

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

ORIGINAL

PRINTED: 05/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>Handwritten:</i> Addendum is noted with an asterisk per 4/16/15 telephone to facility DON. JKSDOH/IME</p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/27/15 through 4/29/15. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F226, F280, and F281.</p>	F 000	<p><i>Handwritten:</i> For resident # 10 facility is not able to go back and complete an incident report and do a thorough investigation with the resident to resident encounter between this resident and resident #4 on 3/12/15.</p> <p><i>Handwritten:</i> * Resident #10 passed away on 3/20/15.</p> <p>For resident # 11- The facility is not able to complete a thorough investigation which involved this resident and resident # 4 on 4/7/15. The facility will ensure this resident is not subjected to abuse /neglect by anyone, including other residents. The facility must ensure the staff will intervene immediately to ensure the safety of each resident. The licensed nurse will initiate an incident report and begin a thorough investigation for each resident involved in a resident to resident encounter in which alleged or suspected abuse/neglect or mistreatment may have been witnessed or reported. The licensed nurse must notify the administrator immediately following incident.</p> <p>For resident # 4- who has a history of inappropriate behaviors and encounters with female residents- the care plan reflects these behaviors with measurable goals and interventions of re-directing of</p>	
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and review of the State of South Dakota reporting requirements, the provider failed to thoroughly investigate and report two of two resident-to-resident (10 and 11) incidents for abuse and neglect involving one of one sampled resident (4). Findings include:</p> <p>1. Review of resident 4's entire medical record revealed: *An admission date of 7/17/14. *Diagnoses of dementia (forgetfulness), Parkinson's disease (progressive disease that affects movement), insomnia (inability to sleep), and depression (sadness). *A 4/13/15 Brief Interview for Mental Status</p>	F 226		

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

TITLE

(X6) DATE

Handwritten Signature: Angela Loh - Quinn

Handwritten Title: LHA

Handwritten Date: 5/19/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STREET ADDRESS, CITY, STATE, ZIP CODE
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NEW UNDERWOOD, SD 57761**

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A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/27/15 through 4/29/15. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F226, F280, and F281.

F 226 SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
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Based on record review, interview, and review of the State of South Dakota reporting requirements, the provider failed to thoroughly investigate and report two of two resident-to-resident (10 and 11) incidents for abuse and neglect involving one of one sampled resident (4). Findings include:

1. Review of resident 4's entire medical record revealed:
*An admission date of 7/17/14.
*Diagnoses of dementia (forgetfulness), Parkinson's disease (progressive disease that affects movement), insomnia (inability to sleep), and depression (sadness).
*A 4/13/15 Brief Interview for Mental Status

F 000

For resident # 10- The facility is not able to go back and complete an incident report and do a thorough investigation with the resident to resident encounter between this resident and resident #4 on 3/12/15.

F 226

For resident # 11- The facility is not able to complete a thorough investigation which involved this resident and resident # 4 on 4/7/15. The facility will ensure this resident is not subjected to abuse /neglect by anyone, including other residents. The facility must ensure the staff will intervene immediately to ensure the safety of each resident. The licensed nurse will initiate an incident report and begin a thorough investigation for each resident involved in a resident to resident encounter in which alleged or suspected abuse/neglect or mistreatment may have been witnessed or reported. The licensed nurse must notify the administrator.

For resident # 4- who has a history of inappropriate behaviors and encounters with female residents- the care plan reflects these behaviors with measurable goals and interventions of re-directing of

