

ORIGINAL

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

PRINTED: 11/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2015
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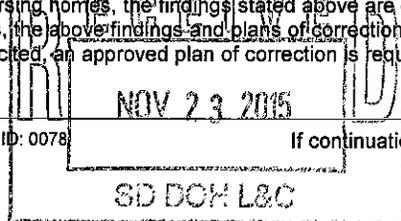
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/27/15 through 10/28/15. Good Samaritan Society Scotland was found not in compliance with the following requirement(s): F226, F281, F360, and F431.</p> <p>F 226 SS=E 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: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate two of three reviewed incident reports for one of one sampled resident (1) and one of two random residents (12) to verify no abuse or neglect had occurred. Findings include:</p> <p>1. Review of resident 12's 9/2/15 incident report revealed: *The incident description had been: -"Nurse summoned to room by housekeeping via [by] radio. -Resident laying face down on floor in front of recliner, head turned towards the left. -Legs outstretched towards the door. -Blood observed on the floor from forehead gash.</p>	F 000	<p>*Addendums noted with an asterisk per 12/11/15 per telephone with facility administrator and DON.</p> <p>KG/SDDOH/EL</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julie Ramer Amin</i>	TITLE <i>11/19/2015</i>	(X6) DATE
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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 226	<p>Continued From page 1 and nose bleed. -I forgot I couldn't walk." *The immediate action taken had been: -"ROM [range of motion, moving arms and legs]. -Resident denies pain to extremities [arms and legs]. -Resident was rolled onto back and assisted to her wheelchair with sling lift [mechanical device used to move resident from place to place] x [times] 2. -Icepack applied to forehead. -Skin tear was noted to left knee, kling [soft dressing] applied. -Dr. [doctor] ambulance and family notified." *Her mental status had been oriented to person [knows herself when spoken to]. *The predisposing environmental factor section had "not applicable" checked. *The predisposing physiological [mental] factors section had "confused" checked. *The predisposing situation factors section had "not applicable" checked. **"No witnesses found" had been typed in under the witness section. *There had been no other documentation regarding what had occurred prior to the fall, who had been working with the resident, or when she had last been assisted with any personal care.</p> <p>2. Review of resident 1's 7/24/15 incident report revealed: *The incident description had been: -"This RN [registered nurse] was called to resident's room by [certified nursing assistant (CNA) name]. -CNA states resident's roommate was looking for money to go shopping. -Apparently res [resident] roommate took resident's piggybank off of the shelf.</p>	F 226	<p>F F-226</p> <p>Unable to amend the incident report for resident to include areas checked not applicable or documentation of the investigation related to the fall. The broken coin bank for resident has been repaired and the money has been replaced back into the coin bank as requested by the resident.</p> <p>All resident incidents will be reviewed and investigated thoroughly to assure no abuse/neglect was involved by the administrator, DNS, and social services on the following working day. The investigation will be done using the GSS #415 and is not a part of the GSS Medical Record; this investigation will be kept within the social service office.</p>	<p><i>*12</i> <i>H/S/D/11/15</i></p> <p><i>#1</i> <i>11-19-15</i></p>

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F 226	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Roommate broke the bank trying to get the money out. -Money was noted on the dresser and on roommate bedside table." *The immediate action taken had been: -"[CNA name] picked up all the money and noted there was \$14.95. -Money was put into a white foam cup along with the broken bank into the med room. -Will keep it in med [medication] room until social services returns on Monday. -Floor was swept to clean up any broken glass. -Resident's roommate has a history of dementia [unable to think well enough to do normal activities] and Alzheimer's [disease, loss of mental functioning]." *There had been no follow-up documentation regarding what social services had done and what had happened with the money after it went into the med room. <p>3. Interview on 10/28/15 at 2:10 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> *They had an internal investigation form they used but per the administrator it was not a part of the resident's medical record. *There had not been a form for resident 1's incident. *There was no additional information on resident 12's form that documented a thorough investigation had been completed. <p>Review of the provider's June 2014 Abuse and Neglect policy revealed:</p> <ul style="list-style-type: none"> *The investigation team should have reviewed all incidents no later than the next working day following the incident. *They should have determined whether further investigation was needed. 	F 226	<p><i>cont.</i></p> <p>GSS National Campus consultant provided education to the administrator, DNS, and social service to review the GSS policy/procedure regarding investigations of all incidents on 11/19/2015.</p> <p>The QAPI coordinator will review incident reports weekly X4 and then monthly X4 to assure all incident reports have been fully investigated with the use of the GSS #415. The QAPI coordinator will report these findings monthly to the QAPI committee, the committee will determine if further auditing is needed.</p> <p> *KG/SDDO/H/EL</p>		

