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

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435117	A. BUILDING _____ B. WING _____	C 04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY DEUEL COUNTY	913 COLONEL PETE STREET CLEAR LAKE, SD 57226

(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	INITIAL COMMENTS *Addendums noted with an asterisk per 6/6/16 per telephone with facility DON. DK/SDDOH/EL Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/26/16 through 4/27/16. Good Samaritan Society Deuel County was found not in compliance with the following requirements: F253, F309, F425, F431, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/26/16 through 4/27/16. Areas surveyed included nursing services and rehabilitative services. Good Samaritan Society Deuel County was found in compliance.	F 000	F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES **Plan of repair for the wooden doors throughout our Facility:** The Maintenance Department has conducted a facility wide inspection of all wooden doors on April 28, 2016 utilizing GSS form #712 (Door Checklist). Any newly identified damaged doors will be treated with wood filler after the curing period is complete, the wood filler is to be sanded and a stain/varnish combination product applied to seal the area. On April 28, 2016 attachments for a rotary tool were received to remove small imperfections in the door with little effect. On May 6, 2016 router bits were purchased to gain the maximum cutting depth which does remove all but the deepest imperfections. On March 1, 2016 paint stripper and paint was purchased to remove the excess paint from the door frames so they would not chip as easily. Maintenance staff (continued)	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to ensure numerous randomly observed doors, door jambs (framework that surrounds the doors), and resident furniture located in the lounge were maintained in a homelike environment. Findings include: 1. Random observations from 4/26/16 at 8:00	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Block, NHA
TITLE: Administrator
(X6) DATE: 5/19/16

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 253	Continued From page 1 a.m. through 5:00 p.m. and again on 4/27/16 from 8:00 a.m. through 2:30 p.m. in the facility revealed: *Numerous doors with chips of wood missing were seen throughout the facility. *The jambs around those doors had numerous paint chips, especially towards the bottom. *The double doors in the lounge area facing the hallway had large amounts of wood putty on the back sides. *There was no stain or paint that had been placed over the top of the putty, and it crumbled off when touched. *In the lounge was: -A side table with varnish that had been worn down in many spots on the top surface. -A riser that had been built and placed under a recliner to increase its height. The riser had not been stained, painted, or sealed in any way, and the wood remained bare. Interview on 4/27/16 at 1:00 p.m. with the maintenance supervisor in the lounge revealed: *He wanted to find a router bit to repair the doors in the lounge. *Doors were to have been replaced when he felt they were no longer repairable. *Painting was to have been done as needed. *He was unaware furniture risers needed to be painted or sealed, and not left bare. *He agreed surfaces needed to be re-varnished, re-painted, or repaired when worn. Interview on 4/27/16 at 3:00 p.m. with the director of nursing regarding the above observations revealed she agreed the above doors, jambs, and resident furniture needed to be repainted, replaced, or maintained to keep the facility in a homelike environment.	F 253	F-253 (continued) were tasked with speeding up the progress of this task. The Maintenance Director or designee will audit monthly 5 resident room doors per wing and 5 common area doors to provide services necessary to maintain a sanitary, orderly, and comfortable interior. **Plan of repair for the wooden chair risers throughout our Facility:** An inventory of chair risers was completed on May 5, 2016. The Housekeeping Department has added the cleaning of the carpeted risers to the bed washing schedule. The Maintenance Department is recovering the unused risers with an easier cleanable surface, and then replacing the carpeted risers to resurface them. The Maintenance Director or designee will audit monthly all chair risers to provide services necessary to maintain a sanitary, orderly, and comfortable interior. **Plan of repair for the wooden furniture in the lounge of our Facility:** (continued)	

