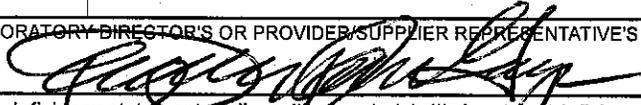


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/04/2015</b>
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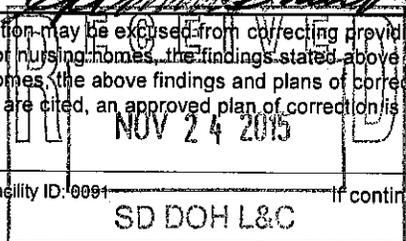
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TRIPP</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 N DOBSON ST TRIPP, SD 57376</b>
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F 000	INITIAL COMMENTS  Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/2/15 through 11/4/15. Good Samaritan Society Tripp was found not in compliance with the following requirements: F226, F280, F325, F431, and F441.	F 000	*Addendums noted with an asterisk per 12/18/15 per telephone with facility DON.  JK/SDDOH/EL	
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: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to thoroughly investigate five of five incidents (abnormal event) for abuse and neglect for one of one sampled resident (4) with cognitive (thinking) impairment. Findings include:  1. Review of resident 4's incident reports from December 2014 through November 2015 revealed: *On 2/24/15 she had a skin tear to her left forearm found during a weekly skin check. *On 4/10/15 she had a skin tear and scab to her right fourth toe. *On 8/21/15 she had a bruise on her right shin (front of lower leg).	F 226	F-226  1. Unable to amend the incident report for Resident #4.  2. All resident incidents will be investigated by the staff person initiating the incident report. The investigation will continue with administrator, DNS, and social services. All areas of the investigation will be complete and the care plan will be updated with interventions to prevent further injury.  3. The administrator will provide education on complete investigation to the nursing and social service staff on 11/24/15. This will include the Abuse/Neglect policy and procedure, a review on using	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>11/3/15</b>
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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</p> <p>*On 9/15/15 she had an abrasion (scraped skin) to her right great toe.</p> <p>*On 10/13/15 she had a bruise to her right lower leg, a skin tear to her right elbow, and a skin tear to her right great toe.</p> <p>*For all the above incidents: -She was unable to give an explanation for the injury. -There were no witnesses regarding what had happened.</p> <p>Random observations from 11/2/15 through 11/4/15 of resident 4 revealed she: *Did not speak much. *Utilized a wheelchair assisted by staff to move around. *Required staff assistance with a mechanical lift (equipment to move resident) to transfer to and from her wheelchair. *Wore socks and no shoes. *Had a foot support pad on the pedals of her wheelchair.</p> <p>Review of resident 4's medical record revealed she: *Had a diagnosis of Alzheimer's (impaired thinking and decision making) disease. *Short and long term memory issues. *Had a Brief Interview for Memory Status (BIMS) score of 0 which indicated she had severely impaired cognitive status. *Required extensive staff assistance with activities of daily living (dressing, bathing, moving, toileting, hygiene, and eating).</p> <p>Review of resident 4's 11/2/15 care plan related to skin revealed: *She had a history of dry scabs on her toes, and she bruised easily at times.</p>	F 226	<p>the GSS#415 Investigation form, and updating care plans.</p> <p>4. The QAPI coordinator will audit incident reports weekly X4 and then monthly X4 to assure a complete investigation was done on all incident reports. The QAPI coordinator will report these audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>5. Date Completed 11/24/15</p>	<p>#11/24/15 JK/SDDD/EL</p>	

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F 226	<p>Continued From page 2</p> <p>*Interventions for her skin included: -Assistance from staff to turn and reposition at least every two hours and total lift (mechanical equipment using a sling to lift resident from one place to another) as needed. -To inform the resident and her family of any new area of skin breakdown. -Provide a pressure reducing cushion in her wheelchair, a pressure reducing mattress on her bed, heel protectors on both feet, and a foot cradle (to keep the blankets off her feet) to her bed at bedtime. -Notify the nurse immediately of any new areas of skin breakdown during bath or daily care. *Those interventions had been implemented in 2012 and had not been revised since 3/13/14. *There were no specific interventions implemented related to the incidents above.</p> <p>Review of resident 4's investigation reports for the above incidents revealed they: *Were blank in the following areas: -"Names of witnesses." -"If no witnesses, list names of caregivers/staff for past 72 hours." *They were all checked as repeat incidents except the 2/24/15 report. *To describe the corrective actions taken to prevent recurrence of the above incident several options could have been marked. -On all of the above reports: --Only one option was checked. --"Other" had been checked with "Monitor" written behind it. --"Nursing" was written for who would have completed that corrective action. *There were no specific interventions listed to prevent recurrence. *For the results of the investigation the following</p>	F 226		

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F 226	<p>Continued From page 3</p> <p>were written in:</p> <p>-On 2/24/15, "Res [resident] denies anyone harming her; Does not recall but claims "bumped" it. Does not appear suspicious."</p> <p>-On 4/10/15, "Staff and Tx [treatment] nurse to monitor toe daily and Tx nurse to complete weekly skin assessments."</p> <p>-On 8/21/15, "Res believes she may have bumped self, but uncertain on what; denies anyone harmed her. Said "bumped self on knee." Area does not appear suspicious."</p> <p>-On 9/15/15, "Denies anyone hurting her. Does not recall bumping it. Resident has hx [history] of scabs on top of toes."</p> <p>-On 10/13/15, "Bruises easily at times - ? [question] legs bumped on Hoyer [type of mechanical equipment using a sling to lift a resident from one place to another], scabbed (9/15/15) area over R [right] toes not new. Has freq [frequent] abrasions on toes. Hx of Alzheimer's - diabetes [disease affecting blood sugar levels]. Does not appear suspicious. On daily ASA [aspirin, blood thinning medication] treatment."</p> <p>*All the above reports had been signed by the director of nursing, administrator, and social worker.</p> <p>Interview on 11/3/15 at 3:55 p.m. with registered nurse A revealed:</p> <p>*When an incident with a resident occurred the nurse completed an initial incident report.</p> <p>*They did not complete the investigation.</p> <p>*The social worker and director of nursing (DON) completed the investigation.</p> <p>*She agreed there should have been changes to the resident's care plan to help prevent future incidents.</p>	F 226			