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F 226	<p>Continued From page 1</p> <p>(special type of memory assessment) score of 15 indicating he had good memory recall. *He had a history of resident-to-resident inappropriate interactions involving female residents who had poor memory recall.</p> <p>Review of resident 4's 3/12/15 incident report revealed: *On 3/12/15 at 7:45 p.m. he had been witnessed by the dietary and nursing staff inappropriately touching resident 10 in the dining room. *Two handwritten notes by unidentified staff members who had witnessed the above interaction had been attached. Those notes revealed: -He had been seen in the dining room sitting in his wheelchair (w/c). -He had his pants pulled down to his knees, was sitting next to resident 10, and was rubbing her upper leg/thigh area. -The observation had been reported to the charge nurse and the social services designee (SSD). *No documentation the South Dakota Department of Health had been notified of the 3/12/15 witnessed resident-to-resident encounter.</p> <p>The provider had not been able to provide an incident report and investigation for abuse and neglect for resident 10 from the above incident.</p> <p>Review of resident 4's 4/7/15 incident report revealed: *On 4/7/15 at 7:15 p.m. he had been witnessed inappropriately touching resident 11 in front of the nurse's station. *The charge nurse had documented "Contact made with [resident name] resident 11 in front of the nurses station. Resident 4 placed hand on her [resident 11] thigh and was vigorously rubbing</p>	F 226	<p>resident, observation by staff when resident is out and about in the center. Deer Oaks counseling services are seeing resident, had Neurological appointment on 5/7/15 with no new orders due to Parkinson's and has a Psychology appointment scheduled for 6/1/15 due to inappropriate behaviors. The facility will complete an incident report, initiate an investigation and report any alleged or suspected abuse/neglect to the SD DOH if this resident is involved in inappropriate behavior with other female residents.</p> <p>For all other potential residents the facility must ensure it has in place an effective system that prevents mistreatment, abuse/neglect of residents. To ensure that residents are not subjected to abuse/neglect by anyone, including but not limited to staff and other residents. The center must identify and remedy any abusive situations and prevent future incidents from occurring.</p> <p><i>This training to be provided to all staff on 5-21-15</i> 232</p> <p>IN-SERVICE TRAINING: The administrator will provide education to all staff. This education will include: GSS Policy/Procedures for</p>		

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F 226	<p>Continued From page 2 inside of her upper left thigh." *No documentation the South Dakota Department of Health had been notified of the 4/7/15 witnessed resident-to-resident encounter.</p> <p>The director of nursing (DON) and SSD had not been able to provide an incident report and investigation for abuse and neglect for resident 11 from the above incident.</p> <p>Interview on 4/29/15 at 8:25 a.m. with the DON and SSD revealed: *They confirmed resident 4 was alert and oriented. *They had been aware the last two months resident 4 was actively seeking out cognitively impaired (memory loss) women and had been witnessed inappropriately touching some of them. He had been referred to Deer Oaks for their counseling services. *They identified residents 10 and 11 as being cognitively impaired, unable to voice their concerns, unaware of their surroundings, and were not interviewable. *They had not been aware the above written incidents should have been fully investigated to ensure residents 10 and 11 were safe and free from any further physical and mental abuse. *They agreed both of the above incidents regarding resident 4 should have been reported to the South Dakota Department of Health and separate reports should have been completed on residents 10 and 11.</p> <p>Review of the provider's September 2013 Abuse and Neglect policy revealed: **The resident has the right to be free from verbal, sexual, physical, and mental abuse." **Residents must not be subjected to abuse by</p>	F 226	<p>Abuse and Neglect, GSS Policy /Procedure on Resident Incident Reports, GSS Policy/Procedure on Investigation and reporting to our state agency and law enforcement and SD DOH guidelines and work flow sheet for reporting incidents. This education will include the center's system to identify abuse/neglect. All staff are responsible to intervene for the safety of each resident. The staff must report all witnessed or reported alleged or suspected abuse to the charge nurse immediately. The licensed nurse must notify the administrator or designee. <i>The immediately</i></p> <p>The facility must ensure that a complete review of existing incidents is documented in the incident report and a thorough investigation has been completed. The facility must ensure that all identified incidents of alleged or suspected abuse /neglect are promptly investigated reported and a remedy for the abusive situation is identified and prevention of future incidents from occurring. <i>*on all incident reports</i></p> <p>AUDITS: Audits will be <i>JK/SSDOH/MT</i> completed by the social worker/designee to determine: 1) The incident report was completed; 2) thorough investigation had been</p>	

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F 226	Continued From page 3 anyone, including, but not limited to center staff, other residents." *"Alleged or suspected violations involving any mistreatment, neglect or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency." *"The center will have evidence that all alleged (doubtful) or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress."	F 226	initiated. 3) The facility reported to the SD DOH any alleged or suspected abuse/neglect situations per GSS policy and procedure and the SD DOH guidelines. Audits will be completed weekly x 4 weeks and monthly. The Social Worker will submit a monthly report of the audit findings to the QA Committee for further recommendations. * [REDACTED]	x 5/27/15 JK/SDDOH/MF
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. This REQUIREMENT is not met as evidenced	F 280		JK/SDDOH/MF

