

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2016
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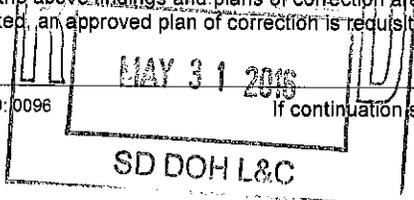
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761
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F 000	INITIAL COMMENTS Surveyor: 22452 An extended/recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/2/16 through 5/5/16. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F226, F274, F281, F311, F323, F371, and F490.	F 000	*Addendums noted with an asterisk per 5/31/16 per telephone with facility administrator. DN/SDDOH/EL	
F 226 SS=E	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: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate three of three sampled residents' (9, 14, and 15) incidents for neglect or abuse. Findings include: 1. Review of resident 15's computerized 1/5/16 incident report revealed: *She was "Found laying on the floor with her head under the bed and feet towards the dresser. The wheelchair was sitting upright next to her. Resident's face was bruised and swollen, and there was a large pool of blood on the floor around her head." *She was oriented to person and disoriented to place, situation, or time.	F 226 *	For resident #15- The facility is not able to go back and gather important information and gather witness statements from the incident of 1/5/16. However, moving forward the facility must ensure a thorough investigation has been completed which will include witness statements, staff interviews and identify risk factors. The care plan has been reviewed and updated as needed. For resident #9- The facility is not able to go back and gather important information, get witness statements, and interview staff from the incident of 1/26/16. However, moving forward the facility must ensure a thorough investigation has been completed which will include witness statements, staff interviews and identify risk factors. The care plan has been reviewed and updated. For resident #14- The facility is not able to go back and gather important information, witness statements and staff interviews from the incident of 2/3/16. However, moving forward	*5/31/16 DN/SDDOH/EL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela J. Quinn</i>	TITLE LHA	(X6) DATE 5/27/16
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

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F 226	<p>Continued From page 1</p> <p>*The predisposing factors check marked had been:</p> <ul style="list-style-type: none"> -Equipment/assistive devices. -Impaired memory. -Current UTI (urinary tract infection). -Gait imbalance. -Wheelchair. <p>*Under witnesses it stated "No witnesses found."</p> <p>*The note section stated "Staff unable to determine if resident had attempted to get out of bed and ambulate without assistance or fell out of bed."</p> <p>*There was no documentation of staff interviews having been conducted.</p> <p>*There was no documentation of when she had last been checked on or assisted to the bathroom, who had been working, or if the care plan had been followed.</p> <p>Review of resident 15's 1/5/16 nursing progress note revealed "At 0355 [3:55 a.m.], staff heard a loud noise from resident's room. Found resident laying on the floor on her left side with her head under her bed and feet towards the dresser. Resident's face was bruised and swollen, and there was a large pool of blood around her head. At least 2 lacerations found and one large hematoma to the back of her head. Resident only oriented to person. Very confused, didn't remember that she fell."</p> <p>2. Review of resident 9's 1/26/16 computerized incident report revealed:</p> <ul style="list-style-type: none"> *He had a dark bruise on his left elbow/upper arm. *It had measured 2.5 centimeters (cm) by 2.6 cm in diameter. *Under nursing description it was typed "Resident unable to give" but the sentence had not been 	F 226	<p>the facility must ensure a thorough investigation has been completed which will include witness statements, staff interviews and identify risk factors. The care plan has been reviewed and updated.</p> <p>For all other potential residents- The facility must ensure it has an effective system to identify and prevent abuse and neglect. The facility must ensure that all incidents are investigated completely to determine probable cause of any unknown injury. The administrator, DNS and social worker will meet to review the incident report and ensure the investigation and documentation is completed and when possible determine probable cause of unknown injury or possible abuse and neglect.</p> <p>Documentation of the incident is in risk management of PCC. Investigation and interview of witnesses and/or staff will be completed and filed per GSS policy and procedure.</p> <p>IN-SERVICE TRAINING: The administrator/designee will re-educate all staff per GSS policy and procedure: Abuse/Neglect and Incident Reports. Re-education will include the investigation process and to include the witness statements as part of gathering objective information. The Interdisciplinary</p>	

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F 226	<p>Continued From page 2 finished. *He had been oriented to person and place but not to situation or time. *The predisposing factors check marked had been: -Equipment/assistive devices. -Tubing/cords. -Incontinent. -Mechanical lift-total lift. *There had been no documentation under other information. *Under witnesses it stated "No witnesses found." *The note section had "See progress notes written by charge nurse. Nsg [nursing] staff to monitor area until resolved. Resident requires sit to stand lift for all transfers - may have bumped elbow on door frame of bathroom. Staff instructed to use more caution with moving resident on the lift into bathroom-passed on in Nsg update." *There had been no documentation regarding who had been working with the resident or if any other staff had seen the bruise. *There had been no staff interviews.</p> <p>Review of resident 9's 1/26/16 nursing progress note revealed the registered nurse had stated "Dark bruise found to left elbow/upper arm. Pain with palpation. No open area noted."</p> <p>3. Review of resident 14's 2/3/16 computerized incident report revealed: *"Resident was found to have a 4.4 cm x 4.3 cm bruise to right leg above ankle. Skin is intact, resident was unsure what caused bruise and does not report discomfort to area unable to determine cause, reports no pain or discomfort." *She had been oriented to person but not to place, situation, or time. *The predisposing factors check marked had</p>	F 226	<p>team will identify root causes to prevent similar occurrences in the future. The education will include that all staff should be knowledgeable in reporting and the investigation process to identify possible abuse and neglect. AUDITS: The administrator/designee will complete audits to ensure the following: Incident report has been documented in PCC under Risk management Investigation process has been completed (GSS 415) Witness statements have been completed and attached to GSS #415 Progress note has been entered in PCC Reporting to state has been completed when determined per DOH requirements Any identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause. Care plan has been reviewed and updated to implement interventions to remedy future injuries. Audits will be completed by the administrator/designee weekly x 4 weeks and monthly x 4 months. The administrator/designee will submit findings monthly to the QAPI committee for further recommendations and root cause analysis if needed.</p>		

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F 226	<p>Continued From page 3</p> <p>been:</p> <ul style="list-style-type: none"> -No apparent unsafe condition. -Wheelchair. -Under physiological factors "not applicable" had been checked. <p>*The note section had "See progress note written by charge nurse. Nsg staff to monitor area until resolved. Resident propels self in w/c [wheelchair]; has fragile skin - Coumadin, requires hooyer lift for all transfers."</p> <p>*There had been no documentation regarding who had been working with the resident or if any other staff had seen the bruise.</p> <p>*There had been no staff interviews.</p> <p>Review of resident 14's 2/3/16 nursing progress note revealed "Resident was found to have a bruise to her right leg above her outer ankle, measuring 4.4. cm x 4.3 cm. No pain reported to area. Skin intact, unsure of cause of bruise. [Physician name] notified by fax and [family name] notified via phone."</p> <p>4. Interview on 5/4/16 at 3:00 p.m. with the executive director and licensed practical nurse D revealed the computerized incident report was considered the investigation. There was no other documentation regarding the above incident reports.</p> <p>Review of the provider's August 2015 Abuse and Neglect policy revealed:</p> <p>**All identified incidents involving injuries of unknown origin are promptly investigated to determine probable cause of unknown origin injuries."</p> <p>**"The investigation may include interviewing staff, residents or other witnesses to the incident. Interview all involved staff individually."</p>	F 226			