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F 226	<p>Continued From page 4</p> <p>Interview on 11/4/15 at 8:30 a.m. with the DON revealed: *She and the social worker completed the investigations and the investigation reports. *When there was an incident involving a resident that had impaired cognition they: -Reviewed the staff who worked around the time of the injury. -Investigated to determine the cause of the injury. -Looked for a pattern related to the injuries. *She agreed the investigation reports for resident 4 had: -Areas that had not been filled out including the witness or staff that had worked in the previous 72 hours. -Not identified interventions to prevent recurrence. -Not fully determined the cause of the injury. *She agreed resident 4 had impaired cognition and was not able to reliably participate in the investigation.</p> <p>Interview on 11/4/15 at 8:45 a.m. with the licensed social worker revealed: *She, the DON, and the administrator discussed resident incidents and completed the investigations. *Sometimes the nurse helped with the investigations. *She agreed resident 4 had impaired cognition and would not have been reliable to tell them what had happened to cause the above injuries. *For investigations she and the DON would have: -Assessed the resident. -Talked to the resident. -Talked to staff. -Looked at the resident's care plan. *She agreed: -The investigation reports for resident 4 had not</p>	F 226			

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F 226	Continued From page 5 been filled out completely. -They had not documented their full investigation. -There should have been interventions implemented to prevent recurrent injuries. -Resident care plans should have reflected their current care and interventions.  Review of the provider's revised August 2015 Abuse and Neglect policy revealed: *The purpose included: -"To ensure that all identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries." -"To prevent future injuries." -"To ensure that a complete review of existing incidents is documented." -"To identify events, such as suspicious bruising of residents, occurrences, patterns and trends that may constitute abuse and to determine the direction of the investigation."	F 226			
F 280 SS=E	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	F 280	F-280 1. Resident #4, resident #3, resident #8, resident #2, resident #6, resident #11, resident #9, had care plan updated on 11/24/15 to reflect their current status. 2. All resident will have their care plan reflect their current medication needs, their ADL assistance needs, changes in dietary equipment, diet changes, and self-administration status. The care plan must reflect the needs of the resident and updated to meet their current assistance needed. * <i>on next page</i> 3. The MDS Nurse will provide education to the care plan team and the nurses regarding the care plan process utilizing GSS policy and procedures on how to implement a new care plan, how to make changes to a current care plan, and how to resolve interventions that		

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F 280	<p>Continued From page 6</p> <p>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to ensure seven of nine residents' (2, 3, 4, 6, 8, 9, and 11) care plans reflected the resident's current status. Findings include:</p> <p>1. Review of resident 4's incident reports from December 2014 through November 2015 revealed: *On 2/24/15 she had a skin tear to her left forearm found during a weekly skin check. *On 4/10/15 she had a skin tear and scab to her right fourth toe. *On 8/21/15 she had a bruise on her right shin (front of lower leg). *On 9/15/15 she had an abrasion (scraped skin) to her right great toe. *On 10/13/15 she had a bruise to her right lower leg, a skin tear to her right elbow, and a skin tear to her right great toe.</p> <p>Random observations from 11/2/15 through 11/4/15 of resident 4 revealed she: *Utilized a wheelchair assisted by staff to move around. *Required staff assistance with a mechanical lift (mechanical equipment used to move a resident from one place to another) to transfer to and from</p>	F 280	<p>may no longer be relevant to that resident; this education will take place on 11/24/15.</p> <p>4. The MDS Nurse will audit care plans to ensure they reflect the current needs of the resident, this audit will include interviews with staff and residents to identify areas that need changing. These audits will be done weekly X4 and then monthly X4. The SDC will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>5. Date Completed 11/28/15</p> <p>→*#2 cont. *All care plans will be reviewed and updated by 12/22/15. JK/SDDO#EL</p>	* 11/28/15 JK/SDDO#EL

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F 280	<p>Continued From page 7</p> <p>her wheelchair. *Wore socks and no shoes. *Had a foot support pad on the pedals of her wheelchair.</p> <p>Review of resident 4's 11/2/15 care plan related to skin revealed: *She had a history of dry scabs on toes and bruised easily at times. *Interventions for her skin included: -Assistance from staff to turn and reposition at least every two hours and total lift (mechanical equipment used to move a resident from one place to another) as needed. -To inform the resident and her family of any new area of skin breakdown. -To provide a pressure reducing cushion in wheelchair, a pressure reducing mattress on her bed, heel protectors on both feet, and a foot cradle (to keep the blankets off her feet) to her bed at bedtime. -Notify the nurse immediately of any new areas of skin breakdown during bath or daily care. *Those interventions had been implemented in 2012 and had not been revised since 3/13/14. *There were no specific interventions implemented related to the incidents above.</p> <p>2. Review of resident 3's medical record revealed he: *Was admitted on 7/24/15. *Had a diagnosis of malnutrition (not eating or drinking enough). -Had a weight loss since he had been admitted. *Currently had open areas to his right foot, right ear, left buttock, and right ankle. *Was on a NAS (no-added salt) regular diet. *Had started Ensure (nutrition supplement) three times a day with meals on 10/26/15.</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>*Had started receiving protein powder or eggs daily for wound healing on 10/23/15.</p> <p>Random observations from 11/2/15 through 11/4/15 revealed he:</p> <p>*Was a tall, thin man.</p> <p>*Ate independently in his wheelchair in the dining room.</p> <p>*Had received scrambled eggs for breakfast on 11/3/15.</p> <p>Review of resident 3's 11/2/15 care plan related to nutrition revealed:</p> <p>*There was no mention of:</p> <ul style="list-style-type: none"> <li>-His diet.</li> <li>-The addition of Ensure or protein supplements.</li> <li>-His open areas on his skin in various places.</li> <li>-His weight loss.</li> </ul> <p>*Interventions had not been revised since 8/4/15.</p> <p>3. Review of resident 8's medical record revealed:</p> <p>*He received a Level 2 mechanical texture (soft, ground, easy-to-swallow foods) diet.</p> <p>*He received nectar-thick consistency liquids.</p> <p>Review of resident 8's 11/3/15 care plan related to nutrition revealed his mechanical texture diet and the nectar-thick liquids were not mentioned. Interventions had not been revised since 10/22/14.</p> <p>4. Interview on 11/4/15 at 8:30 a.m. with the director of nursing (DON) confirmed:</p> <p>*Resident 4's care plan had not been revised and updated with interventions related to her incidents involving her skin.</p> <p>*Resident 3's care plan had not been updated with the interventions related to his nutritional</p>	F 280			

