

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

ORIGINAL

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362
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F 000	<p><i>*Addendums noted with an asterisk per 9/17/15 by telephone from facility administrator. kg/sddoh/el</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 8/3/15 through 8/5/15. Good Samaritan Society Miller was found not in compliance with the following requirement(s): F166, F241, F280, F315, F325, F360, and F371.</p>	F 000		
F 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview, record review, and policy review, the provider failed to resolve grievances (residents' complaints, concerns) addressed in resident council meetings from February 2015 through July 2015. Findings include:</p> <p>1. Review of the resident council minutes from January 2015 through July 2015 revealed it had been documented during the following meetings: *On 2/17/15 "Waiting time is long for service staff says they will be back and don't return as promptly like they said. They are tired of being second wheel to staff breaks." *On 3/17/15 "They would like tasks of cares finished before they leave, not do some part of task, leave and return to finish tasks." *On 4/15/15 "Also make staff aware that call</p>	F 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Laura J. Pospisil</i>	TITLE <i>Administrata</i>	(X6) DATE <i>9/16/15</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 166	<p>Continued From page 1</p> <p>lights should be in reach at all times in the rooms."</p> <p>*On 5/19/15 "Call lights are not answered in timely manner this seem to be an increasing problem and when answered states help will come back in few minutes and never return or long time until they return."</p> <p>*On 6/16/15 "Waiting times remains the same for call lights to be answered. Determined it takes longer for lights to be answered late evening and during the night."</p> <p>*On 7/22/15 "Call lights seem to have improved but still have waiting times."</p> <p>*There had been no documentation of when any of the above concerns had been reported to the nursing staff.</p> <p>*There had been no resolution documented for any of the above concerns.</p> <p>Surveyor: 35237</p> <p>Interview of residents on 8/4/15 at 10:35 a.m. during the confidential group meeting revealed:</p> <p>*The residents had complained many times about call lights not having been answered in a timely manner.</p> <p>*It was not uncommon for staff to come into their room and shut off their call light.</p> <p>-They would be told the staff would be right back, and they did not always come back.</p> <p>*They did not want staff to shut the call light off and leave without helping them.</p> <p>*They had to wait many times over one half hour for their call light to be answered.</p> <p>*They had brought up the call light concerns at resident council meetings.</p> <p>*They had not felt the resident council was getting the call light issue resolved.</p> <p>*The staff had not told them what they were doing to work on the call light issue.</p>	F 166	<p>F 166</p> <p>1.* SSD or Designee will audit the promptness of call lights being answered in a timely manner on each hall, 5 different rooms on each hall and on all three shifts by 8/28/2015.</p> <p>*Observations from the day shift on 8/26/2015 and 8/27/2015, on all 3 halls revealed that call lights were answered with the shortest response time of 24 seconds and the longest response time of 10 min. 42 seconds. (Times of study for the 3 halls were 1042 to 1200.)</p> <p>*Observations from the evening shift on 8/26/2015 and 8/27/2015, on all 3 halls revealed that call lights were answered with the shortest response time of 3 minutes and the longest time being 6 minutes. (Times of study for the 3 halls were 1700 to 2000.)</p> <p>*Observations from the night shift on 8/26/2015 and 8/28/2015, on all 3 halls revealed that call lights were answered with the shortest time of 1 minute with the longest time of 7 min. (Times of study for the 3 halls were 2300-0410.)</p> <p>*The SSD or Designee will compile the results of the audit ending on 8/28/2015, date the form, and provide the results to the DNS within 5 days of completion of the initial audit. The DNS will review the audit, correct any issues found with the audit, educate any staff found in the audit to be out of compliance and turn in the completed plan to the SSD or Designee within 5 days of receipt of the audit.</p> <p>* The SSD or Designee will do random audits of promptness of answering call lights on all 3 halls monthly for 3 months then quarterly for 1 year and report findings to the DNS of immediate correction if needed and report all findings at monthly QAPI meetings X 3 months, then quarterly for 1 year.</p>		

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F 166	Continued From page 2 Interview on 8/5/15 at 8:35 a.m. with the social services designee/licensed practical nurse (LPN) that had attended the monthly resident council meetings revealed: *She was responsible for the resident council meetings. *The complaints about the call lights was an ongoing issue. *When she received concerns during a resident council meeting she would have brought that concern to the department head who would have been involved. -She did not necessarily do a grievance or concern form for concerns from resident council. *She stated they would have educated the staff of the concern at staff meetings. *Staff were to have left the call light on if they could not complete what the resident had asked for when they answered the light. *She stated they had not done any audits related to call lights. *She did not know what the average wait time for call lights to be answered would have been since she had not audited them. *She stated she had no formal documentation of what they had done related to the call light concerns from the residents. *At the next months resident council meeting she would have brought up the previous months concerns and asked the residents about how it was going. -If a concern was still ongoing it would be carried on to the next month. *She sometimes put out memos (notes) to staff regarding concerns from resident council. Review of the memos provided by the social services designee/LPN revealed:	F 166	F 166 Continued *SSD or Designee will interview 9 randomly selected residents (3 per hall) on each shift by 9/16/2015. SSD or Designee will also time the call lights for appropriate time to answer them. Residents were asked 3 questions on all 3 shifts. 1) If their call lights were being answered in a timely manner 2)if their needs had been met when their call lights were answered and 3) if the staff are leaving the call light on after answering if they cannot immediately meet the need of the resident and meeting the resident's needs in a timely manner. *Results of interview of are as follows: Day Shift 7AM – 3 PM: 2 of 9 residents waited > 10 min. but <15 min. per our standard. All 9 residents stated their needs were met in a timely manner and no call lights were turned off if a staff person could not immediately assist them. Evening Shift 3PM-11PM: 2 of 9 residents waited >10 min. but <15 min. for their call lights to be answered. 2 call lights had been turned off by staff but both residents stated their needs were met in a timely manner & observation was that these 2 residents' needs were met within 15 min. of initial call light being on. Night Shift: 11PM-7AM: 9 of 9 call lights were answered in a timely manner. 1 resident's needs were not met until just at the at 15 min. endpoint. SUMMARY: The majority of the residents interviewed/audited on all 3 shifts stated that the answering of call lights were better and the wait time was less most of the time.		

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F 166	<p>Continued From page 3</p> <p>*An undated document titled "Information from resident council for FEB [February] for staff" that included: - "The waiting time is very long now for service. They say I will be back in a few minutes and long time before they return and if they return. Some stated it has been 20 minutes or more at times." - There was no specific education to staff of what they should do differently. *An undated document that she stated had been put out to staff the week before was titled "Step to do for grievances, complaints, or concerns" included: - "1. If a family or resident approaches and wants to voice a concern, problem etc. (anything else), you need to furnish them with a Suggestion or Concern form (GSS #213). These are kept in a hanging folder by the resident's telephone and at each nurse's desk." - "3. SS [social services] will review the form or concern and direct to appropriate Dept. [department] head who will then address the concern and investigate, resolution made and follow up will be done with the concerned party."</p> <p>Interview on 8/5/15 at 2:30 p.m. with the director of nursing (DON) revealed: *She had been aware the residents had call light concerns in the past. *She had done call light audits "awhile ago" and quality assurance had records of those. *When she had done the audits the wait time for a call light to be answered was not long. *She expected a call light to be answered in ten to fifteen minutes. *The staff had been educated about the call light concerns. - They did not specifically tell staff to leave the call light on or shut if off if they could not help that</p>	F 166	<p>F 166 Continued</p> <p>* The SSD or Designee will compile the results of the audit, date the form and provide the results to the DNS within 5 days of completion of the initial audit that was completed by 9/16/2015. The DNS will review the audit, correct any issues found with the audit, educate any staff found to be out of compliance of the results and turn in the completed plan to the SS within 5 days of receipt of the audit. * The SSD or Designee will report findings and corrections done from the initial audit at the next QAPI meeting after the form is turned in to the SSD or Designee. * The SSD or Designee will do random audits of promptness of answering of call lights, meeting the needs of the residents and if call light is kept on if staff cannot immediately meet the residents' needs monthly for 3 months then quarterly for 1 year and report findings at QAPI meetings. Any non-compliance will be documented, reported to DNS for immediate correction and also reported to QAPI meetings. * All staff will be educated on the call light answering process by 9/2/2015. This education will include leaving the resident's call light on if the staff person answering cannot immediately meet the needs of the resident. 2.* All concerns brought up in monthly Resident Council will be documented on a Suggestions and Concern form by SSD or Designee the day of Resident Council. * The SSD or Designee will provide the form with the specific concerns/suggestions written on it to the Department Director(s) in which the concern(s) have been made. The Department Director(s) will have 5 days to correct/address the concerns and return the completed forms with corrections written to the SSD or Designee.</p>		