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F 274 SS=D	<p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and resident assessment instructions (RAI) review, the provider failed to complete a significant change of condition assessment for one of one sampled resident (1) with an acute change in condition. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She had fallen on 9/10/15 and was sent to the hospital. *She had fractured her hip and had surgery. *She returned to the facility on 9/15/15. *She was non-weight bearing and had a surgical dressing that covered the wound.</p> <p>Review of resident 1's Minimum Data Set (MDS) assessments revealed a quarterly assessment</p>	* F 274	<p><i>DWISDOOHEL</i></p> <p>For resident #1- The facility is not able to go back to 9/15/15 and capture this resident's significant change. However, moving forward the facility must ensure this resident would be assessed to determine if a significant change occurred per the RAI manual requirements when a change in health status is identified. The interdisciplinary team would identify significant changes per the assessment process and RAI criteria and complete the MDS and update the care plan to reflect this change in status.</p> <p>For all other potential residents- The facility must ensure that residents are assessed with change of condition or health status to ensure a significant change is captured with either decline or improvement per MDS (RAI) criteria. The interdisciplinary team would identify significant changes per the assessment process and RAI criteria and complete the MDS within the days allowed to capture a significant change and update the care plan to reflect this change in status.</p> <p>IN-SERVICE TRAINING: The MDS nurse/ DNS will review the RAI manual in regards to significant change criteria and ensure the facility appropriately assesses and completes the MDS process per the RAI manual's significant change criteria. The resident's care</p>	*5/31/16 <i>DWISDOOHEL</i>	

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F 274	Continued From page 5 had been completed on 10/26/15. There had been no significant change assessment completed upon her return from the hospital on 9/15/15. Interview on 5/4/16 at 11:00 a.m. with the MDS coordinator regarding resident 1 revealed there had not been a significant change assessment completed upon her return. The information had been caught in her five day and thirty day Medicare assessments. Those assessments did not have the care area assessment section that was used to develop the care plan. She agreed the non-weight bearing status had been a change along with the surgical wound dressing. Interview on 5/4/16 at 2:00 p.m. with the director of nursing revealed she was unsure when a significant change MDS would have been completed. She stated "I do not do the MDSs." Review of the April 2012 RAI used by the provider for doing MDS assessments revealed: *A comprehensive assessment should have been completed for the resident once the team determined the resident met the significant change guidelines for either improvement or decline. **A significant change is a decline or improvement in a resident's status that: -Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. -Impacts more than one area of the resident's health status. -Requires interdisciplinary review and/or revision of the care plan."	F 274	plan will be reviewed and updated to reflect the changes in care or status and communicated to the staff members. AUDITS: The MDS/designee will complete the audit to ensure the following: The assessment and/or documentation identify changes in status or health condition either by decline or improvement. The assessment meets the RAI criteria and definition of a significant change The interdisciplinary team reviews the care plan and updated to reflect the change in condition Documentation is completed per GSS policy and MDS regulation. The MDS nurse will complete audits weekly x 4 weeks and monthly x 4 months. The audit findings will be submitted monthly to the QAPI committee for further recommendations and root cause analysis if needed.		
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 281 SS=D	Continued From page 6 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: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure physicians' orders were followed for two of two sampled residents (12 and 13) medication administration.. Findings include: 1. Observation on 5/4/16 at 10:45 a.m. of resident 12's Advair (asthma medication) inhaler in the medication cart revealed: *An opened date of 4/19/16 with sixty inhalations for a starting amount. *There were forty-five inhalations left in the inhaler. Review of resident 12's 4/19/16 through 5/4/16 medication administration record (MAR) revealed there was documentation he had received the Advair inhaler every morning. Review of resident 12's 4/19/16 physician's orders revealed Advair one puff daily. Interview on 5/4/16 at 11:30 a.m. with the director of nursing (DON) regarding resident 12 revealed she: *Confirmed there should have been forty-three inhalations left instead of forty-five. *Had not received any medication error reports since 4/19/16.	F 281	* For resident # 12- Advair inhaler per dosage unit-The facility has put into place a monitoring of each dose administered with date, time and licensed nurse or UAP signature. The DNS/designee will monitor with medication reconciliation. For Resident # 13 – Oxycodone was discontinued per physician orders. It was identified that there was a medication omission, but NO missing medication noted. For all other potential residents: The facility must ensure medications are administered correctly per physician orders. When a medication is given the responsible person has 24 hours to sign, provided there is definitive evidence the medication was actually administered. Medications will be administered according to the "six rights". The facility must provide verification and correct count of all controlled substances. Documentation of the narcotic count must be completed when reconciling the medications and when the medication is administered per GSS #247 Individual Resident's Narcotic record. The facility will monitor that correct dosages were administered per physician orders and correlate to the MAR and the narcotic reconciliation record.	*5/31/16 DN/SDDOHEL	

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F 281	<p>Continued From page 7</p> <p>2. Review of resident 13's January 2016 MAR revealed Oxycodone (narcotic pain medication) 5 milligrams, one tablet every six hours (12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m.).</p> <p>Review of resident 13's 1/7/16 controlled drug reconciliation sheet revealed: *Three doses of Oxycontin had been documented as removed from the locked box in the medication cart for administration. *There was documentation the Oxycontin had been removed from the box for administration at 12:30 a.m., 5:00 a.m., and 12:17 p.m. *There was no documentation the 6:00 p.m. dose had been removed from the locked box for administration.</p> <p>Review of resident 13's 1/7/16 MAR revealed documentation the 6:00 p.m. dose had been administered.</p> <p>Review of resident 13's 12/31/15's physician's orders revealed Oxycodone 5 mg every six hours.</p> <p>Interview on 5/4/16 at 11:40 a.m. with the DON regarding resident 13 revealed she: *Confirmed there was documentation on the 1/7/16 MAR the 6:00 p.m. Oxycontin had been administered. *Confirmed there was no documentation on the drug reconciliation sheet the Oxycontin had been removed from the locked box. *Had not received any medication error reports for 1/7/16.</p> <p>Review of the provider's September 12, 2012 Medication Administration and Scheduling policy revealed: **Purpose if to administer medications correctly</p>	F 281	<p>IN-SERVICE TRAINING: The DNS/designee will re-educate all staff per GSS policy and procedure on Medication administration and Controlled Substances. Re-education will include the procedure for medication administration and documentation. The facility must have in place a process for controlled substance count and administration and medication error reporting.</p> <p>AUDITS: The DNS/designee will complete the following: Medication administration records are complete per documentation-date, time and initial Narcotic counts have been reconciled upon administration of the medication and with shift change. The correct dosages were administered per the physician orders Dosage Units are monitored for administration in correlation to the amount such as unit dose inhalants. The audits will be completed by the DNS/designee weekly x 4 weeks and monthly x 4 months. The audit findings will be submitted monthly to the QAPI committee for further recommendations and root cause analysis if needed.</p>		

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F 281	Continued From page 8 and timely." **Medications will be administered to the resident according to the six rights: -Right medication. -Right resident. -Right route. -Right time. -Right dose. -Right documentation." **An incident report should be completed for all medication errors."	F 281			
F 311 SS=F	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Surveyor: 22452 Based on observation, interview, record review, job description review, and policy review, the provider failed to to: *Follow the restorative programs for fourteen of fourteen sampled residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25) who were on a nursing restorative programs. *Evaluate the residents' outcomes without an active nursing restorative program for fourteen of fourteen sampled residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25). Findings include: 1. Group interview on 5/3/16 at 10:30 a.m. with	F 311	* For residents # 1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23 and 24- The facility is not able to go back to provide restorative programs to the listed residents for the past weeks and months. The facility will review and re-evaluate each resident's restorative program and determine their programs continue to be appropriate and/or beneficial. The care plans will be reviewed and updated over the next 8 weeks to capture the residents listed above in this citation. The interdisciplinary team will review weekly over the next 8 weeks during the Quality of Life meeting to complete the fourteen residents listed above and then within the quarter to review all remaining residents' restorative programs and care plans during their MDS schedule. The facility will provide restorative services and staff will be assigned to		

