

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

ORIGINAL

PRINTED: 03/09/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435106</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY WAGNER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 W HWY 46 WAGNER, SD 57380</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<b>INITIAL COMMENTS</b>  Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/22/16 through 2/24/16. Good Samaritan Society Wagner was found not in compliance with the following requirements: F157, F226, F281, and F514.	F 000	* Addendums noted with an asterisk per 3/28/16 per telephone with facility administrator. hw/sddott/el	
F 157 SS=D	<b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b>  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	. Unable to go back and inform the physician of the wound on resident #9. . All residents will be assured that their physician will be notified promptly of any changes in condition including new wounds. . The DNS or designee will educate all nursing staff on 3/16/16 of the immediate need to inform the physician when wounds or other significant changes occur. . The Staff Development coordinator or designee will audit the medical records of residents who have a new wound or other significant change in condition to determine if prompt notification was made to physician and family weekly x4 and then monthly x3. The SD coordinator or designee will report audit findings to the QUAPI committee monthly and the committee will determine if further auditing is needed.	4/12/16

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

*Michael Ryan*

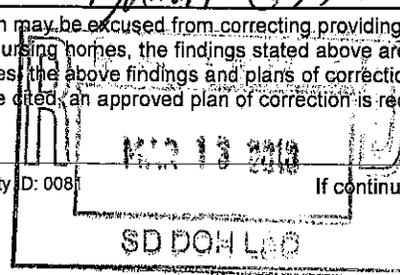
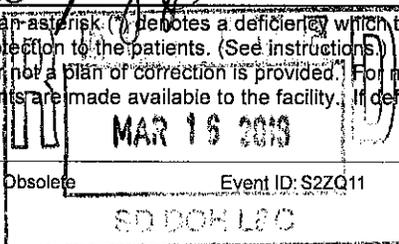
TITLE

*Admin GSSW*

(X6) DATE

*3/16/16*

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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F 157	Continued From page 1  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to notify the physician regarding the development of new pressure ulcers (a sore caused by unrelieved pressure that resulted in tissue damage) in a timely manner for one of four sampled residents (9). Findings include:  1. Record review and interview on 2/23/16 at 2:45 p.m. and again on 2/24/16 at 11:30 a.m. with the director of nursing regarding resident 9 revealed a new pressure ulcer had developed to his right buttock on 12/16/15. They had not notified the physician about that pressure ulcer until 12/22/15. On 12/28/15 a new pressure ulcer had developed on his left buttock. They had not notified the physician of that pressure ulcer at all. The DON stated the staff had missed it and should have notified the physician.  Review of the provider's December 2015 Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements policy revealed if a pressure ulcer had been identified staff should have notified the physician of the ulcer and the resident's condition to obtain orders for a treatment.	F 157			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226			

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F 226	Continued From page 2  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 four of four residents (1, 4, 17, and 18) falls for abuse and neglect. Findings include:  1. Review of resident 1's 1/21/16 investigation report revealed he had a fall on 1/20/16 that resulted in a skin tear. He had dementia (loss of mental functions such as thinking, memory, and reasoning that was severe enough to interfere with a person's daily functioning) and Alzheimer's disease (a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception). He had been found sitting on the floor on his buttocks with his back to his recliner. His wheelchair was behind him, and blood was noted on the left arm of the recliner. He had his left shoe on, his right shoe off, and his coat was under his feet.  2. Review of resident 4's 12/21/15 investigation report revealed she had a fall on 11/27/15. She was found sitting on the dining room floor. She had dementia. She had removed the lap buddy (assistive device used to prevent falls) and was seen by the dining room staff walking behind her wheelchair.	F 226	. An investigation into the falls of resident's #1,4,17, and 18 was done to identify if any abuse/neglect was involved in these falls. . All residents who sustain a fall will have an investigation started at the time of the fall by the charge nurse including a Falls Huddle with staff in the area of the fall, interviews with staff as to what the resident was doing prior to the fall, a review of the environment where the fall occurred, a review of any medications given, changes in the mental status of the resident, and any care plan deviations. The investigation team (administrator, DNS, and Social Worker) will continue the investigation to rule out any indicators of abuse/neglect. . The SD coordinator and DNS will educate all staff on the use of the Falls Huddle using the Falls Scene Investigation Report on 3/23/16. This education will include the continuation of the investigation process, how and when incidents are reported to the Department of Health, physicians, and family members. . The SD coordinator and/or QAPI Coordinator will review all falls to assure a complete	