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F 166	<p>Continued From page 4 resident right away. *She stated they had added an additional evening nursing assistant on one unit about five or six months ago, and that had helped with the call light complaints. -She felt residents had been aware of that additional staff. *She thought the social services designee/LPN would have brought back how they had addressed the concerns to the next resident council meeting.</p> <p>Interview on 8/5/15 at 4:00 p.m. with the DON and the quality assurance performance improvement (QAPI)/staff development nurse revealed: *They had done audits related to call lights in December 2014 and January 2015 but had no documentation of those audits. *They had talked about call light concerns in QAPI meetings for a few months. *The QAPI nurse asked for any resident and family concerns to be brought up at the monthly QAPI meetings and had not heard about call lights for several months. *The social services designee had not brought the concern of the call light wait times to either of their attention.</p> <p>Review of the provider's February 2013 Grievances, Complaints, or Concerns policy and procedure revealed: **"There will be prompt efforts by the center to resolve resident grievances." **4. If a complaint comes directly to the social services department, then the director of social services will complete a Suggestion or Concern (GSS #213) form upon receipt of the complaint." **5. The social services director will route the</p>	F 166	<p>F 166 Continued</p> <p>*SSD or Designee will report the concerns/suggestions with their corrections to the next monthly Resident Council for determination correction by the residents at that meeting. Any further issues with the concerns/suggestions will be documented on the form and returned to the appropriate Department Director for continued correction. *The SSD or Designee will report all findings to monthly QAPI meetings. *SSD or Designee will place all completed forms in a binder for 1 year. *All staff will be educated on this process by 9/2/2015. 3.* All other individuals bringing concerns (families, visitors, staff) will be encouraged to complete the "Suggestions and Concern" form and give to the SSD or Designee. These concerns will be addressed in the same manner as in #2 above by the SSD or Designee with the exception that the SSD or Designee will contact the individual(s) with the suggestion/concern on an individual basis within 10 days of date of the suggestion/concern. *DSS or Designee will report findings to QAPI monthly.</p>	


*09/16/2015,
Corrections to PoC

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F 166	Continued From page 5 Suggestion or Concern (GSS #213) form to the appropriate department head as soon as is reasonably possible." **6. An investigation must be completed for all grievances. The investigation may be informal, but must be thorough, affording all interested persons an opportunity to submit evidence related to the complaint." **7. The social services director then will report the findings to the individuals filing the concerns and to the center administrator." **8. If the grievance is not resolved, the center social services director will channel the concern directly to the administrator..."	F 166			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to ensure: *A dignified dining experience had occurred for one of one sampled resident (2) who needed staff assistance. *Serving trays were removed from the table once the meal was served for all residents who needed assistance with eating during two of two observed meals. Findings include: 1. Observation on 8/3/15 from 4:45 p.m. through	F 241			

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F 241	<p>Continued From page 6</p> <p>6:30 p.m. of resident 2 revealed at: *4:45 p.m. and 5:15 p.m. she had been in her bed sleeping. *6:00 p.m. she was in the day room. Supper was being served in the dining room at that time. *6:10 p.m. she had been taken into the dining room and placed at the table for those who required assistance in a spot another resident had just left. -The residents who did not require assistance were done eating. -Two other residents who had been eating prior to that were still at the table. *6:15 p.m. she had been served her meal. She was the last person to be served in the dining room. Clean-up had already begun in the dining room. *6:30 p.m. when this surveyor returned to the dining room she had been removed from the table and taken back to her room. -There were no residents left in the dining room.</p> <p>Interview on 8/3/15 at 5:20 p.m. with certified nursing assistant (CNA) K revealed: *Supper started around 5:00 p.m. *There were three CNAs working on the north and south halls. *One of those CNAs was in the dining room assisting residents with their meals. *She was getting residents up on the south hall and the other CNA was getting them up on the north hall. *She had not gotten resident 2 up yet, because she sat at one of the assisted tables. *They did not have enough staff to feed the residents who needed assistance all at one time. *She waited to get resident 2 up until she was notified a staff member was available to assist her with her meal.</p>	F 241	<p>F241</p> <p>1.* Resident #2 expired on 8/19/2015. 2.*Currently, 11 residents are being assisted to dine. Residents that need assistance with dining will be brought to the dining room and set up to be assisted to dine by 11:30 AM and 5:00 PM. We will have 3 assist tables with 3 qualified staff available to assist. *All resident tables will have table cloths for the noon meal. All meals delivered to the tables will be removed from the trays and set at the resident's place at the table. *Places will not be cleared at each individual table until all 4 tablemates has completed their meal. 3.* The Facility will have 3 qualified staff assisting those residents who require assisting with dining for noon and evening meals at all times. *All Nursing and Dietary staff will be educated on the new process on 9/2/2015 and updated with the new changes requested by DON by 9/16/2015. Those staff not attending the education in person will have the education mailed to them on 9/16/2015, with a returned signed document to the Center that they have received the education. 4.*DNS, DM, QAPI Coordinator and Administrator will alternate observing the noon and evening dining service for compliance 2 meals/week for one month, 1 meal per week for 4 months. Any non-compliance will be addressed immediately. Results of all audits will be reported to QAPI meetings monthly X 4 months then on a quarterly basis for one year.</p>	9/2/2015, Initial PoC 9/16/2015, corrected PoC	

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F 241	<p>Continued From page 7</p> <p>*She was the only resident left on her hall to get up for supper.</p> <p>Interview on 8/3/15 at 6:30 p.m. with CNA J regarding resident 2 revealed she had not eaten much. She had taken her back to her room. She had not offered her a second meal option. She was the third CNA working on the north and south halls.</p> <p>Observation on 8/4/15 from 12:00 noon through 12:35 p.m. of resident 2 revealed: *At 12:13 p.m. she had been in the day room. Lunch was being served in the dining room. *At 12:35 p.m. she had been brought to the dining room and served her meal. *She had been the last person served. *The table was on the south wall, and she was facing north. *She could see the whole dining room. *There had been ten tables with residents who had not needed assistance. *Those residents at those ten tables had been finished with their meal. *Those tables were being cleared. *Four of those ten tables were completely cleared of dishes and table clothes had already been removed. *An unidentified staff person was in the middle of the room clearing plates off the other tables.</p> <p>Review of the meal times provided per the entrance conference checklist revealed: *Breakfast started at 7:15 a.m. and ended at 9:00 a.m. *Lunch started at 11:30 a.m. and ended at 12:30 p.m. *Supper started at 5:15 p.m. and ended at 6:00 p.m.</p>	F 241			