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F 311	<p>Continued From page 9</p> <p>nineteen random residents revealed: *Four residents (confidential) who were on restorative programs voiced they wished they would have more restorative therapy. *The residents voiced they had not had restorative therapy consistently for the last six to eight months due to staffing. The certified nursing assistant (CNA) who was assigned to work in the restorative room was often pulled to work as a CNA on the floor.</p> <p>2. Review of resident 2's medical record revealed: *A 1/31/12 admission date. *Diagnoses: post-polio infection (highly infectious viral disease that affects the central nervous system causing paralysis), cerebrovascular vascular accident (CVA, stroke), and hypertension.</p> <p>Interview on 5/4/16 at 2:30 p.m. with resident 2 revealed he: *"Had not had consistent restorative exercises for a long time due to the unavailability of a restorative CNA consistently." *Was dependent on staff for most of his daily activities of living (dressing, grooming, toileting, bathing, and transfers). *Was able to use his hands despite contractures (limitations in movement). *Was able to propel (move) his wheelchair slowly using his left leg and foot. *Wanted to be as independent as he could be. *Felt his arms and hands had gotten weaker without consistent restorative nursing for the past six to eight months.</p> <p>Review of resident 2's 2/19/16 revised care plan revealed:</p>	F 311	<p>provide the restorative programs per each resident's individualized care plan. The restorative nurse will monitor restorative programs for attendance, completion and functional well-being with a quarterly summary documented during the MDS process.</p> <p>For all other potential residents- The facility will review and re-evaluate each resident's restorative program and determine the restorative programs are provided for each resident and care plans reflect these programs. The restorative nurse and/or MDS nurse will evaluate the resident's programs per MDS schedule and during the center's Quality of Life meetings to discuss and update the individual needs of each resident as reviewed. The facility will begin to provide some consistency with restorative staff assigned to provide the restorative programs per each resident's individualized care plan. The restorative nurse will monitor restorative programs for completion and benefit with a quarterly summary during the MDS process.</p> <p>IN-SERVICE TRAINING: The DNS/restorative nurse will re-educate the nursing department on GSS policy and procedure for Restorative Programs and Restorative Care. The education will include the facility's plan to provide</p>	

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F 311	Continued From page 10 *He needed total assistance of two staff for bed mobility, turning, and transfers with the use of a total lift (device used to move resident without using his legs). **"The resident has a need for restorative intervention due to history of CVA and history of polio. Has limited range of motion [ROM, movement] in upper and lower body extremities and contractures." **"Active range of motion [AROM]. Omni cycle with arms soccer activity, resistance level five times twelve minutes. Do one time a day for three to four days/week when available." **"Place clothespin tree on bedside table and have resident use left hand to place clothespins on the clothespin tree. Once they are all on have resident put them back into the bucket one at a time. Do one time a day for three to four days/week when available." **"Place twelve cones on the floor in front of resident on his left side and place cone holder on bedside table located on resident's left side with the brown weight on the cone holder so the resident doesn't knock it over. Have him pick up one cone at a time and place on cone holder one time a day for three to four days/week when available." **"Passive range of motion [PROM]. Elbow stretch place one hand on his shoulder and opposite hand on his forearm. Stretch arm out as far as you can or until the resident has a facial grimace. Hold thirty seconds, then release and repeat five repetitions. Do one time a day for three to four days/week when available." **"Grip hand with both of your hands thumbs in palms and fingers on top of wrist. Extend wrist upward until resident has a facial expression. Hold for thirty seconds. Do one time a day for three to four days/week when available."	F 311	restorative to each resident per their individual care plans and schedule. Care plan updates and changes. The center will determine the staffing and scheduling to ensure the restorative programs are completed. The importance of documentation with each program completed. AUDITS: The MDS/Restorative Nurse will complete the following: Each resident that has a scheduled restorative program will be reviewed during the MDS completion and within their scheduled Quality of Life meeting to determine the program goals and interventions are appropriate. The care plan has been reviewed and updated to reflect changes in the restorative programs The restorative nurse will oversee the restorative programs to determine restorative programs are being completed and a summary of restorative program and benefit is documented in progress notes both in the Quality of Life weekly meeting and per the MDS process. <i>*and in collaboration with the administrator be reviewed</i> The audits will be completed by the restorative nurse weekly x 8 weeks and then monthly x 4 months. The audit findings will be submitted monthly by the restorative nurse to the QAPI committee for further recommendations and root cause analysis if needed.		

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F 311	<p>Continued From page 11</p> <p>***Grip each finger straightening it out as far as allowed until resident displays a facial grimace. Then let finger go back to starting position. Repeat five repetitions on each finger. You do not have to do the thumb. Do one time a day for three to four days/week when available.</p> <p>***Have resident sit on the edge of the mat unsupported for eight to ten minutes focusing on maintaining his balance. Do one time a day for three to four days/week when available.</p> <p>Review of resident 2's 1/1/16 through 4/30/16 daily restorative attendance record revealed: *Eleven days were checked he had received services. *One day was documented "refused."</p> <p>Review of resident 2's physical therapy (PT) and occupational therapy (OT) records revealed he had received skilled therapy from 2/24/16 through 3/29/16.</p> <p>Review of resident 2's 3/1/16 through 3/29/16 weekly therapy notes revealed: *"Continue with Hoyer [total] lift for all transfers." *"When he is in bed have him stretch his legs out straight, not in a bent position all the time." *On his 2/19/16 care plan the straightening of his legs was not addressed.</p> <p>3. Review of resident 16's medical record revealed: *A 10/15/15 admission date. *Diagnoses: hemiplegia (paralyzed or unable to use extremity/extremities) affecting left nondominant side and muscle weakness.</p> <p>Interview on 5/5/16 at 9:45 a.m. with resident 16 revealed she:</p>	F 311		

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F 311	<p>Continued From page 12</p> <p>*Had been receiving skilled PT and OT. *Was assisted to walk to meals with the nursing staff and usually pushed herself back to her room in her wheelchair. The staff would push the wheelchair behind her when she was walking. *Was not sure how many meals or days she had been walked to the dining room. *Had not been receiving any other exercises with the restorative program.</p> <p>Review of resident 16's 1/5/16 care plan revealed: *May self-transfer from wheelchair to toilet only. One person stand/pivot transfers to/from bed/wheelchair/recliner using gait belt, assist bar (as available), and wheelchair. **"Walk to meals one assist with walker and gait belt. Bring wheelchair along behind her and allow her to sit in it upon arriving in the dining room." **"AROM. Have resident put her left hand in the hand sling and attach it to the handle. Using both hands and legs do for fifteen minutes. Do one time per day three to four days a week when available." **"AROM/balance. Have resident stand and complete any table top activity [thera putty, clothespins, reaching for cones]. Have her remain standing for ten minutes and then let her sit and take a seated break. Do one time per day three to four days a week when available." **"Walking in parallel bars, have her walk forward and backward three to four times and then rest. Do one time per day three to four days a week when available." **"Walking in parallel bars, have her walk sideways to the end and back three to four times and then rest. Do one time per day three to four days a week when available." **"Have resident walk with her red walker from the</p>	F 311		

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F 311	<p>Continued From page 13</p> <p>therapy room to the nurse's station, rest and walk back to the therapy room. Make sure you use a gait belt and hang onto her and that you give her adequate rest between each standing/walking task. Do one time per day three to four days a week when available."</p> <p>Review of resident 16's medical record revealed she received skilled PT and OT from 1/8/16 through 3/11/16.</p> <p>Review of resident 16's 4/18/16 progress notes by the registered nurse (RN) Minimum Data Set (MDS) coordinator revealed: *"Resident is no longer working with skilled therapies." *"She is now working with restorative nursing to maintain what she has accomplished with PT/OT."</p> <p>Review of resident 16's 3/11/16 through 4/30/16 daily restorative attendance record revealed documentation she: *Had received restorative services four times. *Was in an activity one day when restorative services was available.</p> <p>Review of resident 16's 2/1/16 through 3/8/16 weekly therapy update notes revealed: *One person assist for all transfers. *There was no documentation on her 4/12/16 revised care plan she should have been one assist with all transfers. *There was documentation on the care plan she could be independent with toilet transfers). *"Begin walk-to-dine with her walker and one person assist. Make sure you use a gait belt and hang onto her. Bring the wheelchair along with her and let her sit in it upon arriving in the dining</p>	F 311			

