

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

ORIGINAL

PRINTED: 06/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANISTOTA	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WEST MAIN ST CANISTOTA, SD 57012
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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 6/14/16 through 6/16/16. Good Samaritan Society Canistota was found not in compliance with the following requirement(s): F329 and F333.</p>	F 000	<p><i>*Addendums noted with an asterisk per 7/22/16 per telephone with facility administrator, kg/sddat/el</i></p>	
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 329	<p>1. Policy and procedures were reviewed in regards to Behavioral Causes & Interventions, Unecessary Medications, Non-pharmacological Pain Interventions, & Psychopharmacological Medications and Sedative/Hypnotics.</p> <p>2. RN C was educated on 7/1/16 regarding assesment of behavioral causes to determine why a resident may be displaying a behavior, interventions to attempt prior to administering a psychopharmacological medication, and need to complete a re-assesment following administration of PRN medication.</p> <p>3. All information on policies, interventions, and administration of psychomarcological medications were reviewed with all RN and LPN staff on 7/5/16.</p> <p>4. Resident 12's care plan was reviewed and non-pharmacological interventions updated. <i>*All residents receiving psycho pharmacological medications were reviewed and care plans were updated. kg/sddat/el</i></p>	7/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mina Clark, MPA, LWA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/7/16</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 329	<p>Continued From page 1 by: Surveyor: 33265 Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Manage behaviors with non-pharmacological interventions prior to administering lorazepam (anti-anxiety medication) for one of one sampled resident (12) with agitation related to anxiety. *Monitor the response of medication (lorazepam) given for the treatment of agitation related to anxiety for one of one resident (12). Findings include:</p> <p>1. Observation on 6/14/16 at 5:15 p.m. of resident 12 during the supper meal revealed an unidentified assisted living resident pushed her back up to the table, and locked her brakes.</p> <p>Continued observations from 5:16 p.m. through 5:50 p.m. of resident 12 in the dining room revealed: *She tried to back up several times using her feet, but could not due to her wheelchair brakes having been locked. *Her agitation increased until food arrived at her table at 5:30 p.m. *She had tapped CNA E's arm to get her attention. CNA E had asked her if she was in pain. She called to the nurse on her headset asking for pain medication for the resident. *The resident became more agitated again. Her feet continued to push back against the floor trying to move the wheelchair. *She began using verbal behaviors by calling out in garbled speech. *CNA E only faced the resident to feed her and would only speak with her when asking the</p>	F 329	<p>5. C.N.A B and C.N.A E were both educated on 7/1/2016 in regards to non-pharmacological interventions for residents who are displaying behaviors prior to use of medication and to review each resident's care plan for individual non-pharmacological interventions.</p> <p>6. All residents have the potential to be affected by this. Any residents noted to have increased behavior will be assessed by a licensed nurse to determine what may be causing behavior. Non-pharmacological interventions will be attempted prior to administering any psychopharmacological medications.</p> <p>7. AUDITS: The DNS/QAPI Nurse/ Designee will complete audits on Resident 12 and 5 non-pharmacological interventions prior to administration of any psychopharmacological or pain medication weekly times 4 weeks, 2 times a month times 2 months, and monthly times 3 months. All findings will be reported to the QAPI committee for further recommendations and identifying root cause.</p> <p><i>*random residents</i> <i>*on 7/12/16 all staff will be trained on abuse, neglect, and non-pharmacological interventions.</i></p>	

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F 329	<p>Continued From page 2</p> <p>resident to take a sip of fluids.</p> <p>*The resident's agitation continued to increase.</p> <p>*She began hitting the CNA's arm in a fast tapping motion.</p> <p>*Her feet continuously pushed back on the floor in attempts to move her wheelchair.</p> <p>*The resident became teary-eyed at 5:50 p.m., and her agitation increased.</p> <p>*CNA E continued to speak to the other resident at the table who was able to speak and converse in a normal fashion.</p> <p>*The resident moaned and cried and reached for the CNA.</p> <p>*The CNA tried to give her fluids, but she refused.</p> <p>*She continued to push back on the floor with her feet in an attempt to move her wheelchair.</p> <p>*CNA E called on her headset for someone to relieve her at the table, so she could attend to a call light out on the floor.</p> <p>Observation on 6/14/16 at 5:53 p.m. of registered nurse (RN) C in the dining room attending to resident 12 revealed:</p> <p>*She arrived at the table to relieve CNA E.</p> <p>*She advised the resident she had some lorazepam for her and administered the medication.</p> <p>Interview immediately following the above observation with RN C revealed:</p> <p>*She was unaware the resident's wheelchair brakes had been locked.</p> <p>*She assumed her agitation was from pain on her bottom from sitting.</p> <p>*She stated she was going to take the resident to lay down immediately.</p> <p>*She released the brakes on the resident's chair.</p> <p>*The resident immediately pushed her wheelchair back.</p>	F 329		

