recorded. -Seven of those thirty-two weights had more than a three pound weight change. -One of those seven weights had a weight done the next day that showed an additional change of ten pounds with no weight again for five days.</p> <p>Interview on 1/7/15 at 2:30 p.m. with the DON revealed he: *Agreed reweighs after weight changes of more than three pounds were not being done. *Believed it was due to a change in the ability to view previous data when putting weights into computer documentation system.</p> <p>Surveyor: 34030</p> <p>4. Review of resident 8's complete medical record revealed: *An admission date of 11/21/12 with diagnoses that included Parkinson's disease (a neuromuscular disease that results in a gradual decline in function) and Alzheimer's (condition resulting in gradual decline in mental functioning).</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>*No medications or medical conditions that would cause a fluctuation in his weight due to body fluid imbalance.</p> <p>*Weight summary that showed he was weighed weekly and had periods of 3 pounds or greater change in weight from one week to the next that had not been rechecked as per the provider's policy.</p> <p>-On 7/29/14 a weight of 137 pounds was recorded. In the same week on 8/1/14 the weight was recorded at 130.5 pounds. That was a difference of 6.5 pounds.</p> <p>-On 8/5/14, 138.5 pounds was recorded. The next week on 8/13/14, 134.5 pounds was recorded. That was a difference of 4 pounds.</p> <p>-On 10/7/14, 134.5 pounds was recorded. The next week on 10/17/14, 131 pounds was recorded. That was a difference of 3.5 pounds.</p> <p>-On 10/28/14, 130 pounds was recorded. The next week on 11/5/14, 134.5 pounds was recorded. That was a difference of 4.5 pounds.</p> <p>-All weights had been taken on the wheel chair (W/C) scale.</p> <p>Review of resident 8's 8/7/14 significant change and 10/28/14 quarterly Minimum Data Set (MDS) assessments revealed:</p> <p>*A weight loss that appeared to be 8.5 pounds in two months.</p> <p>*No significant change dietary assessment had been done. No mention of that weight loss was found.</p> <p>Review of resident 8's 1/5/15 care plan revealed:</p> <p>*Potential nutritional problem due to Parkinson's and needing assistance with eating.</p> <p>-"Monitor and record intake."</p> <p>-"Weigh weekly."</p>	F 281			

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F 281	Continued From page 5 Interview on 1/6/15 at 4:00 p.m. with the dietary manager revealed: *She agreed the significant change dietary assessment for resident 8 had not been done. *This surveyor pointed out to her what looked like a significant weight loss might or might not have been due to the inability to tell accurate weights from the record. *When asked if she would have expected that weights be redone when such differences were noted she replied, "In a perfect world....."  5. Review of the provider's June 2014 Weight and Height procedure revealed: *Residents at nutritional risk would be weighed weekly, otherwise at a minimum of monthly. *If weight varied by more than three pounds, re-weigh resident and document. Report weight to licensed nurse.	F 281			
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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 record review and interview, the provider failed to combine the hospice plan of care with the provider's plan of care for one of one sampled resident (9) who had been receiving	F 309			