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F 241	<p>Continued From page 8</p> <p>*Resident 2 had not been taken to the dining room until after the stated end times for two of two observed meals.</p> <p>Interview on 8/5/15 at 1:30 p.m. with the director of nursing (DON) and Minimum Data Set (MDS) assessment coordinator revealed: *They had open dining (residents could choose what time they wanted to eat). *Resident 2 was unable to make that decision for herself. *They did not have enough staff to assist all the residents that needed help with eating at one time. *They agreed having tables being cleared while residents were attempting to eat could have been distracting and was not an appropriate dining experience for the resident.</p> <p>Review of the provider's February 2013 Dignity policy revealed they were to promote dignity by: *"Providing a quiet dining room that is well-lit." *"Serving all residents at the table at the same time, so residents can eat together." *It had not addressed residents that needed assistance with their meals.</p> <p>Surveyor: 35237. 2. Observations on 8/3/15 from 5:00 p.m. through 6:00 p.m. and on 8/4/15 from 11:40 a.m. through 12:30 p.m. of the meal service revealed: *Residents who sat at the tables for those who required assistance had been served their meals with the dishes sitting on green plastic trays. -Those trays had been left on the table for their entire meal. *When those residents who required assistance had been finished eating, the tray and dishes had been removed by staff.</p>	F 241			

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F 241	<p>Continued From page 9</p> <p>-Then the next resident who needed assistance was placed at that table and served their meal in the same manner.</p> <p>Interview on 8/4/15 at 12:00 noon with the business office manager who was serving meals in the dining room revealed: *Residents were served first come first served. *They did not have enough staff to assist all the residents that needed assistance at the same time. *The green plastic trays were used only for the residents who needed assistance. -Those trays were used so the staff could remove the whole tray easily and set the next resident at the table who needed assistance.</p> <p>Interview on 8/4/15 at 12:10 p.m. with CNA G who was assisting at one of the assisted tables revealed: *The green plastic trays were used so that it was easier to clean up for the next resident who needed assistance. *Only the residents who required assistance were served with the green plastic trays.</p> <p>Interview on 8/4/15 at 12:12 p.m. with dietary cook F revealed: *The residents who required assistance were served on the trays, because they did not always sit at the same spot or table every time. *Only the residents who required assistance were served with the green plastic trays.</p> <p>Surveyor: 32335 Interview on 8/5/15 at 1:30 p.m. with the DON revealed they used the green trays because multiple residents required assistance at those tables and they thought it would help with</p>	F 241		

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F 241	Continued From page 10 infection control. They had not considered the residents dignity but had agreed they were not treated like the residents who did not need assistance with eating. Interview on 8/5/15 at 1:35 p.m. with the dietary manager revealed: *They used the green plastic trays for the residents who required assistance for sanitation, because they could just pick up the whole tray right away. *She agreed the residents who required assistance were served differently than the other residents.	F 241			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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.	F 280	F280 1.* Care Plan for resident #6 was updated and MDS modifications completed by MDS Coordinator as of 8/25/2015. Modifications were done on assessments on Resident #6 for 1/26/2015 & 7/6/2015, by MDS Coordinator as of 8/25/2015. *Resident #2 expired 8/19/2015. *All other potentially affected residents in the facility have had their care plans updated by the Care Plan Team by 8/27/2015. *All future potentially affected residents will be identified through assessments upon admission, quarterly and at Care Plan review by the Care Plan Team. These identified residents' Care Plans will be updated to reflect their current status. *Changes that will be made in this Provider's System will be to educate staff on policy & procedure of updating Care Plans and to notify nursing staff immediately of changes they are seeing occurring in residents' conditions. Education will be provided to all staff by 9/2/2015.		

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F 280	<p>Continued From page 11</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 revise 2 of 12 sampled residents' (2 and 6) care plans. Findings include:</p> <p>1. Random observations from 8/3/15 through 8/5/15 of resident 2 revealed she had either been in her bed or up in her wheelchair at meals. She slept in her bed in-between meals. She had not participated in any activities. She was not able to answer questions asked by this surveyor. She had not walked during any of the observations.</p> <p>Interview on 8/4/15 at 2:40 p.m. with certified nursing assistant (CNA) J regarding resident 2 revealed she had been using the wheelchair for the past three to four weeks. She had been walking a lot but had a decline in the past several weeks.</p> <p>Review of resident 2's 6/18/15 care plan revealed: *It had not been updated to include the use of the wheelchair or that she was not walking. *It had not addressed the decline she had experienced in the past three to four weeks. *It stated she had a pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to tissue) to her bottom beginning on 3/25/15. -It had not been updated to reflect it healed in April 2015.</p> <p>2. Review of resident 6's 1/26/15 and 7/6/15 Minimum Data Set (MDS) assessments revealed</p>	F 280	<p>F280 Continued from page 11 of 33</p> <p>*Changes that will be made in this Provider's System to ensure Care Plans are updated in a timely manner to reflect current care will be that Care Plans will be updated with any new orders by HealthCare Providers, Changes of Condition, MDS Reviews and Care Plan meetings. *Care Plans will be reviewed to measure effectiveness of the System Change. Care Plans for review will be selected at random by DNS & MDS Coordinator or Designee to determine if Care Plans reflect the current care required of the residents selected by the DNS & MDS Coordinator or Designee. Two Care Plans will be selected and reviewed weekly for 4 weeks then monthly for 4 months, then quarterly for a year by the DNS & MDS Coordinator or Designee for compliance. Any necessary corrections to the Care Plans reviewed will be completed at the time of the audit. *Results of the audits will be reported monthly at QAPI meetings by the MDS Coordinator or Designee.</p>	9/2/2015	

