

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/17/2016
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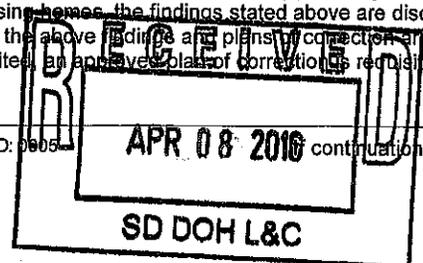
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 401 WEST SECOND STREET SIOUX FALLS, SD 57104
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{F 000}	INITIAL COMMENTS Surveyor: 32335 An onsite visit for follow up to the 1/21/16 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 3/17/16. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement(s): F226, F280, and F314.	{F 000}	* Addendums noted with an asterisk per 4/7/16 per telephone with facility Director of nursing, SC/SDDO/HJL	
{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 interview, record review, policy review, and review of the 2/12/16 plan of correction for the 1/21/16 recertification survey, the provider failed to thoroughly investigate a bruise of unknown origin for one of one sampled resident (24) and an unwitnessed fall for one of one sampled resident (25). Findings include: 1. Review of the 2/12/16 plan of correction for the 1/21/16 recertification survey revealed the provider failed to follow the incident reporting policy and procedure and to include more details and interviews in their investigation reports. Review of an 2/29/16 internal incident report regarding resident 24 revealed:	{F 226}	Resident 24's incident was further investigated with the addition of staff interviews, color of bruising, cognitive functioning level and care plan implementation documented on the Investigation form. Resident 25's incident was further investigated with the addition listed of staff members on duty and staff interviews completed along with location of call light, resident health status prior to fall, cognitive functioning level and care plan implementation documented on the Investigations form. All	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deanna Tardiff</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/5/16</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 226}	<p>Continued From page 1</p> <ul style="list-style-type: none"> *She had a 3.5 centimeter (cm) by 2.3 cm bruise on her left ear. *The resident had stated she was not sure what had happened. *The results of the investigation section had stated "appears to be old bruise and caused by hearing aide and perhaps glasses." *There had been two certified nursing assistants and one licensed practical nurse listed as witnesses. -There was no documentation of those staff being interviewed about the bruising. *There had been no other documentation regarding the coloring of the bruising, who had been working with the resident in the past few days, her cognitive functioning level, or follow-up regarding if the care plan had been implemented accordingly. <p>2. Review of an 3/9/16 internal incident report regarding resident 25 revealed:</p> <ul style="list-style-type: none"> *She had been found on the floor laying on her left side. *She stated she was trying to get to the restroom. *There had been no staff members listed for witnesses or who had been working. *There had been no documentation that staff had been interviewed regarding the incident. *It stated she usually used her call light but had not in this incident. -There was no documentation regarding where the call light had been located, and why she would not have used it. *She had been confused. *She had been hospitalized the following day for an infection. *There was no other documentation regarding what had happened or how she had been acting prior to the fall, who had been working with the 	{F 226}	<p>other residents could be affected. Due to the length of time that has lapsed, prior incidents could not be changed. Since our Re-visit Survey on 3/17/16, incident report investigations have improved in including more details and interviews. Administrator, Social Worker and DNS will complete a full investigation of all incidents using our GSS Investigation form and will complete this in its entirety. All investigations will include more details and resident and staff interviews as appropriate. QAPI Coordinator will report audit findings to the monthly QAPI Committee Meeting. All incident report investigations will be audited by the QAPI Coordinator or designee</p>	
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**When the DNS, administrator and social worker are not available to complete the investigation from an incident the nurse on duty at that time will start the investigation.*