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F 329	<p>Continued From page 3</p> <p>Observation on 6/14/16 at 6:00 p.m. of resident 12 revealed: *The resident was in the hall outside of the dining room. *She was no longer agitated and appeared calm.</p> <p>Interview on 6/14/16 at 6:05 p.m. with CNA E and the director of nursing (DON) revealed: *CNA E was told she could lock the brakes on residents while they were at the dining table. *She was unaware that might have increased resident 12's agitation. *The DON allowed staff to lock brakes on wheelchairs while they were at tables feeding residents. *She was aware resident 12 had agitative behaviors and liked to wander.</p> <p>Interview and record review on 6/16/16 at 8:15 a.m. with RN D regarding resident 12 revealed: *RN A had worked at the facility for a very long time and had also been employed as a CNA. *The resident had been admitted in 2012, so staff knew her well. *She reported the hitting motion as described to her mentioned in the above observations meant "stop; get away; or I'm done" by the resident. *When the resident was restricted from movement in her wheelchair she would get upset. *The resident had lorazepam prescribed for agitation since November 2015. *It had not been documented as administered in the medication administration record as an as needed (PRN) medication since April 2016.</p> <p>Interview on 6/16/16 at 10:20 a.m. with the DON regarding resident 12 revealed it was her expectation:</p>	F 329		

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F 329	<p>Continued From page 4</p> <p>*An assessment of the resident was to have been obtained prior to the administration of a PRN anti-anxiety medication for behaviors.</p> <p>*Non-pharmacological interventions should have been tried prior to any medication intervention.</p> <p>*Re-assessment should have occurred after administration to evaluate effectiveness of the medication and the need for continued therapy.</p> <p>Surveyor: 33265</p> <p>2. Interview on 6/15/16 at 10:50 a.m. with certified nursing assistant B revealed if a resident's personality had changed and the resident was yelling and pushing her away she would ask a nurse to give the resident a "PRN" (as needed) medication to calm the person down.</p> <p>Interview on 6/16/16 at 9:50 a.m. with the DON revealed she agreed that an investigation into why the resident's behavior had changed should have been done before giving a PRN medication.</p> <p>Interview on 6/16/16 at 10:20 a.m. with the administrator and registered nurse C revealed they agreed an investigation into why the resident's behavior had changed should have been done before giving a PRN medication.</p> <p>Surveyor: 33488</p> <p>Review of the provider's May 2016 Medication Administration policy revealed when PRN medication had been given, nursing staff were to have evaluated and documented the efficacy of the medication.</p> <p>Review of the provider's September 2012 Physical Restraint/Psychopharmacological Medications and Sedative/Hypnotics Alternatives policy revealed:</p>	F 329			

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F 329	Continued From page 5 *The purpose was to provide alternatives to the use of medications or restraints such as: -Behavior modification. -Adaptive equipment. -Placement of a chair. -Diversional activities. -Relaxation techniques.	F 329			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to give the correct medication dose to one of twelve randomly observed resident (15) during medication pass. Findings include: 1. Observation and interview on 6/14/16 at 4:00 p.m. of registered nurse (RN) A during medication pass revealed: *She was getting resident 15's medications ready to give. *One of the medications was Hyosyne solution (used to decrease the amount of body secretions). *The concentration was 0.125 milligram (mg) per one milliliter (ml). -The physician ordered dose was 0.25 mg. (that would be 2 ml of the solution) four times a day. *The vial of the medication was in a plastic bag with a syringe and a dropper. -The dropper was marked with 0.25 ml.	F 333	1. Policies and procedures for medication administration and medication errors were reviewed. 2. For resident 15, DNS corrected dose in eMAR of PCC to state 2ml instead of .25 mg to decrease confusion with amount to be administered. DNS also removed dropper from resident 15's Hyosyne medication on 6/14/16 and left syringe for administration. 3. RN A was reprimanded on 6/14/16 for a medication error. Education was provided to RN A in regards to medication administration on 7/5/16. RN A was also assessed and observed by DNS on 7/5/16 on Medication Skills. 4. All residents have the potential to be affected. The "6 rights" of medication administration will be followed. 5. Policies and procedures and medication administration were reviewed all RN and LPN staff on 7/5/16.	7/5/16	

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F 333	<p>Continued From page 6</p> <p>*She drew up the Hyosyne with the dropper to the 0.25 ml. mark. -That would have been the wrong dose as it should have been 2.0 ml. of the medication, not 0.25 ml. *She would have given it to the resident but was stopped by this surveyor. *When asked to double-check the dose she had trouble doing so. *RN A admitted she had given the same wrong dose for the earlier doses at 8:00 a.m. and 12:00 noon.</p> <p>Review of resident 15's medical record revealed: *Diagnoses that included a neuromuscular disease and increased stomach and oral secretions. *He was totally dependant on staff for all of his care. *He needed help getting rid of his oral secretions that could cause him to choke. *The physician's order for Hyosyne was 0.25 mg. four times a day. -Giving too little of a dose of that medication could increase his secretions.</p> <p>Interview on 6/14/16 at 5:15 p.m. with the director of nursing (DON) regarding the above medication error revealed: *She agreed RN A had given and would have given the wrong medication dose to resident 15. *She had contacted the other nurses who gave medication to that resident, and they had used the syringe and given the correct dose. *She would fill out a medication error report.</p> <p>Review of the provider's revised May 2016 Medication Errors policy revealed: *A medication error included giving the wrong</p>	F 333	<p>6. AUDITS: The DNS/QAPI Nurse/ Designee will complete audits on Nurse A and 1 random nurse weekly times 4 weeks, 2 times a month times 2 months and monthly times 3 months. All findings will be reported to the QAPI Committee for further recommendations and identifying root causes.</p>	<p>medication PASS hg/sodathel</p>	