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F 311	<p>Continued From page 14 room."</p> <p>Surveyor: 32335 4a. Review of resident 1's 7/27/15 MDS assessment revealed she had no functional limitation in her upper extremities. She had impairment on both sides of her lower extremities.</p> <p>Review of resident 1's 10/26/15 MDS assessment revealed she had functional impairment on both sides of her upper and lower extremities.</p> <p>Review of resident 1's undated care plan revealed: *She had started a restorative program on 1/13/15. *The goal and interventions had been revised on 1/15/16. *The restorative program included the following interventions: -"Active range of motion Sci Fit manual setting resistance level 9, x [times] 15 minutes OR Omni Cycle with ARMS cycle standing resistance level 6, x 12 minutes. Do 1 x day, 3-4 x/week when available." -"Have resident sit on the edge of her chair, place yellow ball between residents knees and have her squeeze the ball for 6. Do 1 x day x 3-4 x/week when available." -"Have resident sit in a chair, place/tie blue theraband around knees and have her pull her knees apart x 6. Do 1 x day x 3-4 x/week when available." -"Bed mobility laying on mat have resident bend knees with feet placed flat on the mat. Then have her lift buttocks up in the air and bring back down to mat. Repeat 15 x x 2 sets. Do 1 x day x 3-4 x/week when available."</p>	F 311		

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F 311	<p>Continued From page 15</p> <p>-"Transfers place 15 cones across room from resident with blue airex beam placed on the floor between resident and cones. Have her ambulate with her walker over airex, retrieve a cone and bring it back across room. Repeat until all cones are on opposite side of room. Do 1 x day x 3-4 x/week when available."</p> <p>Review of resident 1's 1/1/16 through 4/30/16 daily restorative attendance record revealed: *There had been no documentation from 1/24/16 through 3/25/16. *Of the completed documentation she had received restorative services eleven times and refused one time.</p> <p>b. Review of resident 5's 10/26/15 MDS assessment revealed he had no functional limitation in his upper or lower extremities.</p> <p>Review of resident 5's 1/25/16 MDS assessment revealed he had impairments on one side of his upper and lower extremities.</p> <p>Review of resident 5's undated care plan revealed: *He had started on a restorative program on 5/12/15. *The restorative program included the following interventions: -"Transfers have resident stand with walker x 5 min. Do 1 x day x 3-4 x/week when available." -"Transfers have resident stand up and sit down from dining room chair, repeating 5x's x 2 sets. If he is having difficulty make sure to tell him to lean forward and push up from his chair. He should fully get his balance once standing before sitting again. Do 1 x day x 3-4 x/week when available." -"Walking. Place 5 cones across room from</p>	F 311		

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F 311	<p>Continued From page 16</p> <p>resident. Have him ambulate to cones with walker, grab 1 cone at a time, placing cone on cone stand located at other side of room. Repeat task until all cones are on opposite side of room than when started. Make sure you use gait belt and hang onto him. Do 1 x day x 3-4 x/week when available."</p> <p>-"Walking. Using walker at end of session, have resident walk back to his room. Make sure you use a gait belt and hang onto him. Do 1 x day x 3-4 x/week when available."</p> <p>Review of resident 5's 1/1/16 through 4/30/16 daily restorative attendance record revealed: *There had been no documentation from 1/24/16 through 3/25/16. *Of the completed documentation he had received restorative services six times and refused four times.</p> <p>c. Interview on 5/4/16 at 2:00 p.m. with the director of nursing (DON) revealed they had been short of staff since about June 2015. Restorative staff had been pulled from doing restorative therapy to working on the floor when short staffed. She could not prove the decline in either resident 1 or 5 had been due to the disease process and not due to the lack of restorative programming.</p> <p>Surveyor: 22452</p> <p>5. Review of the 3/26/16 through 4/30/16 daily restorative attendance record revealed documentation for the following: *Resident 18 received restorative services four times and refused services four times. *Resident 19 received restorative services two times and refused services three times. *Resident 20 received restorative services eight</p>	F 311		

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F 311	<p>Continued From page 17 times.</p> <p>*Resident 21 received restorative services one time and refused services seven times.</p> <p>*Resident 23 received restorative services three times and refused services two times.</p> <p>*Resident 24 received restorative services seven times.</p> <p>*Resident 25 received restorative services three times, refused three times, and was at an activity one time.</p> <p>Surveyor: 32331</p> <p>6a. Review of resident 3's medical record revealed:</p> <p>*An admission date of 12/16/14.</p> <p>*Her diagnoses had included:</p> <ul style="list-style-type: none"> -Osteoarthritis (degenerative joint disease). -Cerebrovascular disease. -Left-sided hemiplegia (paralysis) and hemiparesis (weakness). <p>Observation on 5/3/16 at 8:45 a.m. of resident 3 revealed she was:</p> <p>*Seated in a wheelchair (w/c) with her left arm on a lap tray attached to the w/c.</p> <p>*Unable to move from one location to another in the w/c by herself.</p> <p>Review of resident 3's revised 2/18/16 care plan revealed she had goals to:</p> <p>*Maintain her current level of mobility by utilization of the appropriate assist devices and assistance needed with mobilization.</p> <p>*Remain free of complications related to:</p> <ul style="list-style-type: none"> -Decreased mobility, including contractures (shortening of a muscle or joint). -Thrombus (blood clot) formation. -Skin breakdown. -Fall-related injuries. 	F 311			

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F 311	<p>Continued From page 18</p> <p>Review of resident 3's 4/12/16 Minimum Data Set (MDS) quarterly assessment revealed:</p> <p>*In Section C:</p> <ul style="list-style-type: none"> -She had a Brief Interview for Mental Status (testing of thought processes) score of eleven. -A score of eleven indicated moderate impairment. <p>*In Section G:</p> <ul style="list-style-type: none"> -She had a functional limitation in range of motion on both sides including: -Upper and lower extremities. <p>Review of the provider's 4/14/16 PT and OT progress notes and discharge summary for resident 3 revealed:</p> <ul style="list-style-type: none"> *She had been discharged from PT on 4/14/16. -Her treatment diagnosis had been muscle weakness. *A restorative therapy program had been developed. *Discharge plans and instructions to "D/C [discharge] to restorative nursing program." *She had been discharged from OT on 4/14/16. -Her treatment diagnosis had been flaccid (limp) hemiplegia (paralysis) affecting left non-dominant side and muscle weakness. *Discharge plans and instructions had not included a restorative therapy program from OT. <p>Review of the provider's 4/11/16 Restorative Program for resident 3 revealed the following:</p> <ul style="list-style-type: none"> *"1. Have ____ [resident's name] stand in stand aid for 15 minutes. *2. Omni cycle [a type of exercise machine] with RIGHT arm x [times] 10 minutes resistance level 1. 3. Have ____ [resident's name] sit on the edge of the mat. Place 10 cones on a bedside table on her LEFT side. Have her reach and place cones 	F 311		

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F 311	<p>Continued From page 19 on her RIGHT side.</p> <p>4. Omni cycle with BOTH feet x 10 minutes resistance level 1.</p> <p>5. Splint program. Place BLUE splint on LEFT hand after breakfast. Remove before lunch."</p> <p>Review of the provider's untitled 4/15/16 through 4/30/16 restorative log schedule for resident 3 revealed she had received restorative therapy one time on 4/22/16.</p> <p>b. Review of resident 9's medical record revealed: *An admission date of 1/29/07. *His diagnoses had included osteoporosis (weak and brittle bones with decreased strength).</p> <p>Interview and observation on 5/4/16 at 2:10 p.m. of resident 9 revealed he: *Was seated in a lift chair in his room. *Stated "I like my exercises." *Stated he especially liked the ones where he went "up and down."</p> <p>Review of resident 9's revised 3/11/16 care plan revealed: *He had goals to: -Maintain his current level of function in transfers, eating, dressing, and toilet use. -Continue to take part in using grab bars as available for transfers, toileting, feeding self in dining room, and lifting/moving arms to assist with putting his shirt on. *He had a focus for a need for restorative intervention. *He was on four scheduled nursing rehabilitation programs. -Those above programs were to have been completed three to four days per week when</p>	F 311			