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F 226	<p>Continued From page 3</p> <p>3. Review of resident 17's 12/28/15 investigation report revealed she had a fall on 12/27/15 at 5:10 a.m. She was cognitively impaired. She had been found sitting on the floor with her back to her bed. She appeared like she was sleeping. Staff assisted her back to bed.</p> <p>Review of resident 17's 12/28/15 investigation report revealed she had another fall on 12/27/15 at 6:40 a.m. She had been found sitting on her floor with her back against the bed. She stated she had to use the bathroom and was getting up to use the call light.</p> <p>4. Review of resident 18's 1/6/16 investigation report revealed she had a fall on 1/2/16. She had dementia. She was found on the floor in front of her recliner. She said she had fallen out of bed.</p> <p>5. The above investigation reports had no documentation of investigation into the following:          *What had been occurring prior to the fall.          *When the residents had last been assisted with activities of daily living.          *If call lights had been within reach of the resident.          *What staff had been working at the time of the fall.          -There had been no staff interviews.          *If the individual care plans and fall interventions had been followed.          *Possible changes in residents' conditions.          *What the environment looked like at the time of the fall.          *Recent medication changes.</p> <p>Interview on 2/24/16 at 9:05 a.m. with the director of nursing revealed there was no further</p>	F 226	<p>investigation was started by the charge nurse and completed by the Investigatory team to determine that any abuse or neglect was a part of the actual fall including deviation from the care plan. This audit will be done weekly x4 and then monthly x3, SD will report these audit findings to the QUAPI committee monthly, the committee will determine if further auditing is needed.</p>	4/12/16
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F 226	Continued From page 4 documentation regarding the above investigations. The forms in the computer had the same information on them as the investigation report forms. She agreed the reports had not provided detailed information to determine if abuse or neglect had occurred or not.  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 July 2015 Falls Prevention and Management policy revealed if a resident had fallen staff were to begin the investigation using the fall scene investigation report. They should have questioned the resident on what they were doing before the fall. If the resident was unable to answer they were to critically look at the fall scene for clues as to what might have caused the resident to fall. They should have reviewed medications. "Best practice is to complete the Falls Tool UDA in the post-fall huddle when resident, witnesses and staff are at the fall scene. If necessary, re-enactment of the fall can occur and triggered care plan interventions are identified, specified, and communicated."	F 226			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced	F 281			

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F 281	<p>Continued From page 5</p> <p>by: Surveyor: 32335</p> <p>Based on record review, interview, and professional standard review, the provider failed to follow-up on:</p> <ul style="list-style-type: none"> <li>*Low blood pressure readings for one of one sampled resident (9).</li> <li>*A physician's order for monitoring oxygen levels for one of one sampled resident (4).</li> </ul> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of resident 9's medical record revealed: <ul style="list-style-type: none"> <li>*On 1/25/16 his blood pressure was 77/60 (normal reference range 120/80).</li> <li>-His blood pressure was not taken again until 2/1/16 at 1:40 p.m. and was 109/58.</li> <li>*On 2/2/16 at 7:19 p.m., 7:59 p.m., 9:59 p.m., and 10:13 p.m. his blood pressure was 88/54.</li> <li>-His blood pressure was not taken again until 2/4/16 at 9:59 p.m. and was 110/67.</li> <li>*On 2/22/16 his blood pressure was 88/62.</li> <li>-There had been no documentation of his blood pressure being taken after 2/22/16.</li> <li>*There had been no progress notes regarding the above blood pressures.</li> </ul> </li> </ol> <p>Interview on 2/24/16 at 9:05 a.m. with the director of nursing (DON) revealed she would have expected the nurse to have continued monitoring the blood pressures and complete a resident assessment. Regarding the blood pressure on 2/2/16 there should have been other readings prior to 2/4/16.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, pp. 348 and 461, revealed "Nursing documentation must be accurate,</p>	F 281	<p>. Unable to go back and report the low blood pressure reading on resident #9. Unable to go back check the pulse oximetry readings for resident #4. Will review pulse oximetry needs of resident #4 with physician and will go forward with physician recommendation.</p> <p>. All physician orders will be followed as directed including physician notification when outside of the prescribed parameters including blood pressures and pulse oximetry readings.</p> <p>. The DNS and SD coordinator will educate all nursing staff as to the importance of following the complete physician orders including reporting as needed on 03/23/16.</p> <p>The DNS or designee will review medical records including the MAR and TAR records to assure physician orders are followed as prescribed including notification to the physician as ordered. These audits will be done weekly x4 and then monthly x3. The DNS or designee will report the audit findings to the QUAPI committee monthly and the committee will determine if further auditing is needed.</p>	04/12/16
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*with each MDS completed each week MMS/DOCTER*