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F 253	Continued From page 2 Review of the provider's March 2016 Preventative Maintenance Program policy revealed the purpose was to identify potential repair needs and plan maintenance of the physical plant and equipment.	F 253	F-253 (continued) All wood furniture was removed from the lounge and recovered with polyurethane varnish the week of May 16, 2016. The riser under the chair in the lounge was covered with polyurethane varnish on May 17, 2016. The Maintenance Director or designee will audit monthly the lounge area furniture to provide services necessary to maintain a sanitary, orderly, and comfortable interior. Audit results will be reported monthly to the QAPI committee *by Maintenance director. that meets monthly for further direction for review. 6/16/16 DH/SDDCH/EL	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review, interview, and policy review, the provider failed to have an individualized and comprehensive combined care plan for two of two sampled hospice residents (8 and 9). Findings include: 1. Review of resident 8's medical record revealed: *She was admitted to hospice care on 3/15/16. *The only mention of hospice on her current undated care plan was: -"Work with hospice nursing staff, and the physician to provide comfort with adjustments to the resident's drug therapy." -"Adjust provisions of her activities of daily living (ADLs) to compensate for her changing abilities."	F 309	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING On April 28, 2016 interventions were copied directly from the hospice plan of care into the residents's comprehensive Care Plan for all three current hospice residents *8, 9, and 13 DH/SDDCH/EL. The residents Care Plan were further individualized and updated for the remaining two hospice residents on May 17, 2016.	

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F 309	Continued From page 3 Interview on 4/26/16 at 3:00 p.m. with the director of nursing (DON) regarding resident 8 revealed she: *Had recently reviewed resident 8's care plan. *Told one of the staff nurses it was not individualized or combined with the hospice care plan. *Thought it had been corrected prior to the survey. *Agreed there needed to be clear, concise delineation between what the staff was responsible for, and what the hospice staff was to have been responsible for in caring for the resident. Surveyor: 33265 2. Review of resident 9's care plan revealed: *He had been placed on hospice care on 3/14/16. *The provider's updated care plan stated they would: "Work with hospice nursing staff, family, and primary physician to provide maximum comfort for the resident by adjusting medication as needed, reporting increased restlessness, repositioning per resident and families request." *The 3/14/16 hospice provider's care plan identified they would: -Manage the care related to the terminal illness. -Provide the medications and supplies related to the terminal illness. -Work with the long term care provider in all other care areas to meet the needs of the resident and family. *There was no integration of the two separate care plans beyond the above statements. Interview on 4/27/16 at 4:45 p.m. with the DON revealed she agreed: *There was no integration of the two separate	F 309	F-309 (continued) All future hospice resident comprehensive Care Plans will include verbiage directly from the hospice provided plan of care upon admission to Hospice and will be reviewed by IDT upon completion of the Significant Change MDS following Hospice admission. Further updating will continue following Hospice nurse visits when need for changes are identified and as the dying process continues. Care Plans will be routinely reviewed by the GSS IDT at quarterly Quality of Life meetings and during scheduled Care Conferences. The Care Plans will be further reviewed by visiting Hospice Nurses during their recertification process. Hospice Care Plan reviews will be identified in their progress notes. Monthly reviews of the Hospice care plans will be reported at monthly QAPI meetings for three months by MDS Coordinator or in her absence by the Director of Social Services. Further reviews and schedules will be determined by the QAPI	6/16/16

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F 309	Continued From page 4 care plans. *She could not identify from the long term provider's care plan: -Which hospice personnel would be coming (registered nurse, nursing assistant, pastor, social worker). -What dates or frequencies of visits to expect from the hospice staff. -Which tasks (bathing, dressing changes) the hospice provider would be doing. -When to call hospice staff. Review of the provider's revised August 2015 Hospice Services Provided in a Skilled Nursing Facility policy revealed: *A coordinated comprehensive care plan should have been jointly developed. *The care plan should have included directives for care, and should have been revised and updated as necessary to reflect the resident's current condition. *The provider was to have addressed specific needs on the care plan.	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425	F 425 483.60(a),(b) PHARMACEUTICAL SVC-ACCURATE PROCEDURES, RPH On April 29, 2016 DNS contacted the pharmacist and discussed need to implement a new E-kit. Informed pharmacist the E-kit needs to be a locking E-kit and will also need a list of included drugs and outdates for all drugs. We also need to have the earliest outdate noted on the list that is to be kept on top of the E-kit box. (continued)	