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F 280	<p>Continued From page 4 by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure one of nine sampled resident's (2) care plan had been reviewed and revised to reflect the resident's individual needs. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *An admission date of 1/31/12. *Diagnoses of polio (disease causing paralysis) with contractures (limited movement in joints), stroke with left sided weakness, severe disability, and poor vision. *He had required extensive assistance of two staff members for transfers. *He had been at risk for skin breakdown with a history of open areas to his bottom.</p> <p>a. Review of resident 2's 2/24/14 care plan revealed: *A focus area of "The resident has impaired visual function." *A goal provided under that focus area was "Resident will wear corrective lenses daily and as needed (PRN) to promote participation in activities of daily living (ADL) and other activities." *An intervention provided under that focus area was "Offer to clean glasses daily and PRN and place on resident's face."</p> <p>Random observations from 4/27/15 through 4/29/15 of resident 2 revealed he had not been wearing his glasses during that time frame.</p> <p>Interview on 4/29/15 at 8:00 a.m. with resident 2 confirmed he had a pair of glasses. But on his last visit to the eye doctor he had been</p>	F 280	<p>JH00041MF</p> <p>*1 a. On 5/19/15, Care Plan was updated for Resident # 2: Goal now reads – "Corrective lenses will be available to Resident upon his request"; Interventions updated – "Clean glasses and place on Resident's face upon his request".</p>	