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F 280	Continued From page 12 he was on a toileting program. Review of resident 6's 7/15/15 care plan revealed it had not included him being on a toileting program. There had been no measurable goals or interventions identified on the care plan. 3. Interview on 8/5/15 at 1:30 p.m. with the director of nursing (DON) and the MDS assessment coordinator revealed: *Resident 2 had declined in the past several weeks. *The MDS assessment coordinator had been debating about completing a significant change MDS assessment but had not done so yet. *They were unaware she had not been walking the past few days. *The DON left the meeting to speak with a staff member and returned saying they had not been walking her as she had been very week. *She had been using the wheelchair for at least three weeks. *The pressure ulcer had resolved in April. *The care plan should have been updated to reflect those changes. *The MDS assessment coordinator agreed the toileting program had not been addressed on resident 6's care plan. Review of the provider's February 2013 Care Plan policy revealed care plans would be reviewed, evaluated, and updated when there was a significant change in the resident's condition. The plan would be modified to reflect the care currently required or provided for the resident.	F 280			
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	<p>Continued From page 13</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</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 have an individualized toileting program with assessments and measurable goals for six of six sampled residents (2, 4, 5, 6, 8, and 9) who had been identified as being on a toileting program. Findings include:</p> <p>1. Review of resident 2's 10/6/14 and 6/8/15 Minimum Data Set (MDS) assessments revealed: *She was on a urinary toileting program. *Both assessments stated there had been decreased wetness. *She had been frequently incontinent on both assessments.</p> <p>Review of resident 2's 6/18/15 care plan revealed: *A focus area that stated "The resident has an ADL [activities of daily living including bathing, eating, dressing, toileting, and grooming] self care performance deficit [can not do] r/t [related to] Alzheimer's disease, confusion, dementia</p>	F 315	<p>F 315</p> <p>1.* Residents at the Center will be routinely toileted upon awakening, after breakfast, before lunch, mid-afternoon, before supper, after supper, at bedtime, and as needed will no longer be considered to be on a Toileting Program and these plans will not be keyed on the MDS. Residents 4, 5, 6, 8 & 9 will be routinely toileted upon awakening, after breakfast, before lunch, mid-afternoon, before supper, after supper, at bedtime and as needed. Care Plans for residents 4, 5, 6, 8, & 9 have been updated to reflect this. Resident #2 died 8/19/2015. *Bladder incontinence assessments have been completed on all affected residents. Goal will be to keep the resident clean, dry and free of odor. *All other potentially affected residents in the facility who would benefit from routine toileting for urinary purposes have had their Care Plans updated to reflect routine toileting to keep each of these residents clean, dry and free of odor as of 8/27/2015. *All potentially affected residents will be identified through assessments on admission and with change of conditions. 3.*Changes that will be made in this Provider's System will be to educate the nursing staff on policy and procedure for routine toileting and on following each resident's Care Plan for recommended routine toileting. *Education will be provided by 9/2/2015. 4.*All new admissions and residents with significant changes in condition will be audited monthly by MDS Coordinator or Designee and reported to QAPI on a monthly basis for 1 year. Any noncompliance will be corrected immediately when found.</p>	9/2/2015, Initial PoC 9/16/2015, Corrected PoC	

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F 315	<p>Continued From page 14</p> <p>[forgetfulness], limited mobility e/b [evidenced by] inability to do ADL's in an independent setting." *Interventions had included: -"Resident requires assistance of 1 to wash hands, adjust clothing, clean self, and transfer on/off the toilet." -A toileting schedule of "Cue/assist to toilet upon awakening, before and after meals, hs [bedtime], and approx [approximately] q [every] 4 hours or prn [as needed] during night." *There had been no measurable goals or other interventions identified on the care plan.</p> <p>Review of resident 2's medical record revealed there had been no bladder assessments completed.</p> <p>2. Review of resident 6's 1/26/15 MDS assessment revealed: *He was on a urinary toileting program. *There had been decreased wetness. *He had been frequently incontinent.</p> <p>Review of resident 6's 7/6/15 MDS assessment revealed: *He was on a urinary toileting program. *There had been decreased wetness. *He had been occasionally incontinent.</p> <p>Review of resident 6's 7/15/15 care plan revealed it had not included him being on a toileting program. There had been no measurable goals or interventions identified on the care plan.</p> <p>Review of resident 6's medical record revealed there had been no bladder assessments completed.</p>	F 315			

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F 315	<p>Continued From page 15 Surveyor: 35237 3. Observation and interview on 8/4/15 at 12:35 p.m. with certified nursing assistant (CNA) H during resident 4's personal care revealed: *She had assisted her to use the toilet after lunch. *The resident had been incontinent at the time and also urinated in the toilet. *She assisted her with personal care and placed a new disposable undergarment on her. *She stated resident 4 was usually incontinent but also used the toilet appropriately when assisted. *When asked about resident 4's toileting program she stated staff assisted her to the toilet about every two hours. *Sometimes the resident would take herself to the toilet as well.</p> <p>Review of resident 4's 11/5/14 annual MDS assessment revealed she: *Was on a current toileting program. *Had no improvement in her incontinence (unable to control urine) related to the program. *Was frequently incontinent.</p> <p>Review of resident 4's 4/15/15 and 7/6/15 quarterly MDS assessments revealed she: *Was on a current toileting program. *Had decreased wetness related to the program. *Was frequently incontinent.</p> <p>Review of resident 4's current care plan revealed: *A goal with a 9/30/15 target date that stated "resident will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene through the next quarter." *Approaches for that goal had been: -"Toilet use: Resident requires one staff participation to use toilet." -"Toileting schedule bladder incontinence:</p>	F 315			

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F 315	<p>Continued From page 16</p> <p>cue/assist to toilet upon awakening, before and after meals, hs [bedtime] and prn [as needed]."</p> <p>Review of resident 4's medical record revealed no assessments related to her bladder incontinence.</p> <p>Interview on 8/5/15 at 9:05 a.m. with the MDS assessment nurse regarding resident 4 revealed: *Her toileting program would have been to toilet in the morning, before and after meals, at bedtime, and as needed. *She agreed that was "kind of standard." *She felt the program was effective for her, because she did not have skin issues and was less incontinent.</p> <p>Surveyor: 35121 4. Review of resident 5's 11/6/14 significant change MDS assessment revealed: *She was on a current toileting program. *Unable to determine response to toileting program. *She was frequently incontinent.</p> <p>Review of resident 5's 7/6/15 quarterly MDS assessment revealed she: *Was on a current toileting program. *Had decreased wetness. *Was frequently incontinent.</p> <p>Review of resident 5's current care plan revealed: **"ADL needs will be met in a timely manner with res participation." **"Toilet use: Resident requires 1-2 assist with using toilet." **"Toileting schedule: cue/assist to toilet upon awakening, before and after meals, hs and prn."</p>	F 315			

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F 315	<p>Continued From page 17</p> <p>5. Review of resident 8's 1/16/15 admit and 6/24/15 quarterly MDS assessments revealed she: *Was on a current toileting program. *Had decreased wetness. *Was occasionally incontinent.</p> <p>Review of resident 8's current care plan revealed: **Resident will improve current level of function in...toilet use." **"Toilet use: Resident requires 1-2 staff participation to use toilet." **"Toileting schedule: Cue/assist to toilet upon awakening, before and after meals, hs, and prn."</p> <p>6. Review of resident 9's 12/22/14 annual and 6/1/15 quarterly MDS assessments revealed she: *Was on a current toileting program. *Had decreased wetness. *Was frequently incontinent.</p> <p>Review of resident 9's current care plan revealed: **Resident will maintain current level of function in...toilet use." **"Assist with toileting in AM, before and after meals, HS and PRN." **"Toileting schedule: Cue/assist to toilet upon awakening, before and after meals, hs, approx q [every] 4 hours throughout the night and prn."</p> <p>Surveyor: 32335</p> <p>7. Interview on 8/5/15 at 1:30 p.m. with the director of nursing (DON) and MDS assessment coordinator revealed they: *Felt the toileting program had been individualized. *Had only completed the bladder assessments upon admission.</p>	F 315			

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F 315	<p>Continued From page 18</p> <p>*Had not used those continued assessments to determine individual needs.</p> <p>*Had not identified the type of incontinence experienced by resident 2 or 6.</p> <p>*Added every 4 hours at night for resident 2 because the night nurse stated otherwise she would be very wet.</p> <p>*Felt if they did not have those schedules for the residents they would not get assisted to the bathroom.</p> <p>*Stated the standard of practice would be CNAs were to assist residents to the bathroom if they needed help.</p> <p>Review of the provider's September 2012 Toileting Programs policy revealed: **The probable type of incontinence should be identified based on information obtained and evaluated through the use of the Bladder Incontinence Data Collection Tool UDA, Bladder Assessment UDA and the Care Area Assessment (CAA)." **An appropriate toileting program should be implemented based on the type of incontinence and information obtained and evaluated through the use of the Bladder Assessment UDA and completion of the Care Area Assessment (CAA). These toileting programs include: Scheduled toileting, habit training, prompted voiding, and bladder training." **Note: Check and change every two hours would not be considered a scheduled toileting program on the MDS." **The care plan should include measurable goals to maintain or restore the highest level of continence possible for a resident. It is recommended that the goals be progressive and that at least initially be focused on continence during waking hours."</p>	F 315			