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F 281	<p>Continued From page 6</p> <p>comprehensive, and flexible enough to retrieve clinical data, maintain continuity of care, track patient outcomes, and reflect current standards of nursing practice. Information in the patient record provides a detailed account of the level of quality of care delivered to patients. Effective documentation ensures continuity of care, saves time, and minimizes the risk of errors." "Hypotension is present when the systolic BP [blood pressure] falls to 90 mm Hg or below. Although some adults have a low BP normally, for most people low BP is an abnormal finding associated with illness."</p> <p>Surveyor: 29162 2. Review of resident 4's medical record revealed there had been: *Physician's orders on 10/20/15 for: -"Pulse Oximetry [a test for the oxygen level of the blood] every shift and PRN as needed." -Oxygen at 2LPM (liters per minute, the oxygen flow) as needed to keep O2 sats (saturation of oxygen level of the blood) above 92%. *No O2 sats results for February 2016 on the medication or treatment administration records. *No record of the O2 sats for February on the O2 sats summary.</p> <p>Interview on 2/24/16 at 1:15 p.m. with the director of nurses revealed the O2 sats had not been done in February 2016. She stated she did not know why they had stopped taking them. She agreed the pulse oximetry testing was a physician's order and should have been followed.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St. Louis Mo., 2005, page 419, revealed the physician was responsible for directing medical</p>	F 281			

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F 281	Continued From page 7 treatment. Nurses were obligated to follow physicians' orders unless they believed the orders were in error or would harm clients.	F 281		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to document: *A fall for one of one sampled resident (1). *Accurate pressure ulcer data for one of two sampled residents (9) with a pressure ulcer. Findings include:  1. Review of resident 1's medical record revealed: *A 1/22/16 Minimum Data Set (MDS) assessment that indicated he had one fall with a minor injury since his prior MDS assessment on 10/26/15. *A falls assessment had been completed on 1/20/16 indicating he had a fall.	F 514	. Unable to go back and document in the medical record the fall of resident #1 regarding the fall of 1/20/16. Unable to go back and correct the medical record entry regarding the wound on the right buttock for resident #9. . Residents will have documentation correctly entered into the medical record by nursing staff including reporting of falls and the correct area of a wound. . The DNS and SD coordinator will educate all staff on the critical importance of correct documentation on 3/23/16. This education will include a review of the Documentation Policy and Procedure including GSS11.D.8a-Nursing Documentation Guidelines/Timelines. . The SD coordinator or designee will use the Alerts and 24 hour reports on the EMR site to identify new resident concerns or changes and then review the medical record to assure proper and timely documentation was complete. These audits will be done weekly x4 and then monthly x3 and reported monthly to the QUAPI coordinator by the SD	

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F 514	<p>Continued From page 8</p> <p>*There had been no other documentation in his medical record regarding what had happened regarding the fall or if it had been investigated for potential abuse or neglect.</p> <p>2. Record review and interview on 2/23/16 at 2:45 p.m. with the director of nursing (DON) regarding resident 9 revealed on 7/16/15 a pressure ulcer had developed on his left buttock. On 7/21/15 staff had documented data regarding a pressure ulcer on his right buttock. On 1/18/16 he had a pressure ulcer develop on his right buttock.</p> <p>Record review and interview on 2/24/16 at 11:30 a.m. with the DON regarding resident 9 revealed: *She had reviewed the information with her staff and determined they had documented the wrong side on 7/21/15. The whole time the pressure ulcer had been on his left buttock. *They had no documentation on when the 1/18/16 pressure had healed.</p> <p>3. Review of the provider's September 2012 Documentation policy revealed: **"Documentation of all nursing care and observations, assessments and treatments, and effects will be written by an authorized professional. *All documentation is expected to be legible, accurate, understandable, timely and pertinent and held in confidence."</p>	F 514	<p>coordinator or designee. The QUAPI committee will determine if further auditing is needed.</p>	04/12/16	

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/25/16. Good Samaritan Society Wagner was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

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

*Michelle Wagner*

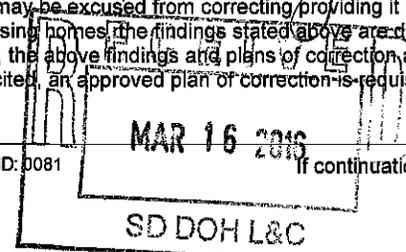
TITLE

*Admin. GSS Wagner*

(X6) DATE

*3/16/16*

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.