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F 280	<p>Continued From page 5 recommended to wear them for reading only.</p> <p>Observation on 4/27/15 at 5:10 p.m. in resident 2's room revealed: *Certified nursing assistants (CNA) A and B prepared to provide personal care and transfer the resident from his bed to the wheelchair (w/c). *After the CNAs performed personal care and transferred him into the w/c they exited the room. *Neither one of the CNAs checked with the resident to make sure he had not needed his glasses.</p> <p>Observation on 4/28/15 at 11:10 a.m. in resident 2's room revealed CNAs C and D repeated the same procedure as above.</p> <p>Review of resident 2's 2/18/15 Minimum Data Set (MDS) annual assessment summary revealed: **"Resident wears corrective lenses due to visual impairment." **"Staff assist with cleaning glasses and placing on face daily and PRN." **"Continue with plan of care due to decreased vision."</p> <p>b. Interview on 4/28/15 at 8:15 a.m. with CNAs C and D regarding resident 2 revealed: *He had required the use of the sit-to-stand aide for transfers only when he needed to use the toilet. *The staff had been directed by the therapy department to make sure a piece of foam was placed between his knees prior to that type of transfer.</p> <p>Observation on 4/28/15 at 4:45 p.m. of resident 2's room revealed a round and long piece of foam laying on his bed.</p>	F 280	<p>b. When Resident # 2 returned from RCRH on 5/11/15, his transfer and mobilization needs were re-assessed according to our new guidelines in our Safe Resident Handling Program. Resident is now a Total Lift for all transfers. Care Plan was updated to reflect these changes on 5/18/15.</p> <p>c. On 5/19/15, it was identified that Resident # 2 has a splint for both hands. Care Plan was updated: Focus now reads – "The Resident has an ADL self-care performance deficit R/T history CVA and Polio E/B limited ROM upper and lower body extremities and bilateral contractures; Interventions now reads – "Apply splints to left and right hands at bedtime – remove upon rising. Make sure to wash and dry hands well prior to putting splints on to prevent skin breakdown".</p>	
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F 280	<p>Continued From page 6</p> <p>Interview on 4/28/15 at the time of the observation with resident 2 confirmed the above interview with CNAs C and D.</p> <p>Review of resident 2's 2/10/15 care plan revealed: *A focus area of "The resident had an ADL self care performance related to his stroke and polio evidenced by limited range of motion." *An intervention for transfers under that focus area. *That intervention revealed "Transfer: Resident requires sit to stand lift and 2 assist for transfers to/from bed, w/c, toilet." *There had been no intervention directing the staff to use a piece of foam between his legs during the transfer with the sit-to-stand aide.</p> <p>c. Observation on 4/28/15 at 10:30 a.m. of resident 2 in his room revealed he had been resting in the bed. On his left arm was a blue colored brace.</p> <p>Interview on 4/28/15 at 11:15 a.m. with CNAs C and D regarding resident 2 revealed he was to have worn that brace between meals.</p> <p>Review of resident 2's 2/18/14 care plan revealed: *A focus area of "The resident has a need for restorative intervention (exercise program). *An intervention under that focus area of "Assistance with splint or brace resident will wear right arm splint for 4 hours daily." *No intervention under that focus area to indicate he had required the use of a brace to his left arm.</p> <p>d. Review of resident 2's progress notes from</p>	F 280	<p>d. On 4/29/15, when the Stage I Pressure Sore was identified, the Care Plan was updated: Focus read – "The Resident has impaired skin integrity R/T Incontinence, impaired mobility, use of W/C for locomotion, history of fungal skin infections E/B Stage 1 Pressure Sore to left sacral area"; Goals read – "Resident's skin injury (Stage I Pressure Sore) of the left sacral area will be healed by review date and Resident will have no further skin break down through the review date"; the following Interventions were added: "Turn and reposition every 2 hrs. Off load sacral area as much as possible. Respect Resident's right to refuse to reposition onto right/left sides when repositioning. In efforts to heal pressure sore: daily monitoring, reposition every 2 hrs and utilize Barrier Crème with Zinc to areas until healed". On 5/11/15 Resident returned from RCRH, at this time the pressure sore to left sacral area was healed and remains healed; Care Plan updated on 5/19/15 to reflect pressure sore to left sacral area is healed.</p>	
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F 280	<p>Continued From page 7.</p> <p>February 2015 through April 2015 revealed several entries made by the nursing staff revealing he had an open area to his coccyx (bony area between both buttocks).</p> <p>Observation on 4/28/15 at 11:10 a.m. of resident 2 revealed: *He had been resting in his bed. *CNAs C and D had prepared to provide personal care for him. *Observation of his coccyx during personal care confirmed that open.</p> <p>Review of resident 2's 2/14/14 care plan with a target date of 5/20/15 revealed: *A focus area of "The resident has potential for skin integrity impairment." *A goal under that focus area of "Resident will have no skin breakdown through the review date." *There had been no documentation to support the resident currently had an open area to his coccyx.</p> <p>e. Interview on 4/29/15 at 8:45 a.m. with the director of nursing and the MDS coordinator revealed: *The interdisciplinary care team and nursing staff had been responsible for the reviewing and revising of the care plans. *They agreed all of the above areas of concerns for resident 2 should have been found on his care plan and updated to reflect the current level of care he had required.</p> <p>Review of the provider's revised September 2012 Care Plan policy revealed: **Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward</p>	F 280	<p>During our weekly Quality of Life Meetings, Interdisciplinary Team Members will review, revise and update all Care Plans as they come due for MDS/Care Team by 9/1/15 to ensure all Care Plans have been reviewed, revised and updated to reflect the care currently required/provided for each Resident. On 5/7/15, education provided to Nurses instructing them to make any necessary changes to the Care Plans for changes that come in Dr.'s orders such as new diagnosis, new or discontinued medication, diet changes and any changes in condition/cognition/function – continue to use short term care plans as well. Interdisciplinary Team Members will continue to review, revise and update Care plans as they come due for MDS/Care Team. QA Coordinator or Designee will review 5 Care Plans every month to ensure Care Plans reflect the cares currently required/provided for each Resident. QA Coordinator or Designee will report findings to QA Committee monthly x3 and then quarterly x 3 for further recommendations.</p>	<p>*5/27/15 JK/SD/DH/MF</p>