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F 311	<p>Continued From page 20 available.</p> <p>Review of the provider's untitled 9/23/15 through 4/30/16 restorative log schedule for resident 9 revealed he had received restorative therapy as follows:</p> <ul style="list-style-type: none"> *Two times in September 2015. *Five times in October 2015. *Zero times in November and December 2015. *Two times in January 2016. *Zero times in February and March 2016. *Two times in April 2016. <p>Review of resident 9's 2/29/16 MDS quarterly assessment revealed:</p> <ul style="list-style-type: none"> *In Section C: <ul style="list-style-type: none"> -He had a Brief Interview for Mental Status score of twelve. -A score of eleven indicated moderate impairment. *In Section G: <ul style="list-style-type: none"> -He had a functional limitation in range of motion on both sides including upper and lower extremities. <p>Review of the provider's 5/14/15 Restorative Program for resident 9 revealed the following:</p> <ul style="list-style-type: none"> **1. ARMS omni cycle resistance level 2 x 12 minutes. *2. LEGS omni cycle resistance level 2 x 12 minutes increase RPM's [revolutions per minute] to 30. 3. Standing in stand aid x 8-10 minutes focusing on holding his trunk upright while standing. 4. Place 10 cones on wooden step directly in front of patient's wheelchair. Have pt [patient] reach forward and grab 1 cone and place on bedside table located at the side of him. Repeat until all cones are picked up and placed on bedside 	F 311			

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F 311	<p>Continued From page 21 table."</p> <p>c. Interview on 5/4/16 at 11:30 a.m. with the therapy coordinator regarding resident 3 and 9 revealed: *Were on a restorative therapy program. *Were to have had restorative therapy three to four times per week. *LPN C was responsible for the care plan with restorative therapy. *Agreed residents were not always receiving their scheduled restorative therapy each week.</p> <p>7. Review of resident 17's 2/10/15 restorative program documentation revealed she was to receive the following program: **"Place one bedside table with 20 cones on pts [patients] right side and another table with the cone holder on her left, with pt standing have her move the cones from the right side to the left and repeat for all 20 cones." **"Leg bike seated in chair x [times] 8, make sure she is sitting up straight in her chair before completing this task." **"Place all clothespins in bowl and have pt put them on the clothespin ladder while standing."</p> <p>Review of resident 17's 1/1/16 through 4/30/16 daily restorative attendance record revealed: *There had been no documentation from 1/24/16 through 3/25/16. *Of the completed documentation she had received restorative services twelve times. *On 4/6/16 "company" had been written on the attendance record.</p> <p>8. Interview on 5/3/16 at 11:45 a.m. with the PT person revealed he: *Had been aware staffing in restorative nursing</p>	F 311			

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F 311	<p>Continued From page 22</p> <p>had been a problem for some time.</p> <p>*Had been employed full-time at the facility about a year.</p> <p>*Felt since June 2015 restorative nursing had been offered to the residents on the restorative program infrequently related to staffing.</p> <p>*Stated there used to be a CNA specifically assigned to work in restorative nursing daily. He knew that CNA was often pulled out to the nursing floor if someone called in sick or they were short-staffed for the day.</p> <p>*Would help some of the residents like resident 20 when he came into the room to get on and off the equipment.</p> <p>*Knew some of CNAs were walking the residents to meals.</p> <p>Interview on 5/3/16 at 3:00 p.m. with licensed practical nurse (LPN) C regarding the restorative therapy program revealed that there was "not enough staff to do it."</p> <p>Interview on 5/3/16 at 3:15 p.m. with the director of nursing (DON) confirmed that there was not a consistent restorative program.</p> <p>Interview on 5/4/16 at 9:45 a.m. with licensed practical nurse C regarding the restorative nursing program revealed she:</p> <p>*Was the nurse who oversaw the restorative program.</p> <p>*Confirmed staffing the restorative nursing program had been a challenge the past six to eight months due to staffing.</p> <p>*Stated there had been some days a restorative CNA had been assigned, but another CNA for the nursing floor would call in sick or not show up. When that happened the restorative CNA would have to work on the nursing floor.</p>	F 311			

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F 311	<p>Continued From page 23</p> <p>*Stated the CNAs on the floor could walk the residents, but they were unable to do the specific restorative nursing exercise programs.</p> <p>*There were only two CNAs now that had been specifically trained and had taken the test to work in the restorative nursing department.</p> <p>*Was unsure if any of the residents had any declines related to the lack of the restorative nursing, but she did not think so.</p> <p>*Was not sure if any of the residents had an increase in contractures, as she did not code that section on the MDS.</p> <p>*Had not specifically revised any of the residents' care plans who were on the restorative program.</p> <p>*She and the OT staff were planning on looking at some the care plans, but had not done that yet.</p> <p>Interview on 5/4/16 at 11:35 a.m. with certified nurse assistant (CNA) A regarding the restorative therapy program revealed: *"Don't have time for restorative." *Stated that it had been at least two weeks since the last restorative program had been completed. *A scheduled restorative therapy shift was usually 6 a.m. until about noon. *There were two trained CNAs for the restorative aide position and one in the process of being trained.</p> <p>Interview on 5/4/16 at 1:40 p.m. with the physical therapist and the therapy coordinator regarding the restorative therapy program revealed: *The therapy coordinator was responsible for typing up the restorative program for residents recommended for it. *Two copies of the program were made for each resident on a program and placed in a plastic sleeve attached to the wall in the therapy room. *The restorative aide was responsible for picking</p>	F 311			

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F 311	<p>Continued From page 24</p> <p>up those copies for placement in the following: -One copy in the restorative book. -Second copy to LPN C for input into the resident's care plan. *LPN C was responsible for any care plan updates with the restorative program.</p> <p>Interview on 5/4/16 at 4:30 p.m. with the administrator, executive director, and the DON regarding the restorative program revealed they: *Confirmed it had been a problem to staff in the restorative nursing department the past six to eight months. *Had not really evaluated if any of the residents on the restorative program had shown a decline in their function due to the lack of restorative nursing. *Had not trained any more CNAs to work in the restorative nursing department, as they were needed to provide care on the nursing wings. *Had not made any adjustments in the residents' care plans to compensate for the lack of restorative nursing care. *Knew the CNAs were walking the residents who could to meals, but they were unable to document that related to their computer system. *Had been unable to hire nursing staff from the temporary agencies. The agencies did not "come through" with staffing for them.</p> <p>Interview on 5/5/16 at 7:50 a.m. with the physical therapist and the therapy coordinator regarding the restorative therapy program confirmed there had been staffing concerns.</p> <p>Phone interview on 5/5/16 at 9:00 a.m. with the medical director revealed he: *Knew staffing the restorative nursing department had been a challenge for some time due to</p>	F 311			

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F 311	<p>Continued From page 25 staffing.</p> <p>*Did not know of any specific residents who had declined in their daily activities of daily function related to the lack of restorative nursing care.</p> <p>*Felt the CNAs were trying to walk the residents as much as they could.</p> <p>Interview on 5/5/16 at 9:15 a.m. with CNA A regarding the restorative therapy program revealed: *A CNA had needed additional training to have provided restorative therapy. *LPN C and therapy provided the training in the facility along with a study book and testing.</p> <p>Interview on 5/5/16 at 9:30 a.m. with the DON regarding the restorative therapy program confirmed: *A CNA required additional training to have provided restorative therapy. *Currently there were two full time CNAs that had received that training.</p> <p>Review of the provider's December 2015 Rehabilitation Nurse LPN job summary revealed: *"Documents services provided. Provides training on programs, adaptive equipment, and positioning." *"Receives and shares information, provides direct consultation with physician and/or interdisciplinary team members.</p> <p>Review of the provider's March 2016 CNA/nursing assistant certified job description revealed "Assists residents in transferring, repositioning and walking, using correct and appropriate transfer techniques and equipment, provides range of motion and passive exercise."</p>	F 311			