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F 226	Continued From page 3 *Investigations might have included interviewing staff, residents, or other witnesses to the incident. *If possible they should have gotten signed and dated statements from any witnesses.	F 226			
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: 32335 Based on observation, interview, record review, and procedure review, the provider failed to ensure: *A UAP (unlicensed assistive personnel) had notified and consulted with the licensed nurse prior to administering a PRN (as needed) pain medication for one of one sampled resident (1) having pain. *A physician's order had been obtained to self-administer a nebulizer treatment for one of one sampled resident (6) and one of one randomly observed resident (12). Findings include: 1. Observation and interview on 10/27/15 from 5:10 p.m. through 5:25 p.m. with resident 1 revealed: *She had difficulty speaking due to several past strokes (blood clots in the brain). *She had winced a few times at the end of the interview. *She grabbed at her right arm with her left while grimacing. *When asked if she was okay she stated no.	F 281			

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F 281	<p>Continued From page 4</p> <p>*When asked if her arm hurt she stated yes. *When asked if she wanted me to get a nurse she stated no, and instead she loudly hollered "hey" to the certified nursing assistant (CNA) in the hallway. *At 5:20 p.m. CNA D came into the room. *She had asked the resident what she needed. *The resident was having difficulty expressing her pain. *The CNA asked if she needed something to drink. *She stated no. *After a few minutes of struggling with her speech she was asked if she wanted to tell the CNA about her arm. She stated yes. *CNA D then asked if she was in pain and she stated yes. *CNA D asked her what number of pain based on a scale of one to ten with ten being the worst. *She stated her pain was at a 10. *CNA D stated she would go tell the nurse. *At 5:25 p.m. UAP/CNA E went into resident 1's room with medication. *A licensed nurse had not gone into the resident's room to assess her pain prior to the medication being administered.</p> <p>Interview on 10/27/15 at 5:25 p.m. with UAP/CNA E regarding resident 1 revealed she had been told by CNA D the resident was having pain in her arm. CNA D had told her the pain level was at a ten. She had given the resident Tylenol since she had a PRN order for it. She gave the Tylenol instead of something else, because the resident would be getting scheduled pain pills at bedtime.</p> <p>Review of resident 1's medical record revealed UAP/CNA E had documented registered nurse (RN) F had approved the Tylenol given at 5:25</p>	F 281	<p>F 281: Services Provided Meet Professional Standards</p> <p>Unable to amend the circumstances regarding pain medication and nurse assessment for resident 1. On 11/4/2015 the Interdisciplinary Team (IDT) completed the Resident Self-Administration of Medication's User Defined Assessment (UDA) for residents 6 and 12 in order to determine if they could self-administer nebulizer treatments. The determination of the IDT team was shared with resident 6 and 12 medical provider and a physician's order was obtained for resident 12 on 11/5/15, and for resident 6 on 11/6/15, allowing them to self-administer nebulized medications. Facility failure to provide opportunity for nurse assessment before delegating an "as needed" medication puts all residents at risk. Facility failure to have the IDT assess a resident's safety for self-administration of medications, and failure to obtain a physician's order before allowing the practice of self-administration, puts each resident choosing to self-administer medications at risk.</p> <p>All residents needing an "as needed" or PRN medication will be assessed by a nurse prior to the administration of that medication by a UAP. All residents who wish to self-administer medication will be assessed for ability to safely to so by the IDT, using the Resident Self-Administration of Medication's UDA. If the IDT deems it appropriate, a physician's order allowing self-administration to occur will be obtained.</p>		