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{F 226}	Continued From page 2 resident in the past few days, her cognitive functioning level, or follow-up regarding if the care plan had been implemented accordingly. 3. Interview and record review on 3/17/16 at 3:45 p.m. with the administrator, director of nursing, and the social worker revealed there was no further documentation to verify a thorough investigation had been completed regarding the above two situations. The audits they had been using had not checked for specific details in the investigation or if interviews had been completed. Review of the provider's September 2013 II.A.1 Abuse and Neglect policy revealed "The Center will have evidence that all alleged or suspected violations are thoroughly investigated and will prevent further potential abuse while the investigation is in progress." Review of the provider's August 2015 II.A.1a Abuse and Neglect policy revealed: *Purpose was to ensure a complete review of existing incidents was documented. *If a staff member received an allegation of abuse they would then report the allegation to a supervisor. *The charge nurse would be notified immediately, assess the situation, and complete an initial investigation. *If it was an allegation of staff-to-resident abuse, the staff person would be removed from providing direct care to all residents. *Additionally that staff member should have been placed on suspension pending the results of the internal investigation. *The investigation could include interviewing staff, residents, or other witnesses to the incident. *The investigation team (social worker,	{F 226}	weekly x 4 and then monthly x 3 and then QAPI Committee will recommend further action.	4/8/16	

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{F 226}	Continued From page 3 administrator, and the DON) were to have reviewed "all incidents no later than the next working day following the incident."	{F 226}	<p>→ *All residents will have their care plans updated with any significant change to their status or care.</p> <p>No follow-up could be completed for Resident 23 SC/SDDOH/EL because this resident has been discharged. All other residents could be affected. All care plans will be reviewed quarterly during the MDS review and following a change in condition to ensure the care plans accurately reflect their current status and needs. In addition, MDS Coordinators will use daily nursing report sheets to make needed changes to the care plans. ADNS will report audit findings to the monthly QAPI Committee Meeting. ADNS or designee will audit 5 care plans weekly x 4, then bi-monthly x 2 and then monthly x 3. QAPI</p>	
{F 280} SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview, record review, policy review, and review of the 2/12/16 plan of correction for the 1/21/16 recertification survey, the provider failed to review, revise, and update care plans to accurately reflect their current status and needs for one of two sampled residents (23). Findings	{F 280}		

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{F 280}	Continued From page 4 include: 1. Review of the 2/12/16 plan of correction for the 1/21/16 recertification survey revealed the provider was to follow their Care Plan Policy. Review of resident 23's medical record revealed she had been admitted with a hard cast to her foot. On 2/29/16 she had the cast removed and was placed into a walking boot. She had also been identified at risk for developing pressure ulcers. Those items had not been documented on her care plan. Refer to F314, finding 1. Review of the provider's September 2012 Care Plan policy revealed: *Care plans should have been reviewed, evaluated, and updated when there was a significant change in the resident's condition. *The plan of care should have been modified to reflect the current care required or provided for the resident.	{F 280}	Committee will then recommend further action.	4/8/16
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	{F 314}	No follow-up could be completed for Resident 23 because this resident has been discharged. No follow-up could be completed for Resident 14 because her skin area is now healed. All other residents could be affected. No other residents have an acquired pressure ulcer at	

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{F 314}	<p>Continued From page 5 Surveyor: 32335 Based on interview, record review, policy review, and review of the 2/18/16 plan of correction for the 1/21/16 recertification survey, the provider failed to assess, implement interventions, and follow their policy to prevent pressure ulcers (a sore caused by unrelieved pressure that resulted in tissue damage) from developing for two of two sampled residents (14 and 23). Findings include:</p> <p>1. Review of the 2/18/16 plan of correction for the 1/21/16 recertification survey revealed the provider failed to follow their policy regarding pressure ulcers.</p> <p>Review of resident 23's medical record revealed she had been admitted on 1/16/16 with a broken ankle. Her discharge plans were to return home after she had completed therapy. She had developed an unstageable pressure ulcer to her left heel on 3/4/16.</p> <p>Review of resident 23's Braden Scale for Predicting Pressure Sore Risk scores revealed: *On 1/24/16 she had a score of 18. A score of 15-18 meant she was at mild risk for developing pressure ulcers. *On 1/29/16 she had a score of 16. *On 2/5/16 she had a score of 18. *On 2/14/16 she had a score of 17. *On 3/11/16 she had a score of 19. That was after the one to her left heel had developed. *Interventions for a resident at mild risk could have included the following: -Frequent turning (e.g., every two hours). -Maximal remobilization. -Pressure-reduction support surfaces if bed or chair bound. -Protect heels.</p>	{F 314}	<p>this time. Our center will begin using a Skin Issue Identification Checklist/Worksheet. This will ensure that our policies and procedures for prevention and treatment of pressure ulcers will be followed correctly and accurately. In addition, our Medical Director has begun making weekly skin rounds with our wound nurse for added support and education. Wound nurse or designee will audit Skin Issue Identification Checklist/Worksheets for completeness to ensure compliance with our policies and procedures weekly x 4, then bi-monthly x2 and then monthly x 3. DNS will report audit findings to the monthly QAPI Committee Meeting. QAPI</p>		