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F 311	Continued From page 26 Review of the provider's 1/27/16 through 4/28/16 daily staffing records revealed there was: *Eighty-seven days there was no restorative CNA. *Six days (4/4/16, 4/5/16, 4/7/16, 4/9/16, 4/10/16, and 4/22/16) there was a restorative CNA on duty. Observation during the survey from 5/2/16 at 4:00 p.m. through 5/5/16 at 11:00 a.m. revealed there was not a restorative CNA scheduled.	F 311			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 A. Based on interview, record review, and policy review, the provider failed to develop, implement, and update interventions for three of five residents (1, 5, and 7) who had falls. Findings include: 1. Review of resident 1's medical record revealed she had fallen eight times from 5/30/15 through 4/25/16. On 7/9/15 she had hit her head. On 9/10/15 she had fallen and fractured her hip. On 4/25/16 she had hit her head and had lacerations to her head.	F 323	* For residents # 1, 5, and 7- The facility must develop a falls prevention and management program that implements a proactive approach to falls. The facility must identify risk factors and implement interventions before a fall occurs and to give prompt treatment and review to prevent further falls if possible. The facility will document falls in PCC under risk management in the incident report with an investigation as to how the fall occurred on GSS #415 and to include witness statements when applicable and to identify risk factors. For all other potential residents- The facility must develop a falls prevention and management program that implements a proactive approach to falls. The facility must	*5/31/16 DW/SDD/H/EL	

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F 323	<p>Continued From page 27</p> <p>Review of resident 1's 9/10/15 computerized incident report revealed: *She was found on the floor in her bathroom. *She had bumped her head on the floor. *Denied pain to her head. *Had begun to have discomfort in her groin area. *She had been oriented to person but not to place, time, or situation. *The predisposing environmental factor check marked had been: -Floors slippery. -Impaired memory. -Impaired hearing and vision. -Weakness/fainted. -Using walker. *She had been sent to a clinic, it was determined she had fractured her left hip, and had required surgery.</p> <p>Review of resident 1's 4/25/16 computerized incident report revealed: *She had exited the dining room with her walker. *She bent over to pick something up and had fallen. *She struck her head on the floor. *She had been oriented to person and place but not to time and situation. *The predisposing environmental factor check marked had been "using walker." *A request had been sent to the physician to obtain orders for physical therapy and occupational therapy to evaluate and treat due to two recent falls.</p> <p>Review of resident 1's undated care plan revealed: *She had been at risk for falls due to her vision problems and history of falls.</p>	F 323	<p>identify risk factors and implement interventions before a fall occurs and to give prompt treatment and review to prevent further falls if possible. The facility will document falls in PCC under risk management in the incident report with an investigation as to how the fall occurred. When a fall occurs staff members should observe the scene of the fall and begin the investigation using the Fall Scene Huddle Worksheet GSS # 409. Use the root-cause analysis process if resident is stable. Observe the fall scene for risk factors per the GSS # 409 and incident report. Complete the falls Tool UDA and use to explore other factors that may be involved. Document any teaching or education provided to the resident in the progress notes. The care plan should be updated to reflect the fall and any interventions that were implemented or changed.</p> <p>IN-SERVICE TRAINING: The DNS/designee will re-educate all staff on GSS policy and procedure for Falls Prevention and Management, the Fall Scene Huddle GSS #409 and the fall work-flow diagram. The facility will include education for all staff members in the utilization of the fall scene huddle at time of fall and review of all risk factors. Education was provided on May 12, 2016 for all licensed nurses. The care plan</p>	

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F 323	<p>Continued From page 28</p> <p>*The three interventions listed were: -"Educate resident/family about safety reminders and what to do if a fall occurs initiated on 11/24/14. -Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function initiated on 11/24/14. -Monitor visual and auditory impairments initiated on 11/24/14." *The above falls had not been listed on the care plan. *There had been no revised or updated interventions added after any of the eight falls she had from 5/30/15 through 4/25/16.</p> <p>2. Review of resident 5's medical record revealed he had eight falls from 6/2/15 through 4/29/16.</p> <p>Review of resident 5's 2/28/16 computerized incident report revealed: *He was found on the floor parallel to his bed. *He had a spot on the right side of his head that was sore to the touch. *He had been oriented to person, place, and situation but not to time. *The predisposing environmental factor check marked had been improper footwear and self-transferring.</p> <p>Review of resident 5's 3/18/16 computerized incident report revealed: *He had been yelling for help and had been found sitting next to his bed. *The soaker pad had been half off of the bed and behind his back. *He had been oriented to person, place, and situation but not to time. *The predisposing environmental factor check</p>	F 323	<p>will be updated to reflect the fall occurred and the interventions that have been implemented. The documentation of any education or teaching to the resident will be in the PCC-progress notes</p> <p>AUDITS: The DNS/designee will complete audits for the following: Fall prevention and management program has been implemented/ educated and is being used routinely Fall Tool UDA has been completed with a fall Fall Scene Huddle GSS#409- has been completed when a fall occurs</p> <p>Staff members have identified root cause when possible and have identified risk factors at the time of the fall. Care plan has been updated to reflect interventions Interventions have been implemented and communicated to the staff Audits will be completed by the DNS/designee after each incident of a fall to ensure the above have been completed. The audits will be completed weekly x 4 weeks and monthly x 4 months. The audit findings will be submitted monthly to QAPI for further recommendation and root cause analysis as needed.</p>		

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F 323	<p>Continued From page 29 marked had been: -Confused. -Incontinent. -Gait imbalance. -Low bed.</p> <p>Review of resident 5's undated care plan revealed: *He had been at risk for falls due to weakness. *The three interventions listed were: -"Resident uses assistive device, bed enabler, to help self sit up on bed and to get into bed initiated on 1/15/15. -To maximize safe, cups will be with in resident reach in the dining room so he can have between meal drinks initiated on 1/12/16. -Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function initiated on 9/15/14." *The above falls had not been addressed on the care plan. *There had been no other interventions added after the above mentioned falls.</p> <p>3. Review of resident 7's medical record revealed she had two falls from 1/1/16 through 4/7/16.</p> <p>Review of resident 7's 1/19/16 computerized incident report revealed: *She was found laying on the floor next to her bed. *She was in pain and appeared to have hit her head. *She had been in her wheelchair prior to the fall.</p> <p>Review of resident 7's 4/7/16 computerized incident report revealed she was found laying in the hallway outside her room.</p>	F 323		

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F 323	<p>Continued From page 30</p> <p>Review of resident 7's undated care plan revealed: *She had been at risk for falls. *The three interventions listed were: -"Remind resident not to bend over to pick up dropped items initiated on 11/20/14. -Ensure the resident is wearing appropriate non-skid footwear when transferring or mobilizing in w/c [wheelchair] initiated on 11/20/14. -Utilize fall mat next to bed to maximize resident safety; position soft call light at hip when in bed to alert staff of movement initiated on 5/11/15." *The above falls had not been addressed on the care plan. *There had been no other interventions added after the above mentioned falls.</p> <p>4. Interview on 5/4/16 at 11:15 a.m. with the Minimum Data Set assessment coordinator revealed: *The resolved areas of the care plan were reviewed at the above time. *There had been no resolved interventions for falls listed for the above mentioned residents.</p> <p>Interview on 5/4/16 at 2:00 p.m. with the director of nursing regarding the above residents revealed the care plans should have been updated with new fall interventions.</p> <p>Review of the provider's September 2012 Care Plan policy revealed each care plan should have been individualized and had measurable goals and timetables. Any problems, needs, and concerns should have been addressed. The care should have reflected the current care required or provided to the resident.</p>	F 323			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 31 B. Based on observation and interview, the provider failed to maintain door thresholds to prevent a trip hazard in two of two hallways. Findings include: 1. Observation on 5/3/16 at 12:00 noon revealed an unidentified resident had difficulty getting over the doorway threshold as he entered the dining room. Resident rooms 108, 109, 202, 205, 207, 209, and 212 had doorway thresholds that were coming off the floor. Observation and interview on 5/4/16 at 2:15 p.m. with the director of nursing revealed the doorway threshold into the dining room was raised approximately 1/4 inch. It made it difficult for residents to get their wheelchairs over it and it was identified as a potential trip hazard. They were aware the resident rooms identified above had doorway thresholds that were coming off the floor. They had intended to replace them with the same type used in the dining room doorway which was raised up approximately 1/4 inch. The maintenance supervisor was unable to be interviewed as he was newly hired and had not started as of 5/4/16.	F 323			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	*DW/SPDOH/EL The fan that was noted to be blowing from dirty to clean dishes. The fan has been made stationary and will be monitored by the CDM. The facility must ensure any fans used or oscillating in the kitchen area do not cross-contaminate a protected dish area. The four hoods filters have been cleaned on	5/31/16 DW/SPDOH/EL	