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F 309	<p>Continued From page 6 hospice service. Findings include:</p> <p>1. Review of resident 9's medical record revealed: *An admission date of 7/7/14. *A change to hospice care on 11/6/14.</p> <p>Review of resident 9's 1/6/15 care plan revealed: **1:1 [one to one] visits with (name of hospice company) hospice staff for mental stimulation." **"Consult with (name of hospice company) hospice with any changes in resident condition." **"Visits from (name of hospice company) hospice staff per hospice care plan: RN [registered nurse] 2 times weekly, Aide 5 times weekly, SW [social worker] 1-2 times monthly, Chaplain 1-2 times monthly, Volunteer 2 times monthly." *No further reference regarding the resident's care to specify responsibility between hospice and the provider had been found.</p> <p>Interview on 1/7/15 at 9:00 a.m. with certified nursing assistant (CNA) E revealed: *She was unsure what care hospice provided to resident 9. *The "nurses tell us."</p> <p>Interview on 1/7/15 at 9:30 a.m. with licensed practical nurse F revealed: *"The nurses do not tell CNAs" what hospice would do for a resident. *She thought the hospice aide communicated with the provider's CNAs. *With regard to resident hospice care and communication she stated "It would be nice to know."</p> <p>Interview on 1/7/15 at 9:45 a.m. with the Minimum Data Set coordinator who writes the care plans</p>	F 309	<p>The care plan for resident 9 has been amended to address combined services between hospice and LTC facility. All future hospice residents will have a coordinated care plan between the facility and hospice. The MDS Coordinator will educate staff on hospice care plans at an all staff meeting on 2-4-15. The MDS Coordinator or designee will audit all current hospice charts for care plan compliance weekly times 4 weeks, then monthly times 3 months, then as determined by the QAPI committee. All findings will be reported to the QAPI committee by the MDS Coordinator or designee.</p> <p><i>x monthly</i> <i>DK/SDDH/ME</i></p>	<p><i>2-5-15</i></p>	



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F 425	<p>Continued From page 8</p> <p>Based on observation, interview, record review, and procedure review, the provider failed to maintain one of one locked emergency medication kit (E kit) with unexpired medications, and one of one medication refrigerator (medication storage room) with the temperature between 36 and 46 degrees Fahrenheit (F). Findings include:</p> <p>1. Observation and refrigerator temperature record review on 1/6/15 from 4:00 p.m. to 4:45 p.m. in the medication storage room with licensed practical nurse F revealed:</p> <ul style="list-style-type: none"> <li>*The E kit was separated into four different containers.</li> <li>-Only one of the four containers was locked with a numbered plastic lock.</li> <li>*After opening the one locked container there were no more numbered plastic locks to replace the one removed.</li> <li>*Two medications in the E kit were past the expiration dates listed on the medication package.</li> <li>*The November 2010 Refrigerator/Freezer Temperature Log identified the medication refrigerator must be kept between 36 to 46 degrees F.</li> <li>-The refrigerator with medications stored in it had been at 32 degrees F since it was checked by the nursing personnel on 1/5/15.</li> <li>-No adjustments to the temperature control had been documented.</li> </ul> <p>Interview on 1/6/14 at 6:00 p.m. with director of nursing revealed he agreed:</p> <ul style="list-style-type: none"> <li>*Not all four containers making up the E kit were locked.</li> <li>*There were two expired medications in the E kit.</li> <li>*The medication refrigerator was not in the 36</li> </ul>	F 425	<p>All medications from the E kit have been moved into one kit that is double locked with numbering locks. All medications in the E kit were reviewed by the local pharmacist on 1/14/15 and double locked with the date of the next expired medication on the top of the E-kit. The setting on the refrigerator was adjusted on 1/6/15 and is being kept in the acceptable range. All licensed nurses and medication aides will be in-serviced by the DON on 2-4-15 on adjusting the refrigerator to proper temp as well as E kit policy and E-kit usage. The DON or designee will audit the E-kit as well as temperature record in the med room 1 time per week times 4 weeks, then monthly times 3 months, then as determined by the QAPI committee. All findings will be reported to the QAPI committee by the DON or designee for further recommendations.</p> <p>*MONTHLY DK/SDDOH/MF</p>	<p>*2/5/15 DK/SDDOH/MF</p>

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F 425	Continued From page 9 degree to 46 degree F range as identified on November 2010 Refrigerator/Freezer Temperature Log.  Review of the provider's September 2012 Emergency Drug Boxes procedure revealed the: *E kits were to be kept locked. *Pharmacist was responsible for monitoring expiration dates.	F 425		
F 441 SS=F	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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 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	F 441		