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F 425	Continued From page 5 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, and policy and procedure review, the provider failed to monitor and maintain one of one emergency medication kit (E kit) in the north medication room. Findings include: 1. Observation on 4/27/16 at 9:55 a.m. with licensed practical nurse (LPN) A of the north medication room revealed: *The E kit was stored in a metal cabinet. *The E kit was not sealed. *An E kit for refrigerated medications was in the refrigerator with a padlock on it. *Emergency scheduled (highly addictive) medications were kept in a locked box on the wall. *No list of what medications were in the E kits was found on the E kits or in the medication room. *No documentation of when the E kits' medications expired. *No documentation of when the pharmacist had last checked the E kits for supplies or expired medications. Interview on 4/27/16 at 10:32 a.m. and 12:45 p.m.	F 425	F-425 (continued) On April 29, 2016 DNS ordered numbered zip ties to attach to the new E-Kit as well as the refrigerated kit. On May 12, 2016 DNS met with pharmacist to implement the new E-kit. The new E-kit is a hard plastic tool box with a lock. This E-kit has a numbered zip tie that has numbers documented in a log book kept next to E-kit. The fridge E-kit also has numbered zip tie and lock and will also be documented in log book. Night nurses will document check that the correct numbers are in place daily. A calendar for this documentation was placed on cupboard in med room. The keys for both E-kits will be kept on the North nurse's key ring. There will be only one key for each E-kit. South nurse will need to ask North nurse if medications are needed from the E-kit. A list of all medication included in both E-kits and expiration dates for each drug was placed on top of the E-kit. This list also shows the medication with the (continued)	

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F 425	Continued From page 6 with the director of nursing confirmed: *The E kit in the metal cabinet was not sealed. *No list of medications or their expiration dates had been on the E kits. *She would have expected the pharmacist to check the E kits monthly. *She had not known the last time the pharmacist had checked the E kits. Interview on 4/27/16 at 10:55 a.m. with the pharmacist revealed: *The E kit had not been sealed. *She had never posted a list of medications including their expiration dates on the E kits. *She was not sure when she had last checked the E kits for supplies or expired medications. *She had not checked the E kits for at least one-and-a-half or two months. *She was not able to provide documentation of the last time she had checked the E kits for supplies or expired medications by the end of the survey. Review of the provider's September 2012 Emergency Drug Boxes procedure revealed: *E kits were to be kept locked. *A list of emergency medications including the amounts, dosages, and strengths was to be posted on the outside of the E kit. *The pharmacist was responsible for monitoring expiration dates. *"Recordkeeping will be in accordance with the pharmacy system." Review of the provider's September 2012 Pharmaceutical Services policy revealed: *"Emergency medications will be provided...with a pharmacy service that meets professional standards and principles." *by DNS DH/SDOH/EL	F 425	F-425 (continued) closest expiration date. This medication list also has space to record date used, if reordered and nurse signature. This medication list sheet will be faxed to pharmacy for re-fill and a new sheet will accompany the medications when delivered. These completed sheets will be given to DNS and filed in her office. The pharmacist will provide DNS with documentation supporting monthly inspections of the E-kit and updated expiration dates. On May 13, 2016 communication was provided to all nurses, including administration nurses explaining the new process and instructions on new implementations. On May 6, 2016 DNS conducted a nurses meeting and reviewed all the new implementations. The DNS will perform a weekly audit on E-kit for 4 weeks and then monthly checks after that. These reports will be presented monthly to the QAPI committee that meets monthly for further direction for review.	6/16/16

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 35121	F 431	F 431 483.60(b), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS On April 29, 2016 DNS ordered a new locked box for medications needing to be discarded. This box arrived and was permanently affixed on May 13, 2016. This box has an opening for placing the medications and count sheet on the outside wall of North medication room. The medications are deposited and fall into a separately locked box that only the DNS can access. The medications are then retrieved by DNS and destroyed with the pharmacist. The old narcotics box on the wall was removed and disposed. A sign was placed above the opening instructing nurses to place medications to be destroyed here. Any extra controlled medications that were previously kept in the medication room are now kept double locked on the medication carts and counted each shift. (continued)	

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F 431	Continued From page 8 Based on observation, interview, and policy and procedure review, the provider failed to have a complete system to prevent potential diversion (illegal use or distribution of drugs) or loss of controlled (highly addictive) medications. Findings include: 1. Observation and interview on 4/27/16 at 9:55 a.m. with licensed practical nurse (LPN) A of the north medication room revealed: *An E kit for refrigerated controlled medications was in the refrigerator with a padlock on it. *The nurses who were to administer medications had keys to the padlock. *Emergency controlled medications that had not required refrigeration were kept in a locked box on the wall. *Controlled medications that were to be destroyed were kept in the locked box on the wall. *An extra supply of controlled medications for individual resident use was kept in the locked box on the wall. *The key to the locked wall box was hanging on a wall in the medication room. *The nurses who were to administer medications and the director of nursing (DON) had keys to the medication room. Interview on 4/27/16 at 10:32 a.m. with the DON revealed: *The medication nurses and the DON had keys to the medication room and the E kit padlock. *Housekeeping and maintenance staff needed to enter the medication room periodically. *She would have expected a nurse to supervise other staff while in the medication room. Interview on 4/27/16 at 10:55 a.m. with the pharmacist revealed she:	F 431	F-431 (continued) The DNS will perform a weekly audit on controlled medications for 4 weeks and then monthly checks after that. These reports will be presented monthly to the QAPI committee that meets monthly for further direction for review. *by DNS DK/SDOOH/EL	6/16/16