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F 281	<p>Continued From page 5</p> <p>p.m. on 10/27/15. There had been no assessment or documentation completed by RN F regarding resident 1's pain. Resident 1 had four different PRN pain medications that could have been administered.</p> <p>Interview on 10/28/15 at 9:40 a.m. with the director of nursing (DON) regarding resident 1 revealed a licensed nurse should have completed an assessment on her pain. The licensed nurse should have decided which medication to administer.</p> <p>Interview on 10/28/15 at 1:10 p.m. with the DON revealed she had called RN F and asked about resident 1's pain the night before. RN F was not aware of the pain issue from 10/27/15. She had not been consulted by UAP/CNA E. The DON had also called UAP/CNA E regarding the situation. She had not consulted RN F regarding resident 1's pain prior to administering the PRN pain medication.</p> <p>Review of the provider's September 2012 Medication Administration and Scheduling policy revealed: *Medication administration is a nursing task. *Nursing assessment is a function of the registered nurse. *When the center utilizes medication aides, the delegating nurse is accountable for assessing a situation and making the final decision to delegate. *Prior to delegating medication administration, the nurse assesses the resident's nursing care needs." Surveyor: 33265 2. Observation and interview on 10/27/15 at 11:44 a.m. with licensed practical nurse (LPN) C while</p>	F 281 <i>cont.</i>	<p>The Director of Nursing Services (DNS) and Staff Development Coordinator (SDC) will provide education on November 24, 2015 to all nurses, UAP's and IDT members related to the administration of a PRN medication by a UAP, with emphasis placed on the need for assessment by a nurse prior to the UAP giving a PRN medication, and on the need for IDT assessment followed by a physician's order before allowing a resident to self-administer medications. This education will review the facilities policy and procedures for Medication Administration and Scheduling, and Resident Self-Administration of Medication. It will also include review of the South Dakota Nurse Practice Act, ARSD 20:48:04.01:01 Criteria for Delegation.</p> <p>The Quality Assurance Performance Improvement (QAPI) Coordinator, or designee, will observe one evening medication pass (UAP's are only scheduled on the PM shift) weekly x4, then one evening med pass monthly x4 to assure the UAP informs the nurse of a need for a PRN medication and that the nurse does an assessment of the resident prior to the UAP administering a PRN medication. This will be reflected by the nurse doing the follow up documentation of the effectiveness of the PRN medication. The QAPI coordinator, or designee, will review medical records for residents choosing self-administration weekly x4, then monthly x4, to assure the IDT has done proper assessment and a physician order is in place to allow for self-administration of medications. The QAPI coordinator, or designee, will report all audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p>	<p><i>*11/19/15 HG/SDDO/HJEL</i></p> <p><i>*11/19/15 HG/SDDO/HJEL</i></p>	

**HG/SDDO/HJEL*

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F 281	<p>Continued From page 6</p> <p>she was administering a nebulizer (device to administer medicine as a mist into lungs) treatment to resident 12 revealed she:</p> <ul style="list-style-type: none"> *Took the medication to the room. *Set-up the nebulizer for use and assisted the resident with preparing for the treatment. *Started the nebulizer machine, said she would be back, and left the room. *Returned at 11:59 a.m. and discontinued the nebulizer treatment. *Stated that was her normal procedure for administering a nebulizer treatment. <p>Review of resident 12's complete medical record revealed there was no physician's order for self administration of nebulizer medication.</p> <p>3. Observation and interview on 10/27/15 at 4:23 p.m. with LPN C while she was administering a nebulizer treatment to resident 6 revealed she:</p> <ul style="list-style-type: none"> *Took the medication to the room. *Set-up the nebulizer for use and assisted the resident with preparing for the treatment. *Started the nebulizer machine, said she would be back, and left the room. <p>Review of resident 6's complete medical record revealed there was no physician's order for self-administration of nebulizer medication.</p> <p>4. Interview on 10/28/15 at 4:00 p.m. with the DON and administrator regarding the above two nebulizer administration observations revealed the DON agreed there were no physicians' orders for residents 6 and 12's self-administration of the nebulizer medication.</p> <p>Review of the provider's July 2014 Resident Self-Administration of Medication procedure</p>	F 281		