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 achieving and maintaining the resident' optimal medical, nursing physical, functional, spiritual, emotional, psychosocial and educational needs." *Care plans would be reviewed at least quarterly and updated with any significant changes in the resident's condition.	F 280		
F 281 SS=D	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: 33488 A. Based on observation, interview, and policy review, the provider failed to maintain a sterile field during one of one observed urinary catheter (tube inserted into the bladder) changes for one of one sampled resident (4). Findings include: 1. Observation on 4/28/15 at 1:40 p.m. of licensed practical nurses (LPN) E and F performing a urinary catheter change on resident 4 revealed: *The resident laid down on his bed for the procedure. *LPN F was the main nurse for the procedure and LPN E was assisting her. *LPN E removed the resident's personal items from his bedside table. *She had not cleaned it with a cleanser or put a clean barrier down prior to LPN F setting the urinary catheter equipment on it. *LPN F opened the sterile urinary catheter package with her un-gloved fingertips. *LPN E instructed LPN F to not open or use the	F 281	<i>*including all LPNs and RNS JK/SDO/HMF</i> <u>Education was provided during Nurses In-Service on 5/7/15</u> - GSS Catheterization Policy and Catheter Procedures were reviewed with all Nurses along with a visual demonstration explaining proper technique in maintaining a sterile field during a catheterization. Currently Resident #4 is our only Resident with a catheter. QA Coordinator or Designee will audit one catheter change monthly x3 then quarterly x3 to ensure policy/procedures are being followed/sterile field is being maintained during catheterization and report findings to QA Committee monthly x3 and quarterly x3 for further recommendations. [REDACTED]	<i>x 5/27/15 JK/SDO/HMF</i>

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

PRINTED: 05/12/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/29/2015
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F 281	<p>Continued From page 9</p> <p>sterile gloves that came inside the sterile urinary catheter package but to put on clean gloves. *LPN F advised LPN E she had not been trained to not use her sterile gloves at the beginning of the procedure. *LPN E told her it was okay to do that and to continue on with the urinary catheter change.</p> <p>With her non-sterile gloves on LPN F did the following: *Reached into the sterile container and grabbed the paper drape and covered the resident's private area. *Reached in again and grabbed the sterile pouch of povidone iodine (an antiseptic cleaner), opened it, and put it on the sterile cotton balls located inside the container. *Then grabbed the sterile tongs inside the container with her non-sterile gloves and picked up the cotton balls soaked in povidone iodine. *She proceeded to cleanse the resident's penis using her non-sterile gloves and set his private part back down on the drape which was no longer sterile. *She then put on her sterile gloves, picked up his penis off the non-sterile drape and inserted his urinary catheter.</p> <p>Once the urinary catheter had been inserted LPN F needed to inflate the balloon on the catheter (keeps the catheter in place inside the bladder). *The sterile water syringe located in the sterile container was to be used to inflate the catheter balloon. *LPN F had the urinary catheter kinked to not spill any urine and was unable to reach the sterile syringe. *LPN E grabbed the sterile syringe with her non-sterile gloves, touched the resident's sterile</p>	F 281		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 281	<p>Continued From page 10</p> <p>catheter, and connected the syringe for LPN F. *LPN F then inflated the urinary catheter balloon while LPN E went to the bathroom and brought the soiled leg collection bag (holds the urine) and tubing that had previously been used. *Neither LPN had brought a new sterile leg collection bag in exchange for the current one in use.</p> <p>Interview on 4/28/15 at 2:20 p.m. with LPN F regarding the above urinary catheter change for resident 4 revealed she agreed she should have: *Placed a clean barrier down on the bedside table or have cleaned it prior to setting her sterile supplies on it. *Used sterile gloves and not clean gloves to maintain a sterile field. *Reviewed the facilities policies and procedures regarding catheter care and sterile technique prior to performing the procedure for clarification on technique that was to be used.</p> <p>Interview on 4/28/15 at 2:30 p.m. with LPN E regarding the above urinary catheter change for resident 4 revealed she: *Had instructed LPN F to proceed with the urinary catheter change. *Stated she reviewed proper sterile technique with urinary catheter changes yearly. *Had not felt she broke the sterile field as she touched the sterile container/equipment after LPN F put on her sterile gloves. *Said "that is the way I have always done it"</p> <p>Interview on 4/29/15 at 9:35 a.m. with the director of nursing (DON) regarding the above urinary catheter change revealed: *Both LPN's should have followed policies and procedures and maintained the sterile field while</p>	F 281			