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F 431	Continued From page 9 *Had never posted a list of medications including their expiration dates on the E kit box. *Had not placed a lock on the E kit. *Was not sure when she had last checked the E kit for supplies or expired medications. 2. Observation and interview on 4/27/16 at 12:45 p.m. with the DON confirmed: *The wall box contained several controlled medications. *The E kit located in the refrigerator contained controlled medications. *Not all of the controlled medications had individual resident narcotic records (a record of the controlled medication name, strength, and amount). *One nurse could access the controlled medications without supervision. *Any of those controlled medications and the individual resident narcotic records could have been taken without being noticed. Review of the provider's September 2012 Emergency Drug Boxes procedure revealed: *E kits were to be kept locked. *"Recordkeeping will be in accordance with the pharmacy system." Review of the provider's revised June 2014 Controlled Substances procedure revealed: *The provider was to have been providing "Safe storage for all controlled substances." *The licensed nursing staff was responsible for "Locking up these substances." Review of the provider's revised December 2015 Disposition (Disposal) of Medications procedure revealed that "Discontinued medications are to be kept in a secure place in the medication room."	F 431		

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F 431	Continued From page 10 Review of the provider's September 2012 Pharmaceutical Services policy revealed: *Pharmacy services were to include procedures to "ensure accurate acquiring, receiving, dispensing and administering of all medications and biologicals." *The pharmacist was to have established: -"A system of records of receipt and disposition of all controlled medications in sufficient detail to enable accurate reconciliation." -"An account of all controlled medications is maintained and periodically reconciled." *"Emergency medications will be provided...with a pharmacy service that meets professional standards and principles."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS On April 26, 2016 the corrugated shipping containers and open plastic container of decorations were removed from the 300 hall storage room and debris was cleaned from the floor. Floor stripping chemicals were also removed from the store room on April 26, 2016. On May 3, 2016 wood platforms were removed and metal wire shelving for supplies was installed in the 300 hall storage room. (continued)	

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GOOD SAMARITAN SOCIETY DEUEL COUNTY	913 COLONEL PETE STREET CLEAR LAKE, SD 57226

(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 441	Continued From page 11 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, record review, interview, and policy review, the provider failed to maintain appropriate infection control technique in: *One of one store room in the 300 hall. *One of one record room in the 300 hall. *One of one clean utility room between the 100 and 200 halls. *One of one nurse store room. Findings include: 1. Observation on 4/26/16 at 1:30 p.m. of the 300 hall storage room revealed: *Numerous sterile items (syringes, needles, etc.) had been stored on shelves next to and on top of corrugated shipping containers. *Hazardous floor stripping chemicals had been stored next to resident drinking cups and toilet paper rolls.	F 441	F-441 (continued) Metal wire shelving for supplies was installed 6 inches or higher above floor surface and the floor was swept and mopped. On April 27, 2016 the corrugated shipping containers were removed from the 300 hall record room and the resident supplies were relocated for storage in the 300 hall storage room and the floor was cleaned of debris. On April 27, 2016, the lunch box, open bottle of Lipton iced tea, and opened bottle of peach flavored water were removed from the refrigerator in the clean utility room between the 100 and 200 halls. On May 13, 2016 this refrigerator was cleaned and placed on a weekly cleaning schedule by the dietary staff per facility dietary policy & procedure. On April 27, 2016 a freezer for therapy ice packs was ordered, and on May 11, 2016 the freezer was installed in the utility room and the ice packs were removed from the resident food refrigerator/freezer and placed in the new freezer for therapy ice packs.(continued)	