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F 281	Continued From page 7 revealed: **"A physician's order must be obtained prior to the resident self-administering medications." **"The order must be specific to the medication being self-administered." Review of the provider's July 2015 Self Consumption of Medications procedure revealed: **"Self consumption of medications may not begin until the physician has been involved and signed an order for such." **"The order must state which medications a resident may self consume."	F 281			
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 procedure review, the provider failed to offer fortified foods (have added calories and/or protein) to 22 of 22 residents who were to receive them during 1 of 2 observed meals. Findings include: 1. Observation and interview on 10/27/15 at 5:35 p.m. with cook A revealed: *Residents' diet cards with an "F" written on them were to have received fortified foods. *Foods were fortified by adding butter or gravy to the food.	F 360			

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F 360	<p>Continued From page 8</p> <p>*Whole milk was to have been served. *The food items offered were: -Crispy fish fillet. -Hamburger on a bun. -Oven french fries. -Corn -Dinner roll -Tomato slice on lettuce. -Peach crisp.</p> <p>*She did not serve fortified foods to twenty-two residents who were to have received them. *She stated there was not much she could have added to the food items for that meal.</p> <p>Interview on 10/28/15 at 2:15 p.m. with the dietary manager revealed: *Foods were fortified for residents who needed more calories and/or protein. *Residents' diet cards with an "F" written on them were to have received fortified foods. *There were twenty-two residents on a list to receive fortified foods. *They: -Fortified foods by adding butter, gravy, sour cream, cream, or whole milk to them. -Served whole milk with meals for residents who were to receive fortified foods. -Did not have a fortified foods menu or recipes for fortified foods. -Used the February 2013 Procedure for Fortified Foods as their fortified foods policy. -Were not following their fortified foods policy. *She expected the cook to have added cheese or butter to the foods or to have served a larger dessert to those residents needing fortified foods.</p> <p>Interview on 10/28/15 at 3:25 p.m. with the registered dietician revealed: *The provider did not have:</p>	F 360			

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F 360	<p>Continued From page 9</p> <p>-A fortified foods menu. -Recipes for fortified food items. *Some meals would not be able to be fortified. *She did not expect to have fortified foods at every meal.</p> <p>Interview on 10/28/15 at 3:50 p.m. with dietary consultant B revealed she stated the provider's: *Fortified foods policy was under review. *Fortified food menus were not effective. *Process was to address that issue on the residents' care plans and to update their diet cards. *Dietary staff could have written their own fortified foods menu. *Diet manual could have been referred to for recipes for fortified foods.</p> <p>Interview on 10/28/15 at 4:28 p.m. with the director of nursing revealed: *Foods were fortified to provide additional calories and/or protein to promote wound healing or weight management. *There were residents with weight loss or facility acquired pressure ulcers (injury to skin usually from pressure and frequently over a bony area). -She had expected fortified foods would have been provided to those residents during meals and at snack times.</p> <p>Review of the provider's February 2013 Fortified Foods procedure 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.</p>	F 360	<p>F360 Provided Diet Meets Needs Of Each Resident</p> <p>The Certified Dietary Manager (CDM) and Registered Dietitian (RD) discussed the fortified foods procedure on November 17, 2015. Addendum revised on 11/19/15 to Procedure to eliminate paragraph 7 and add paragraph 7a.</p> <p>7a. In this facility when the word fortified or "F" appears on the care plan and diet card the following will be added to foods as appropriate to promote wound healing and weight maintenance. Super Cereal, Extra Margarine/Butter, Extra Gravy, Sour cream, half and half cream, whole milk and/or chocolate milk per resident preference. Health Shake will be served between meals if extra calories are needed. Extra protein will be added when appropriate of extra egg at breakfast and 4-5 oz. of meat at Noon and Supper meal.</p> <p>Dietary Staff will serve fortified foods to residents with fortified or "F" on care plan and diet card. This process will be audited at meal times weekly for 4 weeks and then monthly for 4 months by the CDM or designee. All staff will be in serviced on November 24 2015. CDM or designee will provide Quality Assurance Performance Improvement (QAPI) Coordinator or designee with audits monthly. The QAPI coordinator or designee, will report all audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p>	<p><i>Handwritten:</i> *12/17/15</p> <p><i>Handwritten:</i> *KPL/SDDSA/EL</p>