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F 315	Continued From page 19 **Establishment of a continence management program typically may take 12 to 16 weeks or, in some cases, longer." *Documentation should have been done at least quarterly in the Toileting Program Assessment UDA one a successful toileting program had been established.	F 315			
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. This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to implement additional interventions to prevent unplanned weight loss for one of three sampled residents (7) who had a significant weight loss. Findings include: 1. Review of resident 7's medical record revealed: *He was originally admitted on 3/26/15. *He had been hospitalized twice in June and his most recent re-admission date was 6/17/15.	F 325			

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F 325	<p>Continued From page 20</p> <p>*His diagnoses included cerebrovascular disease (affects circulation of blood in the brain), diabetes (affects sugar levels in the blood), dysphasia (difficulty swallowing), epilepsy (seizure disorder), high blood pressure, anemia (low iron in the blood), hypothyroidism (lack of thyroid hormone), constipation, depression (sadness), anxiety (anxiousness).</p> <p>Observations on 8/3/15 from 5:50 p.m. through 6:15 p.m. and on 8/4/15 from 11:40 a.m. through 12:30 p.m. of resident 7 in the dining room revealed:</p> <p>*He sat at a table for those who required assistance with eating in a wheelchair. *He was able to feed himself at times and at other times needed assistance. *He had cups of thickened water and milk at both meals. -No other liquids were served to him. *On 8/3/15 during the supper meal he was served vegetable beef soup, Sloppy Joe sandwich on a bun, potato wedges, and a vegetable salad. -He ate the sandwich and soup. *On 8/4/15 during the lunch meal he was served wild rice with cut up chicken, cottage cheese, a slice of bread with butter on it, and green jello with fruit. -He ate approximately 75 percent (%) of that meal. *He should have gotten fortified foods but had not during those meals. Refer to F360.</p> <p>Review of resident 7's diet card that the certified dietary manager (CDM) confirmed was what the dietary staff used when serving the residents' meals revealed: *His diet was CCHO (concentrated carbohydrate diabetic diet) and NIP (Nutrition Intervention</p>	F 325	<p>F 325</p> <p>1.* Resident #7 was started on 240cc Glucerna T1D (3 times daily) for weight loss on 8/6/2015. Resident #7 has a scheduled snack of choice from the snack cart as of 8/6/2015. Resident #7 is on NIP and diet has been changed to NDD4 as of 8/24/2015. 2*Residents will be weighed weekly and recorded as per policy. 3.*Nursing staff will notify DDS and resident's health care provider for any and all residents when there is a significant weight change of 5% in the past 30 days; 7.5% in the past 90 days or 10% in the last 180 days and document. 4.*Dietary staff, CNA's and dining assistants will notify charge nurse and DDS of any decline in caloric or fluid intake of residents at the time it happens. DDS will notify RD and discuss with resident to implement a resident-specific snack program. *DDS will monitor weights on a weekly basis for effectiveness of snack interventions. DDS will notify RD of intervention effectiveness on a weekly basis and discuss other possible interventions for residents with the above note weight loss such as NIP, supplements or other interventions specific to resident preference. *DDS will educate nursing and dietary staff by 9/2/2015, on this process. *DDS or designee will monitor weights and do weekly audits for 4 weeks then monthly for 6 months</p>	9/2/2015	

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F 325	<p>Continued From page 21 Program [fortified foods]). *At breakfast, lunch, and dinner he should have gotten one cup of milk. *There was no mention of additional supplements or that he had a weight loss.</p> <p>Review of resident 7's Minimum Data Set (MDS) assessments related to swallowing and weight loss revealed: *On the 4/2/15 admission MDS: -His current weight was 128 pounds (lb). -Documentation of no weight loss. -He was on a therapeutic diet. *On the 4/12/15 Medicare fourteen day MDS: -His current weight was 129 lb. -Documentation of no weight loss. -He was on a therapeutic diet. *On the 6/2/15 and 6/12/15 discharge MDS: -His current weight was 118 lb. -Documentation of no weight loss. -There were no checks in the diet section. *On the 6/22/15 quarterly MDS: -His current weight was 109 lb. -Documentation of having weight loss that was not prescribed by the physician. -He was on a therapeutic diet.</p> <p>Review of resident 7's weights in pounds from admission through the survey included: *3/26/15 - 128. *4/22/15 - 125. *5/27/15 - 117.5. *6/25/15 - 109. *7/31/15 - 104. *The resident's weight loss from 3/26/15 to 7/31/15 was 24 pounds or 18.75 % in four months.</p> <p>Review of resident 7's current care plan revealed:</p>	F 325			

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F 325	<p>Continued From page 22</p> <p>*He required cues and assistance to eat. *He sat at table for those required assistance in the dining room. *He had a nutrition focus problem related to his cerebrovascular disease, intracerebral hemorrhage (bleeding in the brain), dysphasia, and esophageal reflux (stomach acid disease), and needing assistance with eating. *Interventions for the above focus area included: -A 7/14/15 entry for "give resident fortified menu." -A 7/14/15 entry "Resident requires nectar thickened liquids. -The other interventions had been implemented and revised on 4/2/15 and 4/6/15. *No further revisions, additions, or interventions were implemented on his care plan for his weight loss. *His weight loss was not mentioned on his care plan.</p> <p>Review of resident 7's food and fluid intake reports from 6/3/15 through 8/5/15 from the CDM revealed: *For bedtime snacks he: -Had accepted them eighteen times. -Had refused them twenty-six times. -Had been sleeping thirteen times. -Was not available five times. *There was no documentation of what snack he had or how much he had eaten. *There was no documentation of morning or afternoon snacks. *For meals he: -Had 76-100% intake ninety-five times. -Had 51-75% intake twenty-eight times. -Had 26-50% intake fifteen times. -Had 0-25% intake ten times.</p> <p>Interview on 8/3/15 at 6:15 p.m. and on 8/4/15 at</p>	F 325			

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F 325	<p>Continued From page 23</p> <p>5:20 p.m. with resident 7's family member revealed:</p> <ul style="list-style-type: none"> *She visited him daily and helped him with supper most evenings. *He had lost quite a bit of weight since he was admitted. *His usual weight was around 130 pounds. *She was unsure why he had lost so much weight since he ate pretty well. *She stated staff helped him to eat when she was not there. <p>Interview on 8/5/15 at 9:05 a.m. and again at 10:10 a.m. with the CDM regarding resident 7's weight loss revealed:</p> <ul style="list-style-type: none"> *He had a significant weight loss. *They had him at an table for those who required assistance. *Dietary had him on the nutrition intervention program (NIP) (fortified foods) program at meals. *She had been monitoring his weights. *He was reviewed monthly by the registered dietitian (RD). *The RD's recommendations were given to dietary and nursing staff. *She agreed there had been no additional interventions added other than the NIP related to his weight loss. *The NIP would have added calories to the food he was served. *She stated they had not tried any additional supplements. *She confirmed she had not documented much related to his weight loss. *He would have been offered snacks by the CNAs in between meals but nothing specific. *The CNAs would not wake him up for a snack if he was sleeping. *Dietary did not monitor snack intakes normally. 	F 325			