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	435117		C 04/27/2016

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F 441	Continued From page 12 *Some sterile items and clean items (disposable cups, toilet paper, and numerous miscellaneous personal care supplies) were stored less than two inches off the floor on a wood platform. *Used decorations were placed in an open plastic container and were stored next to the sterile items. *That room had been the main freight and storage room for the entire building. *The floor was heavily soiled with dirt and debris. *Nursing, dietary, and housekeeping had storage areas in that room as noted by handwritten signage on the wall. 2. Observation on 4/26/16 at 1:30 p.m. of the 300 hall records room revealed: *Sterile items had been stored co-mingled with medical records and corrugated shipping containers. *The floor was heavily soiled with dirt and debris. Interview on 4/26/16 at 1:30 p.m. with the maintenance supervisor regarding the above store rooms revealed he: *Had always stored excess and bulk storage for the facility in that manner. *Was not sure when the floor had been cleaned last. *Was not aware outside shipping containers should not be stored next to sterile and clean items for appropriate infection control to be maintained. *Had no use for the floor stripping chemical anymore but had not wanted to throw it away. *Was unaware shelving should be maintained at least six to eight inches in height from the floor. *Stated overflow from the store room went to the records room across the hall. *Agreed the floor in the storage and records room	F 441	F-441 (continued) On April 27, 2016 the bucket of standing water was removed and repair for the ice machine in the clean utility room between the 100 and 200 halls was ordered. On May 13, 2016 the repair part was received and the repair made to the ice machine. On April 27, 2016 the bananas, one can of thickener, and a bowl of uncovered popcorn on the counter top were discarded. On May 11, 2016 individual use packets of thickener to thicken liquids for residents with swallowing problem were ordered. The items in the cabinets in the clean utility room were sorted and stored appropriately to prevent comingling of food items/ utensils used for eating and resident care supplies. The Sani – wipes were removed from the clean utility room. On May 13, 2016 the cabinets were labeled to identify areas of proper placement of items stored in the cabinets. (continued)	

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F 441	Continued From page 13 had not been cleaned regularly as they were heavily soiled with dirt and debris. 3. Observation from 4/26/16 at 8:30 a.m. through 4/27/16 at 2:00 p.m. of the clean utility room shared between the 100 and 300 halls revealed: *The refrigerator freezer had a sign on the door that read it was for resident's food only. No staff food or drink was to have been allowed. *Inside the refrigerator and freezer there was: -One staff member's lunchbox that contained a cigarette lighter, a protein drink, and a container of yogurt. -One opened bottle of Lipton iced tea. -One opened bottle of peach flavored water. -A red liquid substance had been spilled onto the bottom shelf of the refrigerator and had dripped below the pull-out crisper drawers. -Four cloth therapy ice packs (come in direct contact with resident's skin or clothing) were placed in the freezer. -Next to the ice packs in the freezer were ice cream snack packs for residents. *On the refrigerator temp log dated April 4, 2016, a staff member had written "needs to be wiped out please." Also in that clean utility room was an ice machine. Beneath the ice machine was: *A bucket of standing water. *Next to the bucket was a floor drain. *Next to the ice machine were cupboards and a countertop. *On the countertop there was: -Two bananas. -One can of thickener (thickens liquid for residents with swallowing problem) with the scoop inside the can. -One large bowl of popcorn that was uncovered.	F 441	F-441 (continued) Nurses and CNAs were educated on the proper storage of resident use supplies, ice packs for therapy and food items in the clean utility area and the refrigerator in the clean utility area is for resident food items only on May 4, 2016 and May 5, 2016 by the DNS. Beginning May 16, 2016 dietary staff will check for soiling and remove and discard any non-resident food items found in the refrigerator daily when the refrigerator temp is checked and documented daily. Beginning the week of May 16, 2016 the dietary staff will be responsible for cleaning the resident food refrigerator weekly, or more often if needed and documenting the cleaning per facility dietary policy and procedure. On April 27, 2016 the heavily soiled nebulizer machine and fan in the nurse storage room were discarded, the open case of Osmolite cans with the "do not use" note was removed from the shipping container and relocated (continued)	