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761		
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F 371	Continued From page 32 This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, testing, interview, record review, and policy review, the provider failed to maintain sanitation in the kitchen with the potential of cross-contamination (bacteria transferred from one area to another) in the following areas: *One of one fan was blowing from a dirty to clean area in the dishwashing machine area. *Four of four hood panels above the stove area had not been cleaned and had an accumulation of grease. *Conduit (a pipe for protecting electrical wires) behind the stove and located directly across from an ice machine's ice bin had not been cleaned and had a build-up of dust, grease, and lint on it. Findings include: 1. Observation on 5/2/16 from 4:00 p.m. through 4:30 p.m. in the kitchen revealed: *In the dish machine area: -There was a large fan mounted on the wall and located directly across from the dish machine area. -That fan was running on high and oscillating (moving air back and forth). -It was moving air from the dirty end of the dish machine where dirty dishes and utensils were stored and the garbage disposal was located. -That same air was moving over the cleaned dishes and utensils stored on the clean end of the dish machine. *Testing with a napkin at the dish machine's dirty end and at the clean end counters revealed:	F 371	May 19, 2016 and have been scheduled bi-weekly and as needed per the CDM cleaning schedule. The conduit behind the stove has been cleaned and scheduled to be cleaned per the cleaning schedule IN-SERVICE TRAINING: The CDM and/or RD will re-educate the dietary and maintenance staff on GSS policy and procedures for Kitchen Sanitation and required cleaning schedules. The CDM educated dietary staff verbally per shifts and written instructions to the staff. A scheduled in-service for dietary is scheduled May 26 and May 27 to complete the education AUDITS: The audits will be completed for the following:		

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F 371	<p>Continued From page 33</p> <p>-On the dirty end that same fan's air was blowing directly onto the dirty dishes and utensils stored there.</p> <p>-That same fan's air was then blowing directly onto the clean dishes and utensils on the clean end of the dish machine that were being stored there.</p> <p>*Four hood filters above the stove had a moderate accumulation of grease with multiple brown and black spots on them.</p> <p>*The conduit located between the back of the stove area and located directly across from an ice machine's ice bin contained a moderate build-up of dust, grease, and lint on it.</p> <p>2. Observation on 5/3/16 at 11:55 a.m. and again at 12:25 p.m. with dietary assistant B revealed:</p> <p>*She was loading dirty dishes and utensils into the dish machine.</p> <p>*She was unloading clean dishes from the dish machine and placing them on the clean end of the dish machine.</p> <p>*The fan was running on high and oscillating back and forth between the dirty and clean ends of the dish machine where those dishes and utensils were being stored.</p> <p>Interview on 5/3/16 at 6:00 p.m. with the certified dietary manager (CDM) regarding the above fan in the dish machine, the four hood filters above the stove, and the conduit behind the stove and across from the ice machine's ice bin in the kitchen revealed she agreed:</p> <p>*The fan attached to the wall in the dish room was blowing over the dirty dishes to the clean dishes and utensils stored there.</p> <p>*The fan should not have been blowing from dirty to clean in the dish room.</p> <p>*The hood filters needed to have been cleaned.</p>	F 371			

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F 371	<p>Continued From page 34</p> <ul style="list-style-type: none"> -The filters were located directly above the foods cooked on the stove top. -The maintenance department was responsible for cleaning the hood filters above the stove. -She was uncertain on the last time those filters had been cleaned. *The conduit area behind the stove needed to have been cleaned. -That area was located directly across from an ice machine that had a full bin of ice in it. -That area had not been assigned a specific department to have cleaned it. *The above areas were a potential for cross-contamination from dirty to clean areas. <p>Interview on 5/4/16 at 10:20 a.m. with the CDM, the administrator, and the executive director regarding the above areas confirmed the areas were a potential for cross-contamination from dirty to clean areas.</p> <p>Interview on 5/4/16 at 10:30 a.m. with the CDM regarding the cleaning of the conduit behind the stove located directly in front of the ice machine's ice bin revealed the provider did not have a specific policy regarding that.</p> <p>Record review of the provider's cleaning schedules for April 2016 revealed "None of the above areas were on the cleaning schedule that included the hood filters and conduit."</p> <p>Review of the provider's February 2013 Dishwashing policy revealed dietary staff were to have ensured dishes and utensils were stored in a protected manner.</p> <p>Review of the provider's February 2013 Cleaning Schedules policy revealed "The director of dietary</p>	F 371			

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F 371	Continued From page 35 services was responsible for monitoring staff to ensure that cleaning duties were completed satisfactorily and within the proper timelines." Review of the provider's February 2013 Master Cleaning Schedule information revealed hood filters were to have been cleaned weekly in the dishwashing machine. Review of the provider's February 2013 Kitchen General policy revealed the food preparation and serving area would be cleaned and sanitized on a regular basis to limit contamination and to prevent food-borne illness. Review of the provider's February 2013 Cleaning-Sanitation of Non-Food Contact Surfaces policy revealed: *Was to have stored, prepared, distributed, and served food under sanitary conditions at all times. *Was to have had scheduled weekly cleaning of the hood filters in the dishwasher or other method. *The above policy had no documentation on cleaning of the conduit.	F 371			
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 22452	F 490	Fans are not blowing or oscillating from dirty to clean areas over the dishes Hoods (4) filters are cleaned bi-weekly and as needed by maintenance/CDM assignments Conduit behind the stove has been cleaned and is scheduled to be cleaned by the dietary staff assignments The audits will be completed weekly x 4 weeks and monthly x 4 months by the CDM/designee.	(F490) *5/31/14 DN/SDDOT/EL	