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F 325	<p>Continued From page 24</p> <p>*She would have asked the CNAs if she had questions regarding snacks.</p> <p>*She confirmed there was no documentation that he had received snacks in the morning or afternoon.</p> <p>-Bedtime snacks were documented as accepted, sleeping, or refused. There was no percentage of intake documented.</p> <p>Interview on 8/5/15 at 10:25 a.m. with registered nurse (RN) I revealed:</p> <p>*When a resident had a weight loss the nurse would give ideas to dietary or the physician as needed.</p> <p>*She was aware resident 7 had a significant weight loss.</p> <p>-She stated he sat at an table for those who required assistance.</p> <p>-She was not sure what interventions had been implemented for his weight loss.</p> <p>-The nurses had not been giving him any supplements.</p> <p>*Snacks in between meals would have been prepared by dietary staff and the certified nursing assistants (CNA) would have delivered them to the residents.</p> <p>*She stated he sometimes took a snack and sometimes did not want a snack.</p> <p>*Intakes for snacks and meals would have been documented by the CNAs and dietary.</p> <p>Interview on 8/5/15 at 1:50 p.m. with the RD and the CDM regarding resident 7 revealed:</p> <p>*He had been admitted or readmitted from the hospital and his dietary orders had changed multiple times.</p> <p>*They were aware he had a significant weight loss.</p> <p>*The RD stated he had been changed from</p>	F 325		

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F 325	<p>Continued From page 25</p> <p>CCHO to a regular diet to be on the least restrictive diet.</p> <p>-She had recommended he start the NIP and his Zoloft (depression medication) be changed due to the possible side effects.</p> <p>*She felt they would try to get residents to eat food first, and then go to supplements if that was not working.</p> <p>-There was no set time or percent of weight loss that she would recommend to start supplements.</p> <p>*She reviewed all high risk residents monthly.</p> <p>-Her recommendations were emailed to the director of nursing (DON), CDM, and the Minimum Data Set (MDS) assessment nurse for them to follow-up on.</p> <p>-The CDM would work on the recommendations with nursing when she received them.</p> <p>Review of the RD's Significant Weight Changes reports regarding resident 7 revealed:</p> <p>*On 5/8/15 he had a 6.2% weight loss in thirty days.</p> <p>-She suggested to consider advancing to a regular diet.</p> <p>*On 6/5/15 he had an 8.2% weight loss in ninety days.</p> <p>-She suggested to consider advancing to a regular diet again and to start NIP.</p> <p>*On 7/10/15 he had a 12.3% weight loss in thirty days and 18.5% weight loss in ninety days.</p> <p>-She suggested to consider advancing to a regular diet and start NIP again and to discuss a possible change from Zoloft to Remeron (depression medication) with the physician.</p> <p>Review of the RD's Residents at Nutrition Risk Reports from June and July 2015 regarding resident 7 revealed the same comments of suggesting a regular diet and starting fortified</p>	F 325			

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F 325	<p>Continued From page 26 foods.</p> <p>Review of his last signed physician's orders on 7/13/15 revealed: *He was on a CCHO diet with nectar thickened liquids. -He was not on a regular diet as recommended by the RD. *He was on Zoloft 25 milligrams (mg) a day for depression.</p> <p>Review of the physician's progress note from the 7/13/15 visit revealed there was no mention of changing resident 7 to a regular diet or changing his Zoloft as recommended by the RD.</p> <p>Review of resident 7's July and August 2015 medication and treatment administration records revealed: *He was not receiving any supplements for his weight loss. *He was on Zoloft 25 mg a day until 7/20/15 when it had been increased to 50 mg a day.</p> <p>Interview on 8/5/15 at 2:30 p.m. with the DON regarding resident 7 revealed: *She was aware he had been losing weight and had a significant weight loss. *She felt his weight loss was due to his diabetes that was not controlled, and he had been ill and hospitalized a few times recently. *She stated he was weighed that day and was up to 105 pounds. *If nursing would have given supplements they would have been listed on his physician's orders. *She confirmed there had been no additional interventions from nursing regarding his weight loss. *She stated he refused to eat and take snacks at</p>	F 325			

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F 325	<p>Continued From page 27</p> <p>times.</p> <p>*She confirmed the staff only documented bedtime snacks and not the morning and afternoon snacks.</p> <p>*She would have expected him to be woke up by the CNAs if he had been sleeping when the snacks were passed.</p> <p>Review of the provider's February 2013 Fortified Foods policy revealed: **"Fortified foods are menu items and snacks that are enhanced through the addition of naturally concentrated ingredients while maintaining the identity of the item..."</p> <p>**1. The director of dietary services (DDS) will interview residents for their food preferences and any special dining needs. Determine if fortified foods will assist in meeting the needs of the resident."</p> <p>**11. The DDS will document effectiveness of approaches..."</p> <p>Review of the provider's February 2013 Medical Nutritional Supplements policy revealed: *The purpose included "to provide medical nutritional supplements between meals to residents with decreased appetite, weight loss or special medical conditions when needed." **"When a resident has a decreased meal intake, staff will determine why the resident is not eating their meals and address problems to improve intake. Every effort will be make to provide caloric/nutrient-dense food at meals and between meals to meet nutritional needs versus using a medical nutritional supplement." **"Medical nutritional supplements will be provided by physician order." **"Intake of medical nutritional supplements is documented on the Medication Administration</p>	F 325			

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F 325	Continued From page 28 Record (MAR), Treatment Administration Record (TAR) and evaluated for acceptance. Adjustments are made to optimize intake." Review of the Pfizer Inc., Zoloft Important Safety Information website, 2008-2014, < http://www.zoloft.com > revealed "The most commonly observed adverse reactions in patients treated with ZOLOFT (seen in 5% or more of patients and at least twice as high as the control group) were nausea (25%), delayed ejaculation (14%), shakiness (8%), increased sweating (7%), lack of appetite (6%), and reduced sexual desire (6%)."	F 325			
F 360 SS=E	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, and policy review, the provider failed to provide fortified foods (foods with added calories and/or protein) to 11 of 11 residents (2, 5, 5, 8, 14, 15, 16, 17, 18, 19, and 20) who were to receive them during 2 of 2 observed meals. Findings include: 1. Observation and interview on 8/3/15 from 5:22 p.m. through 6:25 p.m. with dietary assistant (DA) C revealed she: *Did not serve fortified foods to eleven residents	F 360			