See page 7.

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{F 314}	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Manage moisture. -Manage nutrition. -Manage friction and shear." <p>*If other major risk factors were present (advanced age, poor dietary intake of protein, diastolic pressure below 60) then they should have advanced to the next risk level.</p> <p>Review of resident 23's current undated care plan revealed being at risk for pressure ulcers had not been addressed on the care plan. Resolved and completed areas had been reviewed, and none of them addressed being at risk for pressure ulcers.</p> <p>Interview on 3/17/16 at 12:35 p.m. with the director of nursing (DON) revealed an observation of resident 23's left heel was not possible at that time as she was preparing to leave for an appointment.</p> <p>Interview and record review on 3/17/16 from 12:40 p.m. through 2:00 p.m. with the DON and assistant director of nursing (ADON) regarding resident 23 revealed:</p> <ul style="list-style-type: none"> *She had been admitted with a hard cast on her left foot. *She had the cast removed on 2/29/16 and was put into a walking boot. *They had not completed a skin assessment on 2/29/16 when she returned to the facility. *A skin assessment had not been completed until 3/4/16 when she had developed a pressure ulcer to her left heel. *They had not gotten physician's orders for the walking boot and were unsure when or if it was being removed. *There was no documentation regarding orders to remove or keep the walking boot on. *The DON reviewed the care plan and agreed 	{F 314}	<p>Committee will then recommend further action.</p> <p><i>*Nursing staff will be re-educated by the DNS regarding accurate assessment, interventions, monitoring and documentation of all pressure ulcers.</i></p> <p><i>CS/SDDOT/EL</i></p>	4/8/16	

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{F 314}	<p>Continued From page 7</p> <p>that being at risk for pressure ulcers had not been addressed on the care plan.</p> <p>2. Review of resident 14's medical record revealed she had developed two stage 3 pressure ulcers to her coccyx (tailbone) on 3/4/16. The wound data collection tools and registered nurse (RN) assessments had not been completed until 3/7/16. There had been no documentation as to why the initial assessments had not been completed on 3/4/16 and why daily documentation had not occurred on 3/5/16 or 3/6/16. The physician's order for treatment was obtained on 3/7/16 even though a dressing had been applied prior to 3/7/16.</p> <p>Interview and record review on 3/17/16 at 2:00 p.m. with the DON and ADON regarding resident 14 revealed the wound data collection tools and RN assessments should have been completed on 3/4/16. The physician's order for treatment was probably a verbal order, but the nurse should have documented the order in the medical record. The two pressure ulcers had healed on 3/13/16.</p> <p>3. Review of the provider's September 2012 Pressure Ulcers policy revealed "Based on the resident's comprehensive assessment, the center will use prevention and assessment interventions to ensure that a resident entering the center without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable."</p> <p>Review of the provider's December 2015 Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements policy revealed:</p>	{F 314}		
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{F 314}	Continued From page 8 *The Braden Scale for Predicting Pressure Sore Risk UDA would be used to determine if residents were at risk for developing pressure ulcers. *If a pressure ulcer was identified the RN should have recorded the type of wound and degree of tissue damage on the Wound RN Assessment UDA. *Daily monitoring should have been completed when a pressure ulcer was present.	{F 314}			