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F 490	<p>Continued From page 36</p> <p>Based on record review, interview, and policy review, the provider failed to assess, monitor, and document residents' outcomes for fourteen of fourteen sampled residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25) related to the lack of a consistent restorative nursing program. Findings include:</p> <p>1. Interview on 5/4/16 at 5:00 p.m. with the administrator, executive director, and director of nursing regarding the restorative nursing program revealed they had not:</p> <ul style="list-style-type: none"> *Been able to provide restorative nursing for the last six to eight months related to staffing issues. *Evaluated the residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25) who had been on a restorative nursing program during that time for changes or declines in their functional mobility or activities of daily living. *Consistently improvised the care plans on any of the above residents due to the lack of restorative nursing. <p>Refer to F311</p>	F 490	<p>The audit findings will be submitted monthly to the QAPI committee for further recommendations and root cause analysis if needed.</p> <p>Administrator has reviewed the Plan of Correction for F-TAG 311 and will over-see the Restorative Program.</p> <p>For residents # 1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23 and 24- The facility is not able to go back to provide restorative programs to the listed residents for the past weeks and months. The facility will review and re-evaluate each resident's restorative program and determine their programs continue to be appropriate and/or beneficial. The care plans will be reviewed and updated over the next 8 weeks to capture the residents listed above in this citation. The interdisciplinary team will review weekly over the next 8 weeks during the Quality of Life meeting to complete the fourteen residents listed above and then within the quarter to review all remaining residents' restorative programs and care plans during their MDS schedule. The facility will provide restorative services and staff will be assigned to provide the restorative programs per each resident's individualized care plan. The restorative nurse will monitor restorative programs for attendance, completion and</p>		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761		
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F 490	Continued From page 36 Based on record review, interview, and policy review, the provider failed to assess, monitor, and document residents' outcomes for fourteen of fourteen sampled residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25) related to the lack of a consistent restorative nursing program. Findings include: 1. Interview on 5/4/16 at 5:00 p.m. with the administrator, executive director, and director of nursing regarding the restorative nursing program revealed they had not: *Been able to provide restorative nursing for the last six to eight months related to staffing issues. *Evaluated the residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25) who had been on a restorative nursing program during that time for changes or declines in their functional mobility or activities of daily living. *Consistently improvised the care plans on any of the above residents due to the lack of restorative nursing. Refer to F311	F 490	functional well-being with a quarterly summary documented during the MDS process. For all other potential residents- The facility will review and re-evaluate each resident's restorative program and determine the restorative programs are provided for each resident and care plans reflect these programs. The restorative nurse and/or MDS nurse will evaluate the resident's programs per MDS schedule and during the center's Quality of Life meetings to discuss and update the individual needs of each resident as reviewed. The facility will begin to provide some consistency with restorative staff assigned to provide the restorative programs per each resident's individualized care plan. The restorative nurse will monitor restorative programs for completion and benefit with a quarterly summary during the MDS process. IN-SERVICE TRAINING: The DNS/restorative nurse will re-educate the nursing department on GSS policy and procedure for Restorative Programs and Restorative Care. The education will include the facility's plan to provide restorative to each resident per their individual care plans and schedule. Care plan updates and changes. The center will determine the staffing and scheduling to ensure the restorative		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON, POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761		
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F 490	<p>Continued From page 36</p> <p>Based on record review, interview, and policy review, the provider failed to assess, monitor, and document residents' outcomes for fourteen of fourteen sampled residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25) related to the lack of a consistent restorative nursing program. Findings include:</p> <p>1. Interview on 5/4/16 at 5:00 p.m. with the administrator, executive director, and director of nursing regarding the restorative nursing program revealed they had not:</p> <ul style="list-style-type: none"> *Been able to provide restorative nursing for the last six to eight months related to staffing issues. *Evaluated the residents (1, 2, 3, 5, 9, 16, 17, 18, 19, 20, 21, 23, 24, and 25) who had been on a restorative nursing program during that time for changes or declines in their functional mobility or activities of daily living. *Consistently improvised the care plans on any of the above residents due to the lack of restorative nursing. <p>Refer to F311</p>	F 490	<p>programs are completed. The importance of documentation with each program completed.</p> <p>AUDITS: The MDS/Restorative Nurse will complete the following:</p> <p>Each resident that has a scheduled restorative program will be reviewed during the MDS completion and within their scheduled Quality of Life meeting to determine the program goals and interventions are appropriate.</p> <p>The care plan has been reviewed and updated to reflect changes in the restorative programs. The restorative nurse will oversee the restorative programs to determine restorative programs are being completed and a summary of restorative program and benefit is documented in progress notes both in the Quality of Life weekly meeting and per the MDS process.</p> <p>The audits will be completed by the restorative nurse weekly x 8 weeks and then monthly x 4 months. The audit findings will be submitted monthly by the restorative nurse to the QAPI committee for further recommendations and root cause analysis if needed.</p> <p><i>→*and in collaboration with the administrator be reviewed DN/SDDO/H/EL</i></p>	

37B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435104	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/3/16. Good Samaritan Society - New Underwood was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 6/1/16 per telephone with facility administrator. LF/SDDO/H/EL	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure electrical wiring and equipment was maintained in accordance with NFPA 70 the National Electrical code in one randomly observed location (exterior southeast building corner) Findings include: 1. Observation at 9:30 a.m. on 5/3/16 revealed an exterior outlet at the southeast corner of the building. Testing of that outlet revealed it was not provided with ground fault circuit interruption (GFCI). All exterior outlets shall be GFCI protected. Further observation revealed the face of that outlet had what appeared to be a burn mostly like due from an electrical circuit arc.	K 147	1. Maintenance completed an audit of all exterior outlets for GFCI on 5/18/16. All non GFCI outlets will be replaced and in compliance by 6/3/16. 2. The extension cord on the south side of the building was removed on 5/9/16. IN-SERVICE TRAINING: Administrator will remind staff that extension cords are not an acceptable means of permanent wiring on the inside and exterior of the facility. AUDITS: The Administrator/designee will walk the facility grounds ensuring there are no extension cords in use. The audits will be completed weekly x 4 weeks and monthly x 4 months. The audit findings will be submitted monthly to the QAPI committee for further recommendations and root cause analysis if needed.	LF/SDDO/H/EL *5/31/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *LNA* (X6) DATE *5/27/16*

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 147	<p>Continued From page 1</p> <p>2. Observation at the above time revealed an extension cord from that above outlet was plugged in and ran across the south side of the building and coiled next to an exterior detached gazebo at the southwest corner of the building. The extension cord appeared to be used for the decorative exterior lights that were hanging on gazebo. Extension cords are not an acceptable means of permanent wiring and shall only be used on a temporary basis. They shall be removed from outlets and properly stored when not in use to avoid damage and potential circuit arcing.</p> <p>Interview with the administrator at 3:15 p.m. on 5/3/16 revealed she was not aware of the requirement for all exterior outlets to be GFCI protected. She indicated she was also not aware the extension cord was plugged in and unsure how long it had been there.</p> <p>These deficiencies have the potential to affect one of five smoke compartments.</p>	K 147		

ORIGINAL

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWO	STREET ADDRESS, CITY, STATE, ZIP CODE 412 S MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761
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S 000	Compliance/Noncompliance Statement Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 5/2/16 through 5/5/16. Good Samaritan Society New Underwood was found not in compliance with the following requirement: S173.	S 000	*Addendums noted with an asterisk per telephone per 5/31/16 with facility administrator. DN/SDDOHEL	
S 173	44:73:02:18(8-10) Occupant Protection The facility shall take at least the following precautions: (8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any laundry clean linen storage area, or in any medication set-up area shall be equipped with a lens cover or a shatterproof lamp; (9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and (10) The storage and transfilling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure protection of residents was maintained in all residents' rooms. The swivel light fixtures over residents' beds did not have shatterproof bulbs. Findings include:	S 173	1. Shatterproof bulbs were ordered on * 5/24/16. Estimated delivery date of the shatterproof bulbs is 6/6/16. Bulbs will be replaced by 6/13/16. IN-SERVICE TRAINING: Administrator will educate the staff on occupant protection that any light fixture located over a resident bed shall be equipped with a shatterproof bulb. Administrator will instruct the staff as to where the shatterproof replacement bulbs will be kept and the signage that will be used to depict the bulbs as a reminder for staff. AUDITS: Maintenance/designee will inspect the swivel light fixtures above the resident's bed for shatterproof bulbs. The audits will be completed weekly x 4 weeks and monthly x 4 months. The audit findings will be submitted monthly to the QAPI committee for further recommendations and root cause analysis if needed.	*5/31/16 DN/SDDOHEL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Douglas J. Quinn
STATE FORM

6599 E4J011

RECEIVED
MAY 31 2016
SD DOH L&C

(X6) DATE
5/27/16
If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10657	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NEW UNDERWO	STREET ADDRESS, CITY, STATE, ZIP CODE 412 S MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 173	<p>Continued From page 1</p> <p>1. Observation on 5/3/16 at 10:45 a.m. revealed a light fixture over a resident ' s bed in room 110. It was a swivel type adjustable light fixture approximately four feet above the resident's bed. The light bulb in that fixture was not shatterproof and not equipped with a protective lens cover. That condition was also found in the adjacent resident's bed in that semi-private room. Additional observation throughout the survey revealed that condition was also found in all resident's rooms observed.</p> <p>Interview with the maintenance supervisor at the time of the observation confirmed that condition. He indicated he was not aware of the requirement for those bulbs to be shatterproof due to the location of those lighting fixtures above the resident's beds.</p> <p>Interview with the administrator at the time of the exit interview revealed she was also unaware of the requirement for those bulbs to be shatterproof in those locations.</p> <p>This deficiency has the potential to affect the census of thirty-five residents at the time of survey.</p>	S 173		
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