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F 280	<p>Continued From page 9 status and weight loss. *Resident 8's care plan did not reflect his mechanical texture diet and nectar-thick liquids. *Resident care plans should have been updated to reflect their current status.</p> <p>Surveyor: 16385 5. Observations of resident 2 on 11/2/15 and 11/3/15 revealed: *On 11/2/15 at 5:45 p.m. she was assisted with eating supper in the dining room. She had a comfort cushion to support her legs while in her wheelchair. *On 11/3/15 at 8:40 a.m. she was assisted with eating breakfast in the dining room. The licensed social worker removed her comfort cushion from the wheelchair during the meal service. *On 11/3/15 at 12:15 p.m. she was assisted with eating dinner in the dining room. She had a comfort cushion to support her legs while in her wheelchair.</p> <p>Review of resident 2's 8/26/15 revised care plan revealed no interventions for use of the comfort cushion while in her wheelchair.</p> <p>Interview on 11/4/15 at 10:00 a.m. with the DON confirmed interventions for use of the comfort cushion had not been documented on resident 2's care plan. Surveyor: 32355 6. Observation on 11/2/15 at 5:40 p.m. of resident 6 in the dining room revealed: *She had been sitting in her wheelchair at a table. *There had been a medication cup containing medications sitting on the table next to her plate. *No staff had been with the resident to ensure she had taken her medication.</p>	F 280			

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F 280	<p>Continued From page 10</p> <p>Observation on 11/3/15 at 8:10 a.m. of resident 6 in the dining room revealed the same as written above.</p> <p>Interview on 11/3/15 at 8:12 a.m. with resident 6 revealed: *The staff had prepared her medications for her. *She had been responsible for taking those medications on her own. *No staff members would have stayed with her to ensure she had taken the medications.</p> <p>Interview on 11/3/15 at 8:20 a.m. with medication aid C revealed resident 6 had been able to self-administer her medications after the staff had prepared them for her.</p> <p>Review of resident 6's medical record revealed: *A 10/29/15 physician's order stating she "May self consume [take medications] after nurse or med aide [medication aide] sets up." *A self-administration assessment had been completed on 9/2/15.</p> <p>Review of resident 6's current care plan revealed no documentation to support she had been able to self-administer or consume her medications after they were set-up by a nurse or medication aide.</p> <p>7. Observation on 11/3/15 at 9:40 a.m. of registered nurse (RN) A during medication administration of a nebulizer (a device that turns liquid medication into a mist for inhaling into the lungs) treatment for resident 11 revealed she: *Reviewed a 9/14/15 physician's order stating "Resident may wear nebulizer mask unattended." *Placed the medication into the nebulizer</p>	F 280			

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F 280	<p>Continued From page 11 chamber.</p> <p>*Placed the inhalation mask on the resident's face and started the machine.</p> <p>*Left the resident's room to do other treatments.</p> <p>Review of resident 11's medical record revealed a self-administration assessment had been completed on 9/2/15.</p> <p>Review of resident 11's current care plan revealed no documentation to support he had been able to self-administer the nebulizer treatment on his own after set-up by a nurse.</p> <p>Interview on 11/3/15 at 2:20 p.m. with the Minimum Data Set (MDS) assessment coordinator revealed she would not have expected to find documentation to support self-administration of medications on the residents' care plans.</p> <p>Review of the provider's July 2014 Resident Self-Administration of Medication procedure revealed "The care plan must indicate which medications the resident is self-administering, where they are kept, who will document the medication and the location of administration, if applicable."</p> <p>Interview on 11/4/15 at 8:20 a.m. with the DON regarding self-administration of medication revealed she had:</p> <p>*Not been sure if the self-administration of medication should have been documented on the resident's care plan.</p> <p>*Agreed the care plan should have reflected the resident's current care and status.</p> <p>*Stated "Technically you should find it there."</p> <p>*Not been aware the provider's</p>	F 280			

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F 280	<p>Continued From page 12</p> <p>self-administration procedure directed the staff to document it on the care plan.</p> <p>8. Observation on 11/3/15 at 12:15 p.m. of resident 9 in the dining room revealed: *She had been sitting at a dining room table eating her dinner. *Her food had been placed on a plate with built-up sides.</p> <p>Interview on 11/3/15 at 3:00 p.m. with resident 9 revealed: *She was alert and oriented. *Her eyesight was poor and required the assistance of the staff with activities of daily living (transferring from place-to-place, toileting, dressing, eating, bathing, and grooming). *She confirmed she required a special plate for her food during mealtime. *She would have been able to get ready for bed after set-up by the staff. *The staff would have placed her pajamas and call-light on her bed while she was out for supper. *After supper the staff would have assisted her back to her room and to the bed. *The staff would have left the room while she dressed herself for bed.</p> <p>Review of resident 9's current care plan revealed no documentation to support she had *Required a special plate for her food during mealtime. *Been able to dress herself for bedtime after set-up by the staff.</p> <p>Interview on 11/4/15 at 8:40 a.m. with the Medicare and rehabilitation coordinator revealed: *Each department had been responsible for reviewing and revising their area of the care plan.</p>	F 280			