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059		
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F 360	Continued From page 10 *A fortified food menu extension could have been written by either the food vendor or the registered dietician. *There would be recipes for the menu extension.	F 360			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431			

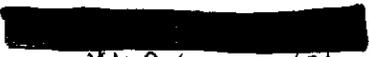
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F 431	Continued From page 11 This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and record review, the provider failed to maintain control of scheduled (government controlled) medications within one of one medication cart. Findings include: 1. Observation on 10/28/15 at 4:30 p.m. with registered nurse (RN) G and the medication cart revealed: *Resident 13's container of liquid morphine sulfate (controlled medication given for pain) one hundred milligrams (mg) per five milliliters (ml) solution had one drop of fluid in it. -There should have been 6.5 ml left in the container according to the narcotic (scheduled pain medication) record. *Resident 14's container of liquid oxycodone hydrochloride (medication given for pain) one hundred mg per five ml solution had fourteen ml in it. -There should have been twenty-two ml according to the narcotic record. *Resident 15's container of liquid promethazine-codeine syrup (medication given for coughing) had forty ml in it. -There should have been forty-eight ml of syrup in it. Observation of the above medication containers, review of the narcotic records, and interview with the director of nursing (DON) and RN G on 10/28/15 at 5:25 p.m. revealed: *There was no explanation for the above missing	F 431	F 431 Drug Records, Labels/Store Drugs and Biologicals Investigations were conducted related to the medication discrepancies cited for residents 13, 14 and 15. Unable to account for these stated discrepancies. The day charge nurse who signed the reconciliation to the medications counts the morning of 10/28/15, and the medication nurse who had access to the controlled medications on 10/28/15 were drug tested before leaving their shifts on 10/28/15. These drug tests came back negative. All residents living here have the potential to be affected by the facilities failure to maintain control of scheduled (government controlled) medications. All controlled medications will be accounted for. If a controlled medication does not reconcile with the medication count sheet, the nurse will immediately search for that medication. If the medication cannot be immediately located, the Director of Nursing Services (DNS) will immediately be notified. The off-going nurse will not leave the facility until the DNS gives permission for such. An incident report will be filed and an investigation will begin immediately. Human Resources will be consulted as to the need for drug testing, suspension, and the involvement of law enforcement.		

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F 431	Continued From page 12 scheduled medications. *The DON had not been notified of any missing medications. A copy of the procedure for dealing with missing scheduled medications was requested of the DON. That procedure was not received before the end of the survey.	F 431 <i>cont</i>	The Human Resources and Regional/Skilled Nurse consultants reviewed the policy and procedures for Controlled Substances, Missing/Diversion of Medication, and Acquisition, Receiving, Dispensing and Medication Storage with the DNS. All nursing staff will receive education review from the DNS of these stated policies and procedures on November 24 th , 2015. The DNS, or designee, will audit the medication reconciliation sheets for controlled medications weekly x4, then monthly x4, to assure controlled medications are counted correctly and well managed per procedures. Audit findings will be reported by the DNS, or designee, to the Quality Assurance Performance Improvement (QAPI) Committee at their monthly meetings. The QAPI committee will determine if further auditing is needed.  *HG/SDDO/H/EL	<i>11-19-15</i>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH STREET SCOTLAND, SD 57059		
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/28/15. Good Samaritan Society Scotland was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 10/28/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K050, K062, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000			
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: 14180 Based on observation and record review, the	K 033			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Quinn Kamey Admin* TITLE _____ (X6) DATE 11/19/2015

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

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K 033	Continued From page 1 provider failed to maintain a protected path of egress from the basement to the exterior of the building for one of two basement stairways (south) that discharged onto the main level. Findings include: 1. Observation at 11:45 a.m. on 10/28/15 revealed the south basement stairway discharged onto the main level adjacent to the staff lounge corridor. A continuous one hour fire resistive enclosure was not provided to the exterior of the building. Review of previous survey data identified the stairway was part of the original facility construction. The facility meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to conduct quarterly fire drills each quarter for the three shifts during four of the four	K 033	K033	F
K 050 SS=F		K 050	K050 Fire Drills Maintenance staff will begin conducting and tracking all required fire drills for all shifts I the facility management software system. Fire drill was performed 10/29/15 and the remaining required fire drills for the 4 th quarter of 2015 will be conducted in the months of November and December. Prior to next fire drill, an all staff in-service will be conducted to provide staff with training on fire drill process and responsibilities. At the conclusion of the drills, an evaluation and feedback will occur with staff to address any concerns. All residents have the potential to be affected by this deficient practice.	