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F 360	<p>Continued From page 29 who were to have received them. *Was to add butter or corn syrup to the foods served to those residents. *Had not been adding anything to the food lately, because it made everything so fatty.</p> <p>Interview on 8/3/15 at 6:20 p.m. with the dietary manager (DM) revealed: *Foods were fortified for residents who needed more calories and/or protein. *They fortified foods by adding butter or corn syrup to them. *There were eleven residents (2, 5, 7, 8, 14, 15, 16, 17, 18, 19, and 20) on a list to receive fortified foods. *Residents' diet cards with NIP written on them were to receive fortified foods. *She was not aware those residents were not receiving fortified foods.</p> <p>2. Observation on 8/4/15 from 11:30 a.m. through 12:35 p.m. with DA F revealed she: *Did not serve fortified foods to the eleven residents (listed above) who were to receive them. *Agreed she did not add anything to any food items for those residents.</p> <p>3. Interviews on 8/5/15 at 8:25 a.m. and at 10:40 a.m. with the DM revealed: *They did not have a fortified foods menu. *They did not have recipes for fortified foods. *She agreed they were not following their fortified foods policy.</p> <p>Interview on 8/5/15 at 1:55 p.m. with the registered dietician revealed the provider did not have: *A specific fortified foods menu.</p>	F 360	<p>F 360</p> <p>1.* Residents 2, 5,7,8,14,15,17, 18, 19 & 20 all started to receive the NIP diets starting on 8/6/2015. Resident #2 died on 8/1/9/2015. *The Director or Dietary Services (DDS) will provide education to all Dietary Staff by 8/31/2015, on the importance of maintaining and serving all resident diets as ordered and ensuring that fortified diets, if ordered, are served properly. All new Dietary staff will receive specific training on the importance of maintaining and serving all resident diets as ordered and ensuring that fortified diets, if ordered, are served. All staff will continue to receive annual education. *All Cook Assistants/Dietary Assistants will add fortified additions required for salads/deserts prior to serving times and are labeled properly for the appropriate residents. *RD provided the added NIP extensions to the menu. * Registered Dietician (RD) provided DDS with recipes for fortified menu items on 8/21/2015. Cooks will make fortified foods ordered for residents based on the recipes provided by the RD and ensure the fortified menu ordered for the appropriate residents is being followed. * DDS or Designee will monitor and conduct weekly audits for 6 weeks and then monthly for 4 months to ensure residents who have fortified foods ordered are receiving them. Any variance from what is ordered for resident will be addressed immediately and noted on the audit form. *DM or designee will report findings to QAPI Coordinator/QAPI Team monthly</p> <p><i>* X 4 months, then quarterly x 1 year. KG/SODH/EL</i></p>	9/2/2015 Original PoC 9/16/2015 Updated PoC	

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F 360	Continued From page 30 *Recipes for fortified food items. Review of the provider's February 2013 Fortified Foods policy revealed: **"Fortified foods are used when a resident's calorie and/or protein needs are increased or when a resident is experiencing weight loss." *Fortified foods were menu items and snacks that were enhanced by increasing calories and protein through the addition of nonfat dried milk, extra margarine, peanut butter, and chocolate. *A fortified food menu extension could be written by either the food vendor or the registered dietician (RD). *There would be recipes for the menu extension.	F 360			
F 371 SS=D	483.35(i) 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 This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, policy review, and interview, the provider failed to prepare, serve, and store food in a sanitary manner for: *Two of two observed meals. *One of one walk-in cooler. Findings include:	F 371			

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F 371	<p>Continued From page 31</p> <p>1. Observation on 8/3/15 from 4:52 p.m. through 6:25 p.m. with dietary assistants (DA) C, D, and E revealed: *DA C: -Placed a small bag over her gloved hand to remove buns from a bag. -Placed the small bag on top of the bun bag, a cart, and the serving table after placing buns on plates several times. -Touched the buns on the plates with her gloved hand after touching other surfaces several times. *DAs D and E placed plates of food on top of bowls of soup that had been on the counter and delivered them to residents. *DA E placed a glass of milk on top of a plate of food that was on top of a bowl of soup and delivered it to a resident.</p> <p>Interview on 8/3/15 at 6:25 p.m. with DA C regarding touching food with the contaminated bag and gloves revealed she stated "I'm not supposed to touch food after touching stuff."</p> <p>2. Observation on 8/3/15 at 2:30 p.m. of the walk-in cooler revealed containers of: *Mushrooms dated 7/3/15. *Chicken broth dated 7/7/15. *Nine pieces of lunch meat dated 7/21/15. *Coleslaw dated 7/24/15. *Six boiled eggs dated 7/26/15.</p> <p>3. Interview on 8/5/15 at 10:40 a.m. with the dietary manager revealed she: *Would have checked the walk-in cooler for outdated items on Mondays. *Agreed: -There were leftover items in the walk-in cooler for more than seventy-two hours.</p>	F 371	<p>F 371</p> <p>1.* The Director or Dietary Services (DDS) will provide education to all Dietary Staff by 8/31/2015, on serving foods in a sanitary manner, including focus on prevention of cross contamination, proper serving of foods and delivery of trays. All new Dietary staff will receive specific training on serving foods properly, including avoidance of cross contamination during orientation. All staff will continue to receive annual education. *DDS or designee will conduct 2 audits alternating between meal times for 6 weeks, then monthly for 4 months. Any variances from proper procedure will be addressed immediately and noted on audit forms. * DDS or designee will report findings to QAPI Coordinator/QAPI Team monthly X 4 months then quarterly X 1 year.</p> <p>2. * All outdated items found in the cooler were removed and discarded by DDS on 8/5/2105. *The DS will provide education to all Dietary Staff by 8/31/2015, on the policy of proper handling of left-overs. All new Dietary staff will receive specific training to the proper handling of left overs policy during orientation. All staff will continue to receive annual education. *DDS or Designee will audit the cooler on Mondays or Thursdays and will discard any outdated items and document on the audit. *The audits will be done weekly for 6 weeks and them monthly for 4 months. Any variances from proper procedure will be addressed immediately and noted on the audit form. *DSS of Designee will report findings to QAPI on a monthly basis X 4 months then quarterly for 1 year.</p>	9/2/2015, Initial PoC 9/16/2015, Corrected PoC	

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

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/05/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER			STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362		
(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	<p>Continued From page 32</p> <p>-They had not followed their policy regarding leftovers.</p> <p>-They had not followed their policy regarding use of gloves.</p> <p>Review of the provider's revised March 2009 Leftovers policy revealed: *Leftovers would be used within the appropriate time frame to maintain food quality and safety. *Refrigerated leftovers would be utilized within seventy-two hours.</p> <p>Review of the provider's revised March 2009 Gloves policy revealed: **The center will store, prepare, distribute and serve food under sanitary conditions." **Gloves are to protect the consumer from cross contamination." **Gloves are to be changed when coming in contact with something that is contaminated."</p>	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435124	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/05/15. Good Samaritan Society Miller 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 8/6/15. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
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: 32334 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. The only basement exit did not meet the standard for a means of egress. Findings include:	K 032		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Laurie J. Pospisil, Administrator</i>	TITLE	(X6) DATE 8/27/2015
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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.

AUG 31 2015

SD DOH

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K 032	Continued From page 1 1. Observation revealed the basement was not provided with an approved means of egress. The only exit from the basement discharged into the main level corridor system. Review of previous life safety code survey data confirmed that finding.	K 032		F	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and record review, the provider failed to maintain a one hour fire resistive path of egress from the basement to the exterior of the building. Findings include: 1. Observation revealed the only basement stairway adjacent to the west nurses station discharged into the main level corridor system. A one hour fire resistive path of egress was not provided to the exterior of the building. Review of previous life safety code survey data confirmed that finding.	K 033		F	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER			STREET ADDRESS, CITY, STATE, ZIP CODE 421 EAST 4TH ST MILLER, SD 57362	
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K 033	Continued From page 2	K 033		
K 045 SS=C	<p>The facility meets the FSES. Please mark an "F" in the completion date column to indicate the facility's intent to correct the deficiencies identified in K000.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to provide proper illumination of the means of egress for the exit discharge at one of eight marked exits from the facility (south wing). Findings include:</p> <p>1. Observation at 11:35 a.m. on 8/5/15 revealed an exit discharge from the south wing. Exit discharge lighting on the exterior of that exit was provided by a single bulb lighting fixture. Failure of that bulb would leave the exit discharge in darkness. Lighting of means of egress including exit discharge shall be arranged such that failure of a single lighting fixture does not leave the area in darkness. Those fixtures shall be tied to the emergency electrical system as part of the type II essential electrical service required for nursing homes.</p> <p>Interview with the plant observation supervisor at</p>	K 045	<p>K 045</p> <p>1. The lighting fixture on the external exit discharge from the south wing was changed from a single bulb lighting fixture to a double lighting fixture by a local electrician on 8/11/15.</p> <p>Center maintenance staff will continue checking of the condition of all exit discharge lighting on a monthly basis per the Center's TELS program. Any issues will be corrected at the time they are found, documented and reported at the monthly QAPI meetings.</p>	8/11/2015