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

PRINTED: 05/12/2015
FORM APPROVED
OMB NO. 0938-0391

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F 281	<p>Continued From page 11 changing resident 4's urinary catheter. *She had given them both the policy and procedure to review prior to performing the urinary catheter change. *The resident's soiled urine collection leg bag should have been discarded and a new sterile bag should have been connected to the catheter at the time it was changed. *It was her expectation the policy and procedure should have been followed.</p> <p>Review of the provider's September 2012 Catheterization policy revealed: *The urine collection leg bag was to be changed when a new catheter was inserted. *Equipment should be assembled on a clean surface. *Once the tray was opened the nurse should maintain the sterile field and place the tray between the resident's legs. *She should have put on her sterile gloves, opened the packets of lubricant and cleanser, and the syringe filled with sterile water. *The balloon on the catheter was to be tested prior to insertion. *The resident's genital (private) area was to be cleansed with the cleansing solution using the left hand (non-dominant hand). *While still holding the penis she should have inserted the catheter with her right hand until the flow of urine began. *Inflate the balloon and connect the sterile closed drainage system.</p> <p>Surveyor: 35121 B. Based on record review, interview, and policy review, the provider failed to follow professional</p>	F 281		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761	
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F 281	<p>Continued From page 12 ,</p> <p>nursing standards by not ensuring a physician's order had been obtained for one of one discharged resident (10). Findings include:</p> <p>1. Review of resident 10's closed (no longer at facility) medical record revealed: *She was admitted on 4/3/13. *She had died on 3/25/15. *Her body had been released to the funeral home. *No order to release the body had been found.</p> <p>Interview on 4/29/15 at 10:00 a.m. with the director of nursing regarding resident 10's death revealed she agreed there was no order to release the body in that medical record.</p> <p>Review of the provider's September 2012 Death and Dying policy revealed when respirations and heartbeat stop, the charge nurse was to notify the physician and "obtain permission to release the body to the mortician."</p>	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761
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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 4/28/15. Good Samaritan Society - New Underwood 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 upon correction of deficiencies identified at K029, K045, K046, K062, and and K066 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 4/21/15 telephone to facility DON. CHRDDH/MF	
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 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of one of four hazardous areas in one randomly observed area (kitchen pantry). Findings include:	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bongala Lakshmi - Quinn</i>	TITLE LNA	(X6) DATE 5/19/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761	
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K 029	Continued From page 1	K 029		
K 045 SS=D	<p>1. Observation at 8:45 a.m. on 4/28/15 revealed the kitchen pantry storage room was over 100 square feet in area. The door to the kitchen was not equipped with a self-closing device. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Doors to hazardous areas are required to be self-closing.</p> <p>The deficiency affected requirements for providing separation of hazardous areas.</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: 18087 Based on observation and interview, the provider failed to maintain adequate illumination of the means of egress at the exit discharge for two randomly observed exits (the northwest exit at laundry and the center east exit door). The failure of any single lighting fixture (bulb) must not leave the area in darkness. Findings include:</p> <p>1. Observation at 9:30 a.m. on 4/28/15 revealed the exterior light at the exit discharge for the northwest exit by laundry was equipped with a single compact fluorescent lamp. That area would be left in darkness in an egress emergency if the lone operating bulb were to burn out.</p>	K 045	<p>On 5/19/15 the Maintenance Supervisor installed self-closing hinges on the kitchen pantry storage room door. No other doors providing separation of hazardous areas were found without self-closing devices. Audits will be completed by the QAPI Coordinator monthly x 3 and quarterly x 3. QAPI Coordinator will report to the QAPI committee monthly.</p> <p>The exterior single compact lamps will be replaced with new LED fixtures. On 5/19/15 the Maintenance Supervisor ordered LED fixtures for all of the exterior doors which include the: northwest, center east, southeast, southwest, main door, dining room, and receiving. Delivery is expected on 5/22/15. All lights will be installed by 5/29/15. Audits will be completed by the QAPI Coordinator monthly x 3 and quarterly x 3. QAPI Coordinator will report to the QAPI committee monthly.</p>	<p>* 01/18/15 CHSDDCH/MF</p> <p>* 01/18/15 CHSDDCH/MF</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 045	Continued From page 2	K 045		
K 046 SS=D	<p>2. Observation at 10:00 a.m. on 4/28/15 revealed there was not an exterior light at the exit discharge for the center east exit (at the designated smoking area).</p> <p>3. Interview with the maintenance supervisor at the time of the observations revealed he was unaware the exit discharge lighting was not in compliance.</p> <p>The deficiency affected requirements for providing egress lighting.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to provide emergency lighting of at least one hour duration for two of two locations (transfer switch location and the south boiler room). The emergency lights at the generator transfer switch and the south boiler room did not work. Findings include:</p> <p>1. Observation at 8:15 a.m. on 4/28/15 revealed the battery pack emergency light at the emergency power transfer switch only had one functioning lamp. Interview with the maintenance supervisor at the time of the observation revealed he had checked the fixture on his preventive maintenance schedule, and it had been functioning properly at that time.</p>	K 046	<p>Two battery pack emergency lights were ordered on 5/19/15. One will be installed at the generator transfer switch and the other in the south boiler room by 6/5/15. The emergency battery pack for the south boiler room will be added to the preventative maintenance program. Testing will be performed by maintenance monthly x 3 and quarterly x 3. Maintenance will report to the QAPI committee monthly.</p>	<p><i>5/19/15</i> <i>CH/SDDO/HMF</i></p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 046	Continued From page 3	K 046		
K 062 SS=E	<p>2. Observation at 11:00 a.m. on 4/28/15 revealed the battery pack emergency light at the south boiler room was not functioning. Interview with the maintenance supervisor at the time of the observation revealed he was not aware of the existence of that light. It was not on his preventive maintenance program. Unless the light switches were turned on the south boiler room had no functioning emergency lighting.</p> <p>The deficiency affected requirements for providing emergency lighting.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review, observation, and interview, the provider failed to verify the required maintenance of the sprinkler system (backflow preventer, five year internal inspection, sidewall sprinkler coverage, spare sprinklers, hydraulic information signage, and mixing of sprinklers in smoke compartments) had been performed. Findings include:</p> <p>1. Review of the provider's sprinkler maintenance records revealed no documentation the required annual testing of the backflow preventer had been performed.</p>	K 062	<p>Administrator and Maintenance Supervisor met with a Project Manager from Rapid Fire Protection, Inc. (RFP) on 5/19/15 to review the Life Safety Code deficiencies and implement a plan of correction.</p> <p>1. Annual testing of the backflow preventer is scheduled for 5/26/15. Documentation of completion will be submitted to the Department of Health Life Safety Code on 5/27/15. The annual testing of the backflow preventer will be completed at the same time as the annual inspection of the sprinkler system.</p>	<p>4/21/15 CHSDDO/MF</p>