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F 280	Continued From page 13 *The care plans should have reflected the residents' current care and status. *There should have been documentation to support resident 9 had required the use of a special plate during meal time. *She had not been aware resident 9 had a special routine at bedtime. She confirmed the resident had poor eyesight and a break in her routine would have created increased anxiety.  9. Interview on 11/4/15 at 9:00 a.m. with the DON confirmed residents' care plans should have been updated to reflect their current status.  Review of the provider's February 2013 Care Plan policy revealed: *"Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment." *"The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and facility responsibility for providing these services."	F 280		
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.	F 325	F-325  1. Unable to amend resident 7 and 8 liquids to proper consistency.  2. All resident will have the physician ordered diet and proper thickened consistency.  3. The RD will provide education on 11/24/15 to all dietary staff on the importance of following physician prescribed diet orders especially with the thickening of liquids to reduce the risk of choking and aspiration.	

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F 325	Continued From page 14  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to ensure physicians' orders were followed for the use of thickened liquids for two of three sampled residents (7 and 8) who were on them. Findings include:  1. Observation on 11/2/15 at 5:30 p.m. of resident 7 revealed she: *Was sitting at the dining room table in her wheelchair. *Had glasses of honey-thickened juice and water in front of her. *Had a cup of tomato soup that appeared not to have been thickened. *Certified nursing assistant (CNA) D had been assisting her to eat that soup for a few minutes and then went to assist another resident.  Observation and interview at 5:35 p.m. with the certified dietary manager of resident 7 revealed: *She was supposed to have all her liquids be honey-thickened. *When asked about the tomato soup being thickened she: -Agreed it was not honey-thickened. -Stated she was just coming to check on that. *She then removed that cup of soup and took it to the kitchen to thicken it.  Interview at 5:50 p.m. with registered nurse (RN) E revealed:	F 325	4. The SDC or designee will audit the dining room to assure all diets are prepared as physician prescribed and that liquids are thickened to the consistency ordered weekly X4 and then monthly X4. The SDC will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.  5. Date Completed 11/24/15	*11/24/15 JK/SDD/EL	

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F 325	<p>Continued From page 15</p> <p>*Three residents received thickened liquids. -Two needed nectar-thickened and one needed honey-thickened. *He agreed: -There was a risk to the resident if their liquids were not thick enough. -The tomato soup was probably thick enough to be the nectar-thickened but was not honey-thickened.</p> <p>Interview at 6:00 p.m. with CNA D regarding resident 7's tomato soup revealed: *She had assisted her to eat the soup, and it was not thick enough. *She agreed the soup had not been honey-thickened and it should have been.</p> <p>Review of resident 7's 10/8/15 physician's orders revealed she should have had honey-thickened liquids.</p> <p>2. Observation and interview on 11/3/15 at 12:05 p.m. of resident 8 revealed: *He was seated in his wheelchair at the dining room table and stated his orange juice was "too thick." *The juice appeared to be pudding-thick consistency.</p> <p>Observation and interview at that same time with the dietary manager revealed: *She agreed resident 8's orange juice was too thick. *He should have had nectar-thickened liquids. *Normally they used pre-thickened water and juices, but the orange juice was not one of the pre-thickened juices. *She stated the dietary assistant had used tablespoons of the thickening powder instead of</p>	F 325			

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F 325	Continued From page 16 teaspoons as the instructions had indicated.  Review of resident 8's 10/5/15 physician's orders revealed he should have had nectar-thickened liquids.  3. Further interview on 11/3/15 at 2:50 p.m. with the dietary manager revealed: *Dietary staff were responsible for the thickened liquids that were served in the dining room. *Most thickened liquids they used were pre-thickened, but the orange juice and soup would not have been pre-thickened. *The dietary staff should have: -Thickened resident 7's tomato soup before it was served. -Used the correct amount of thickening powder for resident 8's orange juice. *She agreed they had not followed the physicians' orders for thickened liquids for those residents.  Review of the provider's February 2013 Thickened Liquids policy revealed: *The purpose was "To ensure all clients [residents] will be served liquids in a form to minimize the risk of choking or aspiration [fluid/food in lungs] and in compliance with the physician's order for thickened liquids." *"All dietary and nursing staff are responsible for thickening liquids to the ordered consistency."	F 325			
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	F 431			

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F 431	<p>Continued From page 17</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 A. Based on observation, interview, procedure, and policy review, the provider failed to ensure accountability was maintained for controlled and highly diverted (high rate of being stolen) medications for one of one emergency medical kit (E-kit). Findings include:</p>	F 431	<p>F-431</p> <ol style="list-style-type: none"> <li>The Ekit tablets that were in cassette were replaced with a blister pack of 8 tablets.</li> <li>Each Blister pack has a label that will be required a signature of the nurse removing medication to sign off each tab removed.</li> <li>Each narcotic in [redacted] has a blue narcotic sheet attached – unit dose has one sheet – blister pack has 8 to sign out the medication and to be filed with the resident chart.</li> <li>Ekit is now reconciled at the change of each shift and [redacted] in the documentation of narcotics.</li> <li>Nursing will be educated on prompt medication destruction at the time of outdate/Dc medication per policy. This education will take place on 11/24/15.</li> </ol>		