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F 441	<p>Continued From page 10</p> <p>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: 33488 Based on observation, interview, and manufacturer's guideline review, the provider failed to ensure one of one shower chair and one of one whirlpool tub were disinfected according to manufacturers' guidelines. Findings include:</p> <p>1a. Observation and interview on 1/6/15 at 8:40 a.m. of certified nursing assistant (CNA) A cleaning the shower chair revealed she: *Was the main bath aide for the facility. She provided the majority of the baths and showers except on her days off. *Sprayed Oxivir TB (cleaner and disinfectant) spray on the shower chair. *Immediately rinsed the shower chair with water. *Was unaware what the manufacturer's guidelines for the Oxivir TB required in order to properly disinfect the shower chair between resident use. *Agreed when reviewing the Oxivir TB bottle's instructions for use that she should have waited the appropriate contact time of ten minutes to ensure disinfection prior to rinsing the shower chair off.</p>	F 441	<p>A new bathing system has been ordered which will have a cleaning system. Until the system is in place all nursing staff will be in-serviced 2-4-15 by the DON on proper cleaning techniques of the bath tub and shower chair including a 10 minute wait time prior to rinsing the tub and chair after the cleaning solution has been applied. The whirlpool solution will be a solution of 2 oz/gallon and will be flushed through the whirlpool cycle for 10 minutes prior to being rinsed. The DON or designee will audit the disinfecting of the area 1 time per week times 4 weeks, then 1 time per month times 3 months, then as determined by the QAPI committee. All findings will be reported to the QAPI committee by the DON or designee.</p> <p><i>*MODIFIED BY DKSDH/MF</i></p>	2-5-15

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F 441	<p>Continued From page 11</p> <p>b. Observation and interview on 1/6/15 at 8:50 a.m. of CNA A cleaning the whirlpool tub revealed she:</p> <ul style="list-style-type: none"> <li>*Sprayed the tub with the same Oxivir TB cleaner.</li> <li>*Rinsed the tub with water immediately after spraying.</li> <li>*Had not disinfected the whirlpool jets.</li> <li>*Stated she had not used the manufacturer's recommended cleaner.</li> </ul> <p>c. Observation and interview on 1/6/15 at 5:30 p.m. with the maintenance supervisor and the director of nursing (DON) regarding the above whirlpool tub revealed:</p> <ul style="list-style-type: none"> <li>*The maintenance supervisor attempted to operate the whirlpool tub's disinfecting mechanism. It had not turned on.</li> <li>*He was unaware if it had worked previously.</li> <li>*He was never notified by staff that it had been inoperable.</li> <li>*The DON stated the whirlpool tub cleaning system had not worked in some time, but a new tub was to be purchased that year.</li> <li>*The DON stated staff used the Oxivir TB to disinfect the whirlpool tub.</li> <li>*He stated staff should have waited five to ten minutes before rinsing.</li> <li>*He was unaware the whirlpool tub jets were not being cleaned appropriately.</li> </ul> <p>Interview on 1/7/15 at 1:15 p.m. with the infection control coordinator regarding the whirlpool tub and shower chair revealed:</p> <ul style="list-style-type: none"> <li>*The whirlpool tub disinfection system had been inoperable "at least six months."</li> <li>*She was unaware the whirlpool jets were not being properly disinfected.</li> <li>*Was unaware the shower chair was also not being disinfected according to manufacturer's</li> </ul>	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435082</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 LENNOX</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</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 441	<p>Continued From page 12 guidelines.</p> <p>*Expected staff to follow manufacturer's guidelines when cleaning the whirlpool bath and shower chair.</p> <p>Review of the Oxivir TB spray label instructions revealed: *It must remain wet for one minute. *Bacteria would be killed in five minutes. *Fungus would be killed within ten minutes.</p> <p>The provider had no specific whirlpool policy except to follow manufacturer's guidelines for cleaning and disinfection.</p> <p>Review of the Parker whirlpool tub manufacturer's instructions regarding disinfection revealed: **"For optimal performance only use Arjo-Huntleigh Disinfectants." **"If the Parker is equipped with Air Spa, the bath must be disinfected with its integrated disinfection system." **"Disinfection should be distributed through all Air Spa nozzles or proper disinfection can not be guaranteed." **"Let the disinfectant agent act for about 10 minutes, during this time scrub all surfaces."</p>	F 441			