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F 333	Continued From page 7 dose. *Medication error was defined by "The observed preparation or administration of medications or biological's which is not in accordance with the prescriber's order, manufacturer's specifications or accepted professional standards and principles." *Significant medication error was defined by "One which causes the resident discomfort or jeopardizes the resident's health and safety."	F 333		

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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 6/14/16. Good Samaritan Society Canistota 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 6/14/16 upon correction of the deficiencies identified below. Please mark an F in the completion date column of those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 028 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on measurement and document review, the provider failed to maintain at least thirty-two inches of clear width for two of two (100 and 200 wings) smoke barrier doors. Findings include: 1. Measurement at 9:00 a.m. on 6/14/16 revealed the cross-corridor doors to the 100 wing measured thirty-one inches of clear width. Further measurement revealed the cross-corridor doors to the 200 wing adjacent to the nurses station measured thirty inches of clear width. Review of	K 028	N/A	F

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

TITLE

(X6) DATE

Mina Clark, MPA, LMSA

Administrator

7/1/16

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K 028	Continued From page 1 the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an F in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 028		F
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain at least two conforming exits from each floor of the building. One of two floors (basement) did not have two conforming exits. Findings include: 1. Observation at 10:00 a.m. on 6/14/16 revealed there was only one exit provided from the basement boiler room. The only exit was a stair enclosure that discharged into the vestibule on the main level. Review of previous survey data also identified that condition. The building meets the FSES. Please mark an F	K 032	N/A	F

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K 032	Continued From page 2 in the completion date column to indicate the provider's intent to correct deficiencies identified in K000. That deficiency would only affect one or two maintenance personnel if in the basement during a fire emergency.	K 032		F

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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 44:73, Nursing Facilities, was conducted from 6/14/16 through 6/16/16. Good Samaritan Society Canistota was found not in compliance with the following requirement(s): S210.</p>	S 000	<p>*Addendums noted with an asterisk per 7/22/16 Per telephone with facility administrator. KG/SDDOH/EL</p>	
S 210	<p>44:73:04:06 Employee Health Program</p> <p>The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview and record review, the provider failed to ensure a health summary indicating no communicable diseases was written for five of five randomly reviewed employees (F, G, H, I, and J). Findings include:</p>	S 210	<p>1. The Health Questionnaire Policy was reviewed by the Administrator, DON and the Staff Development Coordinator (an RN) who is the designee responsible for the completion of the health summary on 7/7/16.</p> <p>2. The staff development coordinator was informed of the mandate to complete the health summary/summary of findings section on the health questionnaire on 6/16/16 and will ensure that a statement is documented demonstrating that all new employees are free from communicable diseases.</p> <p>3. The summary of findings sections for employees F, G, H, I, and J will be reviewed with those respective employees no later than 7/18/16 by the designee and a current statement indicating their being free from communicable diseases will be made.</p>	7/18/16

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

TITLE

(X6) DATE

Mina Khan, MPA, LMHA

Administrator

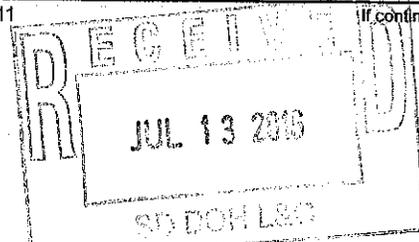
7/7/16

STATE FORM

6800

HYM411

If continuation sheet 1 of 2



SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/16/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY CANISTOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 700 W MAIN STREET CANISTOTA, SD 57012		
(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 210	Continued From page 1 1. Record review and interview on 6/15/16 at 1:30 p.m. with the administrator and director of nursing (DON) regarding the employee health files for the five randomly reviewed employees F, G, H, I, and J revealed they agreed there were no evaluations by a licensed health professional. There should have been a statement for each that said the new employee was free of communicable diseases and signed by a licensed health professional. A policy or procedure regarding the above was requested of the DON on 6/16/16 at 9:50 a.m. No policy or procedure was received before the end of the survey.	S 210 *4. KAPROTH EL	<input checked="" type="checkbox"/> AUDITS: the administrator or designee will audit the health questionnaires of all new employees to ensure an adequate statement is made regarding the lack of communicable diseases in the summary of findings section 1 x a month for 6 months. Audit findings will be submitted to the QAPI committee for further recommendations.	