\*Ekit  
JK/SDD/TEL

\*included [redacted] in the documentation of narcotics JK/SDD/TEL

forms JK/SDD/TEL

\*narcotics are

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F 431	<p>Continued From page 18</p> <p>1. Observation and interview on 11/4/15 at 11:10 a.m. with registered nurse (RN) B of the medication room revealed:</p> <ul style="list-style-type: none"> <li>*A cupboard with key locks attached to it. That cupboard was used as the E-Kit.</li> <li>*The charge nurse and treatment nurse each had a key to access the contents inside of that cupboard.</li> <li>*Inside of the cupboard revealed a plastic tray containing several medication cassettes.</li> <li>*Each of the cassettes could hold a total of eight pills.</li> <li>*One of the cassettes had been labeled Tramadol (controlled pain medication) 50 milligrams. There had been six tablets inside that cassette. That cassette had a dispensed date from the pharmacy of 8/3/15.</li> <li>*RN B retrieved a form labeled "[Pharmacy name] E-Kit Drug List" from a three-ringed binder.</li> <li>*RN B: <ul style="list-style-type: none"> <li>-Stated the form listed all of the medications inside of the E-kit and the amount of each medication.</li> <li>-Confirmed the form indicated there should have been eight Tramadol inside the E-kit.</li> <li>-Could not locate a copy of the form verifying two Tramadol had been removed from the E-kit.</li> <li>-Stated "We are to fax the pharmacy each time we remove a medication from the E-kit, so they can replace it."</li> </ul> </li> <li>*RN B retrieved the staff development nurse to assist her in locating that form.</li> </ul> <p>Interview on 11/4/15 at the time of the above observation with the staff development nurse revealed:</p> <ul style="list-style-type: none"> <li>*She had confirmed the observation and interview with RN B above.</li> <li>*She had not been able to locate a form that</li> </ul>	F 431	<p>6. The QAPI coordinator will audit the medication room, medications and treatment carts weekly X4 and then monthly X4 to assure proper storage of medications, both oral and topical. Audit results will be reported to the QAPI committee monthly by the QAPI coordinator and the committee will determine if further auditing is needed.</p> <p>7. Date Completed 11/28/15</p>	<p>*11/28/15 JK/SDD04/EL</p>	

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F 431	<p>Continued From page 19</p> <p>verified two Tramadol were removed from the E-kit.</p> <p>*At 11:25 a.m. she had called both pharmacy suppliers to verify if they had received a fax that indicated when two Tramadol had been removed from the E-kit. Neither one of the pharmacy suppliers had received notification two Tramadol had been removed from the E-kit.</p> <p>On 11/4/15 at 12:35 p.m. the pharmacist faxed a copy of the E-kit drug list to the staff development nurse. That faxed E-kit drug list revealed: *Two handwritten dates on it "8-26 &amp; [and] 8-27." *There had been several check marks on the page with the date "8-27-15." *The Tramadol had a line drawn through the number eight with a six written beside it and circled. *The updated date on the form remained 8/20/15.</p> <p>Interview on 11/4/15 at 12:40 p.m. with the staff development nurse revealed: *The pharmacist had called and faxed the nurse a copy of her audit of the E-kit when she had been at the facility in August. *The pharmacist had told the nurse there had been six Tramadol in the E-kit on that date. *The pharmacist had no other documentation to support when two Tramadol had been removed from the E-kit.</p> <p>Interview on 11/4/15 at 12:45 p.m. with the pharmacist revealed: *She had confirmed she was in the facility monthly to do chart reviews. *She would not have checked the E-kit every month for expirations and ensure the number for each medication had remained the same. *She would have checked the E-kit quarterly.</p>	F 431			

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F 431	<p>Continued From page 20</p> <p>*She had checked the E-kit when she had been in the facility on 8/26/15 and 8/27/15.</p> <p>*The review of the E-kit in August revealed only two Tramadol. She had reviewed the E-kit with the director of nursing (DON).</p> <p>*The provider had currently been auditing all of their controlled medications due to discrepancies found in the past. Due to those discrepancies the pharmacist and DON had agreed to leave the count for the Tramadol at six as of 8/26/15.</p> <p>*There had been no documentation or signatures on the E-kit form to support the results of their 8/26/15 investigation.</p> <p>Interview on 11/4/15 from 1:50 p.m. through 2:20 p.m. with the Minimum Data Set (MDS) assessment coordinator revealed:</p> <p>*She had been doing weekly audits with the DON on all of the controlled medications in the facility.</p> <p>*She and the DON would have checked both of the medication carts and the E-kit for any discrepancies.</p> <p>*She had no documentation to support the E-kit had been audited weekly along with the medication carts.</p> <p>*She had a medication administration record for resident 14 from August 2015.</p> <p>*The MAR had indicated resident 14 had received a Tramadol order for pain on 8/11/15.</p> <p>*Resident 14 had received:</p> <ul style="list-style-type: none"> <li>-Two doses of Tramadol on 8/12/15 at 1:19 a.m. and at 4:53 p.m.</li> <li>-One dose of Tramadol on 8/13/15.</li> <li>-One dose of Tramadol on 8/14/15.</li> </ul> <p>*She had:</p> <ul style="list-style-type: none"> <li>-Worked during the week of 8/10/15 through 8/15/15 and recognized the Tramadol count from the E-kit had not been correct.</li> <li>-Not been able to remember if she had been</li> </ul>	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/04/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TRIPP</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 N DOBSON ST TRIPP, SD 57376</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 21</p> <p>working as a charge nurse or doing a weekly audit on the E-kit.</p> <p>-Not been able to remember the exact date she had recognized the Tramadol in the E-kit had two tablets missing.</p> <p>-Investigated the missing Tramadol and had been sure those two tablets had been given to resident 14 on 8/12/15.</p> <p>-Reviewed resident 14's Tramadol count sheet at that time. The resident's count sheet had indicated her Tramadol had been delivered on 8/12/15 after 4:00 p.m. and had received two of those tablets on 8/13/15 and 8/14/15.</p> <p>-Provided a different pharmacy E-Kit drug list form than reviewed above. The updated date on the form was 2/2/15. There had been a hand written "6" by the Tramadol.</p> <p>-Not been able to provide documentation to support when an audit of the E-Kit had last occurred and why the number had been changed from eight to six.</p> <p>Interview on 11/4/15 at 2:25 p.m. with the staff development nurse revealed: *She had no audits or documentation to support the E-Kit had been checked weekly. *She agreed there should have been a report or investigation completed supporting the two missing tablets of Tramadol from the E-Kit.</p> <p>Interview on 11/4/15 at 2:30 p.m. with the DON revealed: *She had received a call from the MDS assessment nurse on 8/15/15. The MDS nurse had been working as charge nurse that day. *The MDS assessment nurse: -Had recognized resident 14's Tramadol count sheet had not supported how many tablets she had received from 8/12/15/ through 8/14/15.</p>	F 431			