ORIGINAL

PRINTED: 03/09/2016  
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10700	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  02/25/2016
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY WAGNER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 W HWY 46 WAGNER, SD 57380
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement  Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/22/16 through 2/25/16. Good Samaritan Society Wagner was found not in compliance with the following requirement: S169.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection  The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility;  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32573 Based on observation, interview, and policy review, the provider failed to ensure the front door had been properly alarmed, so the alarm would not automatically shut off when the door closed. Findings include:  1. Observation throughout the survey from	S 169	. Unable to change how door was locked/alarmed during survey hours. . The front door will have alarm sound each time front door is opened when individuals are leaving the center. A staff member will need to go to the front door to determine who left the building, they will have to shut alarm off and reset the alarm at the front door. . All staff will be trained on this process. . Audits will be done by administrator or designee weekly x3 and then monthly x4 and will be reported by administrator or designee at monthly QUAPI meetings. Discussion will occur at monthly QUAPI meeting to determine if further audits need to occur.	04/12/16

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

STATE FORM

6899

TDPB 14

TITLE

(X8) DATE

*Adrian C. Wagner*  
Adrian C. Wagner  
3/16/16

RECEIVED  
MAR 16 2016  
SD DOH L&C

continuation sheet 1 of 4

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10700</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/25/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY WAGNER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 W HWY 46 WAGNER, SD 57380</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 169	<p>Continued From page 1</p> <p>2/22/16 through 2/24/16 revealed:                      *The front door had been unlocked during the survey hours.                      *A doorbell type alarm went off when the front door was opened.                      *The alarm shut off when the door closed.                      *Staff did not have to manually shut the alarm off.                      *A camera overlooked the front door.                      -The monitor for the camera was at the nurses station.</p> <p>Observation on 2/24/16 at 9:40 a.m. at the nurses station revealed:                      *Someone entered through the front door.                      *The alarm could be heard from the nurses station.                      -It shut off when the door closed.                      *No one looked at the video feed to see who had entered the facility.</p> <p>Interview on 2/24/16 at 10:40 a.m. with the director of nursing (DON) revealed:                      *The front door remained open until 10:30 p.m.                      -It was locked after the evening shift left.                      *The alarm was a doorbell that shut off automatically when the door closed.                      *Residents who were at risk for elopement or wandering had wander alert bracelets.                      -The front door would automatically lock if the resident with a bracelet came close to the door.                      -That prevented them from exiting through the front door at any time.                      *She had been unaware the door should have an alarm that did not automatically shut off.</p> <p>Interview on 2/24/16 at 11:15 a.m. with the maintenance manager revealed:                      *The same above information as the DON had shared.                      *He thought using the wander alert bracelets on</p>	S 169		

South Dakota Department of Health

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S 169	<p>Continued From page 2</p> <p>high risk residents was enough protection. *They used the doorbell for evening staff to know when someone entered or left the facility. -There were less staff in the evening. *He had not known the alarm must not automatically shut off. *They had not wanted an alarm constantly going off.</p> <p>Interview on 2/24/16 at 1:50 p.m. with the administrator revealed: *Staff did not always monitor the video at the nurses station when someone entered or left the facility. *Their theory was: -The residents who they were concerned about leaving the facility had the wander alarms. -The doors would lock, so they would be safe. *Residents that might have episodes of confusion would be put on a fifteen minute check schedule. -That would be enough protection for those residents if the situation arose.</p> <p>Review of the January 2014 Alarms policy revealed: **"The center will ensure that a system is in place for all bed, chair and door alarms and these alarms are in proper working order." *The policy had not mentioned: -The front door alarm. -Procedures for monitoring the front door when the doorbell went off. -Procedures for monitoring the video feed at the nurses station.</p> <p>Review of the February 2016 Means of Egress Requirements policy revealed: *The procedures were based on NFPA 101 Life Safety Code requirements. *The policy had not addressed front door alarm or</p>	S 169		

South Dakota Department of Health

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S 169	Continued From page 3 entry/exit requirements.	S 169		
S 000	Compliance/Noncompliance Statement  Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/22/16 through 2/24/16. Good Samaritan Society Wagner was found in compliance.	S 000		