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F 441	Continued From page 14 *In the cupboards co-mingled were: -Sani-wipes (disinfectant wipe). -Cups. -Spoons. -Straws. -Cleaned multiple-use resident electric razors. -A shampoo bottle. -Disposable single use personal care items. 4. Observation on 4/26/16 at 11:20 a.m. in the nurse storage room revealed: *The computer server systems for the building's wifi (wireless internet) and networking were on the right side. *On the left side was a shelving unit. *On that shelving unit was a nebulizer (breathing equipment) that was visibly heavily dirty. *There was an opened case of Osmolite (supplemental nutrition for tube-fed residents) cans with a note saying "Do not use." *Several shipping corrugated containers of Jevity (tube-feeding formula) and two individual containers of Jevity. *The floors and shelves were heavily soiled with dust and debris. *An oscillating fan was placed in the corner and was also heavily soiled in dust and debris. Interview on 4/26/16 at 3:00 p.m. with the director of nursing regarding the above observations revealed she agreed: *Sterile and clean items had not been stored in a manner to maintain appropriate infection control technique. *Chemicals should not be stored with resident use items. *Storage room shelving should be at the appropriate recommended height. *Routine and as-needed cleaning should be	F 441	F-441 (continued) to the wire shelving in the 300 hall store room, the Jevity was removed from the nurse storage room and properly stored on metal wire shelving in the resident rooms for whom the formula will be used. The dust and debris was cleaned from the room, and the shelving removed. This storage room will no longer be used for storage of resident use items. Maintenance, Purchasing and staff responsible for stocking the resident supply areas were educated on receiving, proper unpacking and storage of items for resident use on May 16, 2016. Beginning the week of May 16, 2016 housekeeping staff will clean the identified storage areas weekly and document the task. Beginning the week of May 16, 16 the Infection Prevention Nurse or designee will audit the 300 Hall Storage Area, 300 Hall Record Room, Clean Utility Area and Nurse Storage area to assure corrections are maintained weekly x 4, monthly x 3, reporting monthly to the QAPI Committee (continued)	

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F 441	Continued From page 15 performed in the above rooms to maintain appropriate infection control. *Staff were not to have used the resident's nourishment refrigerator for storing personal items. *Ice packs should not be stored in resident refrigerator freezers co-mingled with resident food items. *Staff should maintain and clean the resident's refrigerator regularly and as-needed. *Thickener scoops should not be stored inside the can of thickener. *Supplies received in corrugated shipping containers needed to be removed from those containers and stored appropriately to avoid contamination to clean and sterile supplies. *Tube feeding supplies (Jevity and Osmolite) should not be stored in the room with the server system. *The standing water in the bucket under the ice machine was a potential source of waterborne bacteria. *Parts were to be on order for the leak in the ice machine. *Water should not be allowed to pool into a bucket. *It should have been drained into the available floor drain. *Resident snack food items such as fruit should not be store directly on countertops. Review of the provider's March 2016 Preventative Maintenance Program policy revealed the purpose was to identify potential repair needs and plan maintenance of the physical plant and equipment. Review of the provider's revised December 2015 Nursing Care Equipment and Supplies policy	F 441	F-441 (continued) for further direction for review of these storage areas. Beginning the week of May 16, 2016 the Infection Control Prevention Nurse or designee will complete a walk thru review of the facility to identify other storage areas for storage of supplies and efforts to control infections and provide a safe clean environment and report to the QAPI Committee in one month for further direction for review of storage areas.	6/16/16

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F 441	Continued From page 16 revealed: *Regular cleaning and maintenance was to have been completed. *Supplies were to have been stored according to manufacturer's instructions and under infection control practices. Review of the provider's March 2016 Procurement and Storage of Equipment, Products, and Supplies policy revealed the storage of supplies supports efforts to control infections and to provide a safe, clean environment.	F 441		

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

ORIGINAL

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435117	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/26/2016

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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/26/16. Good Samaritan Society Deuel County was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Block, NHA
TITLE: Administrator
(X6) DATE: 5/19/16

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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South Dakota Department of Health

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	10608		04/27/2016

NAME OF PROVIDER OR SUPPLIER: GOOD SAMARITAN SOCIETY DEUEL COUNTY

STREET ADDRESS, CITY, STATE, ZIP CODE: 913 COLONEL PETE ST, CLEAR LAKE, SD 57226

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S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/26/16 through 4/27/16. Good Samaritan Society Deuel County was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 16385 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 4/26/16 through 4/27/16. Good Samaritan Society Deuel County was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James Block, NHA

TITLE: Administrator

(X6) DATE: 5/19/16

STATE FORM 6899 M7VD11 If continuation sheet 1 of 1

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