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K 050	Continued From page 2 previous quarters for the twelve month period beginning October 2014. Findings include: 1. Fire drill record review at 11:30 a.m. on 10/28/15 revealed no documentation indicating a fire drill was conducted for: the first shift (7 a.m. to 2 p.m.) or the third shift (10 p.m. to 7 a.m.) during the fourth quarter 2014 (October through December), the second shift (2 p.m. to 10 p.m.) or third shift during the first quarter 1015 (January through March), the third shift during the second quarter 2015 (April through June), and no fire drills were completed during the third quarter 2015 (July through October). Interview with the maintenance director in charge of conducting the drills at the time of the record review confirmed he had not conducted a fire drill since the second shift in June 2015. This deficiency would affect resident safety in all parts of the building.	K 050 <i>cont.</i>	Maintenance staff will conduct and track all required quarterly fire drills for all shifts in the facility management software system on an ongoing basis. The administrator will receive and review an exceptions report from the software the will identify incomplete and overdue tasks. A summary of fire drill procedures will occur monthly as the fire drill occur for 3 months and then quarterly for three quarters and will be reported to the facility's Quality Assurance Performance Committee (QAPI). Additionally, as indicated previously, the administrator will receive and review an exceptions report from the software that will identify incomplete and overdue tasks. In service training for existing staff will be conducted by 11/25/15 regarding fire drill process and responsibilities. All required quarterly fire drills for the 4 th quarter of 2015 will be completed by 12/31/15. Fire drill tasks have been entered in the facility management software.	11-19-15	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had the required quarterly flow testing performed since the installation of the sprinkler system on 4/23/13. Additional record review could	K 062			

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K 144	Continued From page 4 Surveyor: 14180 Based on record review and interview, the provider failed to document monthly exercising of the natural gas powered generator under load for thirty minutes each month for the past twelve months. Test times and length of runs also were not documented in a log book with the dates of testing and hour meter readings. Findings include: 1. Interview with the maintenance director at 10:15 a.m. on 10/28/15 revealed there was not a log book with documentation indicating the generator had been exercised under load each month for the past twelve months. Documentation was not available to indicate the generator was even started without testing it under load. Interview with the maintenance director at the time of the record review confirmed he was not documenting generator testing and could not confirm the last time the generator had been started. This could affected the safety of all residents within the facility.	K 144 <i>cont</i>	All residents have potential to be affected by this deficient practice. Monthly and annual generator testing and inspection tasks will be incorporated into the facility's management software system. The administrator will receive and review exception reports from the software that will identify incomplete and overdue tasks. Documentation recording the results of the testing and inspection will be submitted by maintenance to the Quality Assurance Performance Improvement committee for three (3) months and then quarterly for three (3) quarters. Additionally, as indicated previously, the administrator will receive and review an exceptions report from the software that will identify incomplete and overdue tasks. Testing and inspection tasks have been entered onto the facility management software system. A required monthly 30 minute test load will occur and be documented into the software system by 11/27/2015 by maintenance. Ongoing monthly test loads will be performed and documented by maintenance. Annual inspection occurred on 9/14/2015 and has now been entered into the facility software system.	11-19-15

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10675	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/28/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SCOTLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 130 6TH ST SCOTLAND, SD 57059
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 32335 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 10/27/15 through 10/28/15. Good Samaritan Society Scotland was found in compliance.</p>	S 000		

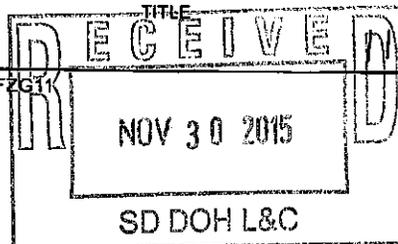
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Glamey Admin

STATE FORM

8888

XFZG11



(X6) DATE

24/15

continuation sheet 1 of 1