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F 431	<p>Continued From page 22</p> <p>-Had checked the E-Kit and was "pretty sure that was where the two extra Tramadol tablets had come from for resident 14."</p> <p>-Had provided the DON with a copy of resident 14's MAR with "e-kit - [minus] 2" written underneath 8/12/15.</p> <p>-Had not provided any further documentation or investigation to support those two Tramadol tablets were from the E-Kit.</p> <p>*She and the pharmacist had recognized two Tramadol had been missing from the E-Kit supply on 8/26/15.</p> <p>*She and the pharmacist had decided to leave the Tramadol count at six in the E-kit.</p> <p>*There had been no formal investigation to support what had happened to those two Tramadol.</p> <p>*She had no documentation to support she and the MDS assessment coordinator had performed an audit on the E-Kit weekly.</p> <p>*She agreed there should have been an E-Kit form filled out and faxed to the pharmacy when medication had been removed from the E-Kit.</p> <p>*The pharmacy would have replaced the two tablets of Tramadol in the E-Kit after receiving a fax supporting the removal of those tablets.</p> <p>Review of the provider's June 2014 Acquisition, Receiving, Dispensing, and Storage of Medications procedure revealed: *"Controlled drugs [Schedule II] and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used." *"These drugs will be reconciled [accounted for] at least daily through an appropriate system of records of receipt and disposition established by the licensed pharmacist."</p>	F 431			

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F 431	Continued From page 23  Review of the provider's controlled Substances procedure revealed: **Purpose: -To provide verification and correct count of all controlled substances on hand. -To provide safe storage for all controlled substances." **At change of shift, on-duty and oncoming nurses count all controlled substances. If your state has a specific law related to this process you must follow that process." **If new controlled drugs are delivered, the licensed nursing staff on duty at the time of delivery is responsible for counting and locking up these substances and adding to the count in the individual resident narcotic record." *No procedure had been in place for the staff to follow when adding or removing a controlled substance from the E-Kit supply.  Review of the provider's September 2012 Emergency Drug Boxes procedure revealed: **To ensure a system is in place for use of the emergency drug box." **Emergency drug boxes are an extension of the providing pharmacist's store and will be kept locked in the med room, accessible to licensed nurses and medication aides." **When a drug is used from the box, the pharmacist or the pharmacist's agent will be notified according to state specific regulation." **A list of emergency medications including the amounts, dosages/strengths will be posted on the outside of the box." **Record keeping will be in accordance with the pharmacy system."  Review of the provider's September 2012	F 431			

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F 431	<p>Continued From page 24</p> <p>Pharmaceutical Services policy revealed:            *"Establish a system of records of receipt and disposition of all controlled medications in sufficient detail to enable accurate reconciliation."            *"Determine that medication records are in order and that an account of all controlled medications is maintained and periodically reconciled."            *"Report any irregularities to the attending physician or the director of nursing services or both. These reports must be acted upon and follow-up documentation maintained."</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure:            *Six randomly observed medications had not been expired in one of one medication room and one of two medication carts (a.m. [morning] cart).            *Two randomly observed controlled medication blister packs (individual card of medication doses) found in one of two medication carts (a.m. cart) had doses that were disposed of properly.            Findings include:</p> <p>1. Observation and interview on 11/4/15 at 11:00 a.m. with RN B of the medication room revealed:            *A plastic tub labeled with resident 13's name.            *Inside that plastic tub was:            -Two bottles of nitroglycerin (medication for chest pain) tablets with discard dates of February 2015 and April 2015.            -One bottle of True Aloe tablets with a discard date of January 2015.            *RN B agreed the above medications were expired and should have been destroyed.            *She stated the medication room was checked monthly by the staff development nurse for expired medications.            Surveyor: 35237</p> <p>2. Observation and interview on 11/4/15 at 11:00</p>	F 431			

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F 431	<p>Continued From page 25</p> <p>a.m. with certified medication aide (CMA) C while auditing the medication cart revealed:</p> <p>*One opened bottle of nitroglycerin tablets had a discard date of 2/20/15.</p> <p>*One full blister pack (individual card of medication doses) of loperamide (medication for diarrhea) had an expiration date of September 2015.</p> <p>*One blister pack of hydrocodone/acetaminophen (controlled narcotic pain medication) containing six tablets had an expiration date of June 2015.</p> <p>-That medication had been given to the resident five times since that expiration date.</p> <p>*CMA C agreed the above medications:</p> <p>-Were expired.</p> <p>-Should not have been given to residents.</p> <p>-Should have been destroyed.</p> <p>*She stated the medication cart was checked monthly by the nurse for expired medications.</p> <p>Interview on 11/4/15 at 1:55 p.m. with the director of nursing confirmed they should not have given residents expired medications. Expired medications should have been destroyed.</p> <p>Review of the provider's revised June 2014 Acquisition, Receiving, Dispensing, and Storage of Medications policy revealed "The center will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations."</p> <p>3. Observation and interview on 11/4/15 at 11:00 a.m. with CMA C while auditing the medication cart revealed:</p> <p>*One blister pack card of hydrocodone/acetaminophen (controlled narcotic pain medication) had ten doses remaining.</p> <p>-On the back of the card tape had been put on</p>	F 431			