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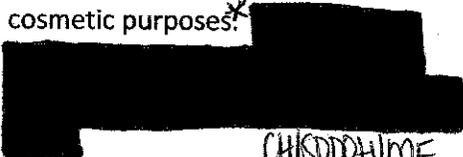
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</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	
K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/06/15. Good Samaritain Society Lennox was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/14/15 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 intent to correct the deficiencies identified at K018, K020, K022, K029, K038, K062, K068, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 01/14/15 telephone to facility administrator. CHSDDOH/ME		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations	K 018			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Les M. Anderson* TITLE: *Administrator* (X6) DATE: *1-29-15*

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 44 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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</b>		
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K 018	Continued From page 1 in all health care facilities.  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain corridor separation from use areas with doors capable of resisting the passage of smoke at one randomly observed door (housekeeping/storage room corridor door). Findings include:  1. Observation at 12:00 noon on 1/06/15 revealed the housekeeping/storage room corridor door had an 8 inch by 15 inch air transfer grill in the top half of the door. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He indicated the door louver/opening had been installed to facilitate air flow through the room due to battery charging equipment being used in the room.  The deficiency affected a single location of numerous locations required to be equipped with a smoketight corridor door.	K 018	After removing cover of air transfer grill it was discovered that hole had previously been filled and cover was for cosmetic purposes.  CH/SDDH/MF	2-5-15
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one	K 020		

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</b>
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K 020 Continued From page 2  
hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.

This STANDARD is not met as evidenced by:  
Surveyor: 18087  
Based on observation and interview, the provider failed to maintain stair enclosures between floors enclosed with construction having a fire-resistance rating of at least one hour (east basement stair enclosure). Findings include:

1. Observation at 1:30 p.m. on 1/06/15 revealed unsealed pipe penetration openings around a four inch waste pipe and a one inch sprinkler pipe in the east wall of the sprinkler riser room into the stair enclosure. Interview with the maintenance supervisor at the time of the observation confirmed those findings.

The deficiency affected one of several stair enclosure locations required to be provided with a one hour protected path of egress.

K 022 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4

K 020

Pipe penetration openings have been filled.

*\*The maintenance supervisor will be responsible for monitoring the completion of the work and reporting to QA. CHISDOOH/MF*

*2-5-15*

K 022

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K 022	Continued From page 3  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to properly identify one of one exits for the basement telecommunications room west of the boiler room. Findings include:  1. Observation at 2:15 p.m. on 1/06/15 revealed the basement telecommunications room west of the boiler room had a designated exit east through the boiler room. Exiting through a hazardous area (basement boiler room) from another area is not acceptable.  2. Observation at 2:20 p.m. on 1/06/15 revealed the basement telecommunications room west of the boiler room did not have signage designating exiting to the main floor using the wood stair. Exiting through a hazardous area (basement boiler room) from another area is not acceptable.  The deficiency affected one location required to be provided with a marked and identifiable path of egress.	K 022	1 Exit sign designating exit east has been removed.  2 The basement telecommunications room is now marked with appropriate identifiable path of egress up the wooden stairs.  <i>*The maintenance supervisor will be responsible for monitoring the completion and reporting to QA. CHSDDH/MF</i>	2-5-15
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029		



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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</b>	
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K 033	Continued From page 5  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, the provider failed to maintain a protected path of egress from the basement to the exterior of the building. One of three basement stairways (from the west exit of the boiler room) discharged onto the main level and was not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include:  1. Observation at 11:30 a.m. on 1/06/15 revealed a basement required egress stairway west of the dining room discharged into the corridor on the main level and did not provide a one hour protected path of egress to the exterior of the building. The egress stair was one of two required means of egress from the basement boiler room. The boiler room had over 500 square feet in area and contained over 400,000 British thermal units input fuel-fired equipment. That condition had existed since the building was constructed in 1960.	K 033		
* K 038 SS=B	 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	K 038		<b>01/15/15</b>  CH/SDDH/MF