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K 062	<p>Continued From page 4</p> <p>2. Review of the provider's sprinkler maintenance records on 4/28/15 revealed no documentation the required five year internal obstruction inspection of the sprinkler system had been performed. Review of the sprinkler installation documentation revealed the complete sprinkler system had been installed 12/18/08 (more than six years ago).</p> <p>3. Observation at 11:45 a.m. on 4/28/15 revealed two sidewall sprinklers in the Friendship Room. The distance from the sprinklers to the opposite wall (exterior wall) was measured to be 21.5 feet. That exceeded the allowable distance for that installation (14 feet maximum for that type of installation).</p> <p>4. Observation at 11:00 a.m. on 4/28/15 revealed there were not spare sprinklers in the two storage boxes for all types of sprinklers in service in the building (example: boiler room sprinklers). Interview with the maintenance supervisor at the time of the observation confirmed that finding.</p> <p>5. Observation at 11:15 a.m. on 4/28/15 revealed no hard sign with the sprinkler system hydraulic design information at the sprinkler riser. There were five decal-type information sheets posted above the entrance to the crawl space where the sprinkler main was located (at the south boiler room). Interview with the maintenance supervisor at the time of the observation confirmed that finding.</p> <p>6. Observation beginning at 11:30 a.m. on 4/28/15 revealed one quick response sprinkler installed in the corridor to semi-private rooms 109 through 112 along with two standard response</p>	K 062	<p>2. The five year internal obstruction inspection of the sprinkler system is scheduled for 5/26/15. Documentation of completion will be submitted to the Department of Health Life Safety Code on 5/27/15.</p> <p>3. On 5/26/15 RFP will address the sprinkler coverage issue in the Friendship Room concerning the two sidewall sprinklers. Administrator will notify the Department of Health Life Safety Code on the detailed plan of correction and completion date.</p> <p>4. On 5/26/15 RFP will inventory our sprinklers and will provide spare sprinklers per the required quantity and type of sprinklers in service by 5/29/15. Spare sprinklers will be audited by the QAPI Coordinator monthly x 3 and quarterly x 3. QAPI Coordinator will report to the QAPI committee monthly.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 062	<p>Continued From page 5</p> <p>sprinklers. Further observation revealed resident rooms 109 and 110 each had a quick response sprinkler installed along with standard response sprinklers. Resident rooms 111 and 112 each had only standard response sprinklers installed. Standard response sprinklers cannot be mixed with required quick response sprinkler installations in the same smoke compartment.</p> <p>7. Interview with the maintenance supervisor revealed the standard response sprinklers were from an earlier installation. The quick response sprinklers were from the 12/18/08 installation of a complete sprinkler system for the building.</p> <p>The deficiencies affected multiple components of the building's automatic fire sprinkler system required maintenance.</p>	K 062	<p>5. RFP is looking through their archives and our maintenance supervisor is looking through blue prints to find all of the sprinkler system hydraulic design information. Hard signs with the sprinkler system hydraulic design information will be posted at all sprinkler risers in the facility by 5/29/15. QAPI Coordinator will audit monthly x 3 and quarterly x 3. QAPI Coordinator will report to the QAPI committee monthly.</p> <p>6. On 5/26/15 RFP will identify the standard response sprinklers that are mixed with the quick response sprinklers in the same smoke compartment. Administrator will notify the Department of Health Life Safety Code on the detailed plan of correction and completion date.</p>	