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F 431	Continued From page 26 one of those doses to hold the pill into the blister pack. *One blister pack card of clonazepam (narcotic anxiety medication) had nine whole tablet doses and one half tablet remaining. -The label indicated it should have contained whole tablets. -The half tablet had tape put onto the back of the card to hold it into the blister pack. -The front of the blister pack had the words "DO NOT USE" written next to the half tablet blister. -CMA C stated one of the nurses had split the tablet and put it back into the card that way. -She was unsure why it was not destroyed. *It was not their policy to tape a medication back into the blister pack. *Medications should have been destroyed and not taped back into the pack.  Interview on 11/4/15 at 1:55 p.m. with the director of nursing revealed: *Medications should not have been taped back into a blister pack. *Doses that were punched out of the pack and not used should have been destroyed.  Review of the provider's September 2012 Disposition of Medications policy revealed "Disposal of any medication will be carried out under local, state and federal guidelines or in consultation of the pharmacist in the appropriate disposal procedure."	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441			

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F 441	<p>Continued From page 27</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> <li>(1) Investigates, controls, and prevents infections in the facility;</li> <li>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</li> <li>(3) Maintains a record of incidents and corrective actions related to infections.</li> </ol> <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> <li>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</li> <li>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</li> <li>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</li> </ol> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p>	F 441	<p>F-441</p> <ol style="list-style-type: none"> <li>1. Unable to go back and change the medication cart storage system or the plastic container of external medications in the medication room.</li> <li>2. All medications and treatment supplies are now stored in a way to prevent the possibility of cross contamination. The external medications are now stored within a plastic bag and have plastic separation drawers installed in the cart. All external medications will be stored away for internal medications including eye drops, nose drops, and oral medications. Single dose</li> </ol>		

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F 441	<p>Continued From page 28 Surveyor: 35237 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions had been maintained for one of one treatment cart and one of one medication room for:</p> <ul style="list-style-type: none"> <li>*Multiple commingled (mixed together) tubes of topical (cream or ointment applied to the body) medications.</li> <li>*Re-use of single dose eye medication.</li> <li>*An opened package of Vaseline gauze dressing.</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Observation and interview on 11/4/15 at 10:40 a.m. of the nurses' treatment cart with registered nurse (RN) B revealed: <ul style="list-style-type: none"> <li>*Multiple open commingled tubes of topical medications were stored in one of the drawers.</li> <li>-Those medications had included antifungals (to treat fungal infections), pain relief gels, lotions, Vaseline, barrier creams, and nasal gels.</li> <li>-They were separated by the unit the resident lived on.</li> <li>-The tubes were for several different residents on those units.</li> <li>-There was no barrier separating the tubes from one another.</li> <li>*She agreed: <ul style="list-style-type: none"> <li>-There was a potential for cross-contamination (spreading germs) from one to another.</li> <li>-If one tube leaked it would have cross-contaminated a different resident's medication.</li> </ul> </li> <li>*There were two boxes of Restasis (specialty eye medication) eye drops for specific residents.</li> <li>-Those boxes contained several unopened unit doses.</li> <li>-One of the boxes had a unit dose taped to the lid:</li> </ul> </li> </ol>	F 441	<p>medications will be used one time only as directed and then discarded per manufacturer recommendations. Lotions, nail files, and any food substances will not be stored in the treatment cart. If a container is used for new, un-used topical or external medications only un-opened items will be stored in this container. If something has been opened it will be dated and placed in the treatment cart with other opened supplies.</p> <ol style="list-style-type: none"> <li>3. The SDC will educate nurses and UAPs on 11/24/15 regarding the risk of contamination and the proper way to store opened and unopened medications. A demonstration of how to manage multiple residents' medications will be shown using either plastic bags to separate items or plastic panels in the cart. If a storage bin is used in the medication room for new, unopened</li> </ol>		

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F 441	<p>Continued From page 29</p> <p>--That unit dose had been opened and re-capped. --The date "11/4" was written on it. *RN B stated they re-used the Restasis unit dose for the whole day. -She had opened the dose that morning, wrote the date on it, and it would be used for the evening dose. -They re-used the unit dose for the whole day for both residents that received that medication. *There was an opened foil package of Vaseline gauze dressing in the top drawer of the cart. -A handwritten resident name was on the outside of the package. -It was sitting in the same plastic container as a package of gum, bottle of lotion, and several nail files. --There was no barrier between the dressing and the above items. *RN B stated she had opened that dressing that day. *She agreed it should not have been in the same area as the gum, lotion, and nail files due to potential for cross-contamination.</p> <p>Interview on 11/4/15 at 1:55 p.m. with the director of nursing confirmed: *Topical medications and the open dressing should have been separated by a barrier such as a baggie to prevent cross-contamination. *Restasis unit doses were meant to be used a single time and should not have been re-capped and re-used.</p> <p>Surveyor: 32355 2. Observation on 11/4/15 at 10:45 a.m. of the medication room revealed: *A small plastic container labeled "Externals." *Inside of that plastic container were multiple tubes and bottles of topical medications.</p>	F 441	<p>treatment items open containers or ointments will not be placed in this container.</p> <p>4. The QAPI coordinator will audit the medication room, medications and treatment carts weekly X4 and then monthly X4 to assure proper storage of medications, both oral and [REDACTED] Audit results will be reported to the QAPI committee monthly by the QAPI coordinator and the committee will determine if further auditing is needed.</p> <p>5. Date Completed 11/28/15</p> <p>*#4 topicals and personal items JK/SDDOTT/EL</p>	<p>*11/28/15 JK/SDDOTT/EL</p>	

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F 441	<p>Continued From page 30</p> <p>*Those medications had included skin barrier ointment, rectal ointments, antifungal powders, lotions, and pain reliever gels.</p> <p>*One of the bottles of antifungal powder had been opened and was half full.</p> <p>*One of the tubes of rectal ointments had been opened and appeared to have been used.</p> <p>Interview on 11/4/15 at 11:00 a.m. with RN B revealed:</p> <p>*All of the medications inside of that plastic container should have been new and not opened.</p> <p>*She had confirmed:</p> <ul style="list-style-type: none"> <li>-The bottle of antifungal powder had been opened and used.</li> <li>-The tube of rectal ointment had been opened and used.</li> <li>-Both of those medications should not have been inside of that container.</li> </ul> <p>*She agreed there was a potential for cross-contamination and the spreading of bacteria from one item to another.</p> <p>Surveyor: 35237</p> <p>Review of the provider's September 2012 Infection Control policy revealed the purpose was "To provide a safe, sanitary and comfortable environment."</p> <p>Review of the revised June 2013 Restasis product information guide revealed "Advise patients that the emulsion [liquid] from one single-use vial is to be used immediately after opening for administration to one or both eyes, and the remaining content should be discarded immediately after administration."</p>	F 441			