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</b>	
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K 038	Continued From page 6  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure exit access locations at three randomly observed locations (rooms 206, 211, and 213) were readily accessible at all times. Findings include:  1. Observation and interview beginning at 11:30 a.m. on 1/06/15 revealed the doors for the following resident toilet rooms had double-action latching hardware: *The 206 side of the shared toilet room of resident rooms 206 and 208. *The 211 side of the shared toilet room of resident rooms 209 and 211. *The 213 side of the shared toilet room of resident rooms 213 and 215. When the latch was locked, the door would not open by trying to turn the lever style handle for the latch. The resident would need to unlock the door latch by twisting the center knob in the lever handle, then open the door. The double-action hardware would impede opening the doors in a fire emergency. Interview with the maintenance supervisor at the time of the observation confirmed the findings. He indicated appropriate single-action hardware would be installed.  The deficiency affected three of numerous locations required to be equipped with single-action hardware.	K 038	The bathroom door handles have been replaced in rooms 206, 211 and 213. Maintenance Supervisor will inspect all resident bathroom doors and replace any others found to be out of compliance.  <i>*The maintenance supervisor is responsible for reporting completion to QA. CH/ODD/HMF</i>
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	

*2-5-15*

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</b>	
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K 062	Continued From page 7 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 unobstructed space adjacent to the sprinkler deflector, so the water discharge was not interrupted in three randomly observed resident rooms (212, 213, and 214). Findings include:  1. Observation beginning at 11:30 a.m. on 1/06/15 revealed a single sprinkler in the ceilings of resident rooms 212, 213, and 214. The rooms were double occupancy rooms with two privacy curtains. The sprinkler discharge pattern would have to penetrate both curtains (in one direction) if both were closed at the same time. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware of the second curtains possible interruption of the sprinkler discharge pattern.  The deficiency affected three of numerous resident room locations required to be equipped with unobstructed fire sprinkler protection.	K 062	Privacy curtain stops have been placed on curtain rail in rooms 212, 213 and 214. Maintenance Supervisor will inspect all resident rooms and put curtain stops in rooms where sprinkler would potentially have to spray through two curtains.  <i>* The maintenance supervisor is responsible for monitoring completion and reporting to RA. CH/SDDH/MF</i>	2-5-15
K 068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2	K 068		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/06/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD 57039</b>	
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K 068	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install and maintain adequate combustion air for the boiler room (two gas-fired boilers) and for the laundry room (three gas-fired dryers). Findings include:</p> <p>1. Observation at 2:30 p.m. on 1/06/15 revealed the 780,000 British Thermal Unit (BTU) input gas-fired Weil boiler and 365,000 A.O. Smith gas-fired boiler within the boiler room did not have adequate free air for combustion. An exterior window with a partially-opened glass pane provided an obstructed free air space of approximately 72 square inches. That provided an inadequate supply of free air and was an unacceptable method of providing free air (window that could be closed). Interview with the maintenance supervisor revealed he was unaware the combustion air supply for the boiler room did not meet the requirements.</p> <p>2. Observation and testing beginning at 3:00 p.m. on 1/06/15 revealed three gas-fired Speed Queen dryers in the laundry room. The dryers had an electrically controlled fresh air damper in the exterior wall. Testing at 3:15 p.m. of the damper's operation with that of the three dryers (D1, D2, and D3) revealed the damper did not function/open with the operation of dryer D1. Interview with the maintenance supervisor at the time of the testing confirmed that finding.</p> <p>The deficiency affected two of two locations required to be provided with dedicated combustion air supply for fuel-fired equipment.</p>	K 068	<p><i>*The maintenance supervisor is responsible for monitoring the combustion air supply for the boilers and reporting to QA for a period of four months. CH/SSDH/mf</i></p> <p>1 Duct work put over window opening to ensure adequate fresh air for boiler room.</p> <p>2 Fresh air damper has been adjusted so it operates appropriately. The maintenance supervisor or designee will educate staff at the all staff in-service on 2-4-15 to report any concern that damper is not operating properly to the maintenance department. The maintenance supervisor or designee will audit the dryer damper weekly x 4 weeks then monthly x 2 months to ensure proper operation of dryer damper then as determined by the QAPI Committee. All finding will be reported to the QAPI committee by the maintenance supervisor or designee for further recommendations</p> <p><i>2-5-15</i></p>