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FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10657	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/29/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWO	STREET ADDRESS, CITY, STATE, ZIP CODE 412 S MADISON NEW UNDERWOOD, SD 57761
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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 4/27/15 through 4/29/15. Good Samaritan Society New Underwood was found not in compliance with the following requirement: S166.	S 000	Addendums noted with an asterisk per W10110 telephone to facility DON. CH/SDDOH/ME	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		

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

Dorinda Lutz - Quinn

STATE FORM

6899

LNHA

LJQL11

TITLE: _____ (X6) DATE

<p>RECEIVED 5/19/15</p> <p>MAY 21 2015</p> <p>SD DOH L&C</p>
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If continuation sheet 1 of 3

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER
GOOD SAMARITAN SOCIETY NEW UNDERWO

STREET ADDRESS, CITY, STATE, ZIP CODE
**412 S MADISON
NEW UNDERWOOD, SD 57761**

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S 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition for six of six exterior doors (main entrance/exit, southwest exit door from the dining room, the west exit door from the north corridor, east/central exit door, east exit door/south wing, and west exit door/south wing). Findings include:</p> <p>1. Observation and testing beginning at 8:00 a.m. on 4/28/15 revealed the exterior exit door at the main entrance was equipped with a delayed egress magnetic lock. A code was posted beside the door that would release the magnetic lock and would also silence the audible alarm required for that location. That condition also existed at the southwest exit door from the dining room, the west exit door from the north corridor, the east/central exit door, the east exit door/south wing, and the west exit door/south wing. The</p>	S 166	<p>1. On 4/28/15 the Administrator removed the codes posted at all the doors. Staff was notified of this change verbally on 4/28/15, in the daily stand up meeting minutes on 4/29/15 and on 5/7/15 in our All Staff In-Service. QAPI Coordinator will audit monthly x 3 and quarterly x 3. QAPI Coordinator will report to the QAPI committee monthly.</p>	<p>*4/18/15 CH/SDDH/ME</p>

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S 166	Continued From page 2 posted code allowed residents to input the code and leave the building without sounding the door alarm. A posted code to release the magnetic door lock is not required at a delayed egress locking mechanism. Interview with the administrator at 12:30 p.m. on 4/28/15 confirmed that condition.	S 166		