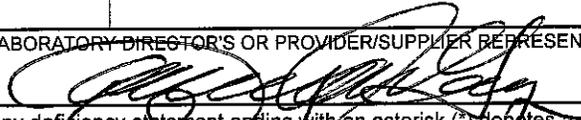
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/05/15. Good Samaritan Society Tripp was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies at K038 and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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



TITLE

*Admission Director*

(X6) DATE

**RECEIVED**  
NOV 24 2015  
SD DPH LSC

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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  435091	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE:  11/5/2015
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY TRIPP	STREET ADDRESS, CITY, STATE, ZIP CODE 300 N DOBSON ST TRIPP, SD		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 038

NFPA 101 LIFE SAFETY CODE STANDARD

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1

This STANDARD is not met as evidenced by:  
Surveyor: 18087

Based on observation, interview, and testing, the provider failed to ensure three randomly observed marked exits (dining room north, dining room south, and the dietary entrance) were readily accessible at all times. Those doors were equipped with magnet locks and were not equipped with delayed egress signage Findings include:

1. Observation beginning at 12:45 p.m. on 11/05/15 revealed the north and south exit doors from the dining room and the dietary entrance door had magnet locks Interview with the maintenance supervisor at the time of the observation revealed the magnet locks were activated by a device worn by residents who were assessed as roaming risks. Testing of the doors when locked by the device revealed the locks were delayed egress type locks. There was not a sign on the doors indicating the magnet lock was a delayed egress style lock Interview with the maintenance supervisor at the time of the observations confirmed those findings He stated the delayed egress signs had been removed recently by staff, because the signs had become wrinkled from the weather. Temporary delayed egress signs were made and installed during the survey

The deficiency has the potential to affect all forty-six residents of the facility.

K 062

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

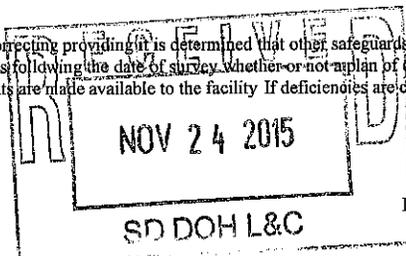
This STANDARD is not met as evidenced by:  
Surveyor: 18087

A. Based on observation, interview, and document review, the provider failed to install a complete automatic sprinkler system in accordance with the National Fire Protection Association (NFPA) 13 (300 wing storage room and utility room were on a separate domestic system). Findings include:

1. Observation at 12:55 p.m. revealed the building was a single story, Type V (111) structure without a

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The above isolated deficiencies pose no actual harm to the residents



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #  <b>435091</b>	MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - MAIN BUILDING 01</b> B. WING _____	DATE SURVEY COMPLETE:  <b>11/5/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TRIPP</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 N DOBSON ST TRIPP, SD</b>		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
<b>K 062</b>	<p>Continued From Page 1</p> <p>complete automatic sprinkler system in accordance with NFPA 13 in the following areas:</p> <p>*The 300 wing storage room and utility room sprinklers were on a separate domestic system from the rest of the building.</p> <p>*Review of the sprinkler service report dated 6/01/15 at 1:22 p.m. revealed the storage room and utility room sprinkler domestic system had been noted.</p> <p>*Interview with the maintenance supervisor at the time of the observation confirmed that finding He revealed the building had become completely sprinklered in 2013. He stated the installing sprinkler contractor was not the same as the current service sprinkler contractor. He stated he did not know why the storage room and the utility rooms had not been added to the new system</p> <p>*Review of correspondence from the Department of Health Office of Licensure and Certification dated 9/17/13 to the installing contractor and copied to the provider stated the domestic system must be removed (see attachment).</p> <p>The deficiency has the potential to affect all forty-six residents of the facility.</p> <p>B. Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector, so the water discharge was not interrupted in one randomly observed linen closet(300 wing). Findings include:</p> <p>1. Observation at 1:11 p.m. on 11/05/15 revealed a single sidewall sprinkler above the shelf in the 300 wing linen closet. The closet had copious amounts of rolled up blankets and quilts stored there There were blankets and quilts double-stacked on the shelf obstructing the sidewall sprinkler on the left side of the closet There was not any method in place to prevent the obstruction of the sprinkler Interview with the maintenance supervisor at the time of the observation confirmed that finding</p> <p>The deficiency affected one of numerous locations required to be equipped with unobstructed fire sprinkler protection.</p>		

**ORIGINAL**

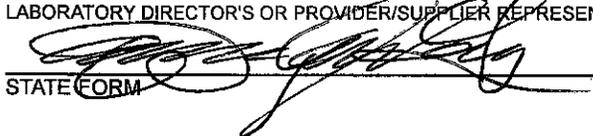
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10694</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/05/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TRIPP</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 N DOBSON ST TRIPP, SD 57376</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 32355 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/2/15 through 11/5/15. Good Samaritan Society Tripp was found in compliance.</p>	S 000		

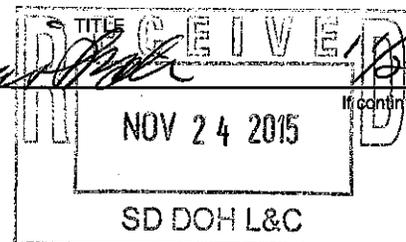
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



STATE FORM

6896

WDJX11



(X6) DATE

11/23/15

If continuation sheet 1 of 1