**ORIGINAL**

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>435082</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE:  <b>1/6/2015</b>
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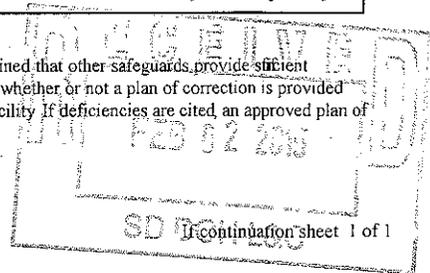
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 EAST 6TH AVENUE LENNOX, SD</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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<b>K 147</b>	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to provide covers on one randomly observed set of electrical wiring protruding through the gypsum board ceiling in the day room Findings include:</p> <p>1. Observation at 2:30 p.m. on 1/06/15 revealed two electrical wires with wire nuts extending below the gypsum board ceiling adjacent to a surface-mounted fluorescent light in the day room Interview with the maintenance supervisor at the time of the observation confirmed that condition He indicated he did not know the exposed wiring was at that location.</p> <p>The deficiency affected a single electrical wiring location required to be equipped with a cover.</p> <p>Electrical wiring will be covered with appropriate cover. <i>2-5-15</i></p> <p><i>Lois M. Anderson</i> Administrator <i>1-29-15</i></p>
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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

The above isolated deficiencies pose no actual harm to the residents



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10642 S</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LENNOX</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 E 6TH AVE LENNOX, SD 57039</b>
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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
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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 1/5/15 through 1/7/15. Good Samaritan Society Lennox was found not in compliance with the following requirement: S236.	S 000	<i>Addendums noted with an asterisk per 2/15/15 telephone to facility rep. DK/SDDCH/MF</i>	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Tuberculin screening requirements for healthcare workers or residents are as follows:  (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to ensure two of five employees (B and C) had their tuberculosis (TB)	S 236		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Les M. Anderson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-29-15</i>
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10642 S</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/07/2015</b>
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S 236	<p>Continued From page 1</p> <p>(a contagious respiratory disease) two-step testing completed in a timely manner after employment. Findings include:</p> <p>1 a. Review of registered nurse B's employee file revealed: *She was hired on 11/13/14. *TB testing had not been done to show whether or not she had the contagious disease that could have been passed on to other workers and residents. *No other records regarding her TB testing were found.</p> <p>b. Review of dietary assistant C's employee file revealed: *She was hired on 11/3/14. *She had completed the first step of TB testing on 11/3/14 but failed to complete the second step. Both steps of testing are required. *She was currently on the employee work schedule.</p> <p>c. Interview on 1/7/15 at 2:00 p.m. with the director of nursing revealed: *The nurse who was in charge of employee testing was currently out on sick leave and unavailable to interview. *No other paperwork could be found for the above employees. He agreed TB testing should have been done.</p> <p>Review of the provider's March 2014 TB skin testing policy revealed: "New employees will have baseline TB screening using the TST two-step method. This involves administering the initial TST [two step tuberculin] to be read in 48 hours by a nursing professional or physician. The second test is administered in one to two weeks and is read 48 to 72 hours after administration by</p>	S 236	<p>The Staff Development Coordinator will follow up on employees B and C to ensure the TB series has been completed or proper documentation has been presented to support a past screen. All new staff will have a TB screen completed within 14 days of employment or documentation to support a past screen. The administrator will educate all staff on the two step TB screen at an all staff meeting on 2-4-15. The Staff Development Coordinator or designee will audit all new hire's medical charts monthly for three months for compliance, then as determined by the QAPI committee. All finding will be reported to the QAPI committee by the Staff Development Coordinator or designee for further recommendations</p> <p><i>*MONTHLY DISCUSS/MT</i></p>	2-5-15
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