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K 045	Continued From page 3 the time of the above observations confirmed that condition. He indicated he was not aware of requirements for exit discharge lighting. He indicated exit discharge lighting was inspected on a regular schedule to ensure lighting was working properly.	K 045			

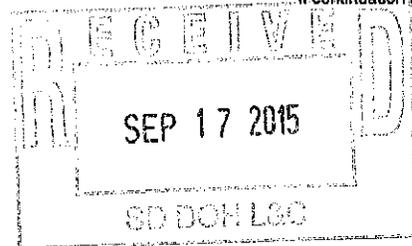
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10651	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/05/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY MILLER	STREET ADDRESS, CITY, STATE, ZIP CODE 421 E 4TH STREET MILLER, SD 57362
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S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/3/15 through 8/5/15. Good Samaritan Society Miller was found not in compliance with the following requirements: S165 and S210.	S 000	*Addendums noted with an asterick per 9/17/15 telephone with facility administrator. KG /SDDOH/EL	
S 165	44:04:02:17 OCCUPANT PROTECTION Each licensed health care facility covered by this article must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the... residents admitted to the facility. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation, record review and interview, the provider failed to maintain the electrically activated audible alarm for nine of nine unattended doors to the exterior of the facility. Findings include: 1. Observation at 11:20 a.m. on 8/5/15 of the main entrance in the facility revealed the door was equipped with a door alarm that was not activated at the time of observation. The door was provided with a keypad that was capable of deactivating the alarm during times when the alarm was on. A code posted above the keypad was displayed indicating the code to deactivate	S 165		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Lauree J. Pospisil</i>	<i>Administrator</i>	<i>9/16/15</i>



South Dakota Department of Health

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S 165	<p>Continued From page 1</p> <p>the alarm. The posted code that was capable of deactivating the alarm is not permitted as residents have the potential to understand the code and elope without staff knowledge. That condition was also found at eight other doors to the exterior throughout the facility.</p> <p>Interview with the maintenance director at the time of the observation confirmed that condition. He indicated he was unaware the egress doors were out of compliance. He indicated a new Watchmate wander management system had just been installed to aid in preventing resident elopements and believed the doors were in compliance. Interview with the administrator during the exit interview at 2:45 p.m. on 8/5/15 revealed she was also unaware the doors were not in compliance.</p> <p>Surveyor: 32335</p> <p>2. Observation on 8/3/15 at 6:40 p.m. and again on 8/4/15 at 6:00 p.m. as the surveyors exited the building revealed the door had not alarmed. There had been no staff at the nursing station to monitor the door.</p> <p>Review of information provided by the South Dakota Department of Health complaint department revealed there had been an elopement out the front door on 7/21/15.</p> <p>Interview on 8/5/15 at 2:25 p.m. with the administrator revealed they did not have anyone designated to monitor the doors. The doors were not alarmed until after usually 8:00 p.m. Office staff left at 5:00 p.m. She agreed there was a potential for residents to get out the front door without staff being aware.</p>	S 165	<p>S 165 44:04:01:17</p> <p>1.* Administrator, Maintenance Assistant and engineer from Dakota Securities met on 8/27/15, to discuss facility Plan of Correction for the Facility.</p> <p>2.*Changes will be made to the facility's egress system for 9 of the 9 unattended doors sited in the Plan of Correction. All 9 doors will be locked and alarmed at all times for anyone exiting the facility. An alarm will sound when anyone attempts to exit any of these 9 doors.</p> <p>*Facility staff will be able to exit all 9 doors by using the staff code (7720*).</p> <p>*Guest codes for visitors will be used on only these 3 doors – front door, door by maintenance office and Assisted Living south door. A keypad will be provided to the entrance to the 3 doors mentioned above and egress. A guest code must be entered in the keypads on these 3 doors in order for visitors to enter or egress. These 3 doors will open with the guest code provided there are no residents in the vicinity of these 3 doors who are wearing watch mates. If a resident is wearing a watch mate in the vicinity of these 3 doors for exiting the facility, the guest code will not be able to be used. The door will remain locked and facility staff will have to come and enter the staff code to allow the visitor to egress the facility.</p> <p>*All Facility staff will be educated on this new process by 9/2/15.</p> <p>*Dakota Securities will make the changes to the 9 doors, including placing the guest code keypads on the 3 above mentioned doors.</p> <p>*Maintenance staff, Administrator or Designee will audit all 9 doors once daily, including the 3 doors with guest code keypads for proper functioning at randomly selected times X 1 week. These 9 doors will then be monitored 2X weekly for 3 weeks, then once weekly for 1 yr. Any issues or problems will be addressed at the time found.</p> <p>*All audit results will be brought to QAPI meetings on a monthly basis by Maintenance staff, Administrator or Designee.</p>	9/24/2015

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S 210	Continued From page 2	S 210		
S 210	<p>44:04:04:06 EMPLOYEE HEALTH PROGRAM</p> <p>The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 35237 Based on employee file review and interview, the provider failed to ensure two of five newly hired sampled employees (A and B) were evaluated by a health professional to determine they were free from a reportable communicable disease. Findings include:</p> <p>1. Review of employees A and B's employee files revealed: *They had both become employed by the provider since June 2015. *They had not been evaluated by a health professional to determine they were free from a reportable communicable disease. *The medical history questionnaire form had been</p>	S 210		

South Dakota Department of Health

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S 210	<p>Continued From page 3</p> <p>signed by the employee and the human resources (HR) designee.</p> <p>Interview on 8/5/15 at 11:30 a.m. with the HR designee revealed: *The medical history questionnaire forms had been changed in May 2015 by the corporate office. *They had been instructed by corporate staff that HR could have signed the forms. *They did not have a specific policy, but they would follow the state requirements.</p> <p>Interview on 8/5/15 at 2:30 p.m. with the director of nursing revealed: *She had been aware of that requirement. *She agreed the health evaluation was not completed by a health professional in the above employees' health records, and it should have been. *She stated the staff development nurse usually did the health evaluation for new employees.</p>	S 210	<p>S210 44:04:04:06</p> <ol style="list-style-type: none"> 1. * Human Resources Coordinator (HR) notified Good Samaritan Society National Campus Workforce Consultant for Region 32 (South Dakota's Region) that South Dakota still requires all personnel to be evaluated by Licensed personnel to ensure they are free of communicable diseases. 2. *Beginning 8/5/2015, a licensed professional will conduct all new employee health screenings and sign the correct place provided on the Employee Health Questionnaire. 3. *HR designee will audit all Healthcare Questionnaires for all employees hired after 5/2015 to 8/5/2015, for licensed professional signature on questionnaire and correct any forms without a licensed professional's signature on the correct place on the form by 8/27/2015. Findings will be reported to the September 2015 QAPI meeting. 3. * The Employee Questionnaire will be audited by HR or Designee on a quarterly basis for the presence of the signature of the licensed professional on all new hires. The results will be reported to QAPI on a quarterly basis for one year. Any non-compliance will be corrected, documented and also reported to QAPI on quarterly basis for 1 year. 	

KE/SDD/H/EL
8/9/15

