

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

ORIGINAL

PRINTED: 02/25/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435045	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/11/2016
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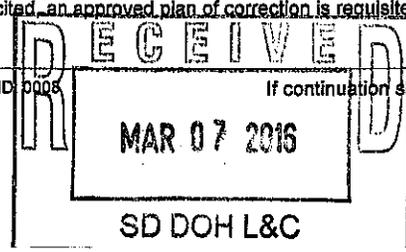
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION RD SIOUX FALLS, SD 57106
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F 000	<p><i>*Addendums noted with an asterisk per 3/2/16 per telephonic with Facility Director of Nursing Services. NLSDDOHTEL</i></p> <p>INITIAL COMMENTS Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/9/16 through 2/11/16. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirement(s): F241, F250, F272, F278, F281, F332, F371, and F514.</p>	F 000	Initial comments	
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 A. Based on observation, record review, interview, and policy review, the provider failed to ensure dignity was maintained by avoiding social isolation and promoting self-esteem during mealtime for 1 of 22 sampled residents (14) while in the rehabilitation dining room. Findings include:</p> <p>1. Review of resident 14's 1/20/16 quarterly Minimum Data Set (MDS) assessment revealed: *She had a Brief Interview for Mental Status</p>	F 241	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by State law. For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilities allegation of compliance in accordance with Section 7305 of the State Operation Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 3-4-16
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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.



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F 241	<p>Continued From page 1</p> <p>score of seven out of fifteen indicating severe cognitive impairment (memory loss). *She required the total assistance of one person for eating.</p> <p>Observation from 2/9/16 at 12:15 p.m. through 12:45 p.m. of resident 14 in the rehabilitation dining room revealed: *At 12:15 p.m. she was seated in a wheelchair next to a dining room table facing the east wall. -There were no other residents at the table. *At 12:42 p.m. a certified nursing assistant (CNA) came and sat next to her at the table to assist her with dining. *There were no interactions with the resident from the staff from 12:15 p.m. to 12:42 p.m.</p> <p>Observation on 2/9/16 at 6:25 p.m. of resident 14 in the rehabilitation dining room revealed: *She was seated in her wheelchair next to a dining room table with two other residents. *CNA C remained standing while providing her assistance with eating.</p> <p>Review of resident 14's 1/20/16 quarterly Minimum Data Set (MDS) assessment revealed: *She had a Brief Interview for Mental Status score of seven out of fifteen indicating severe cognitive impairment (memory loss). *She required the total assistance of one person for eating.</p> <p>Interview on 2/11/16 at 8:00 a.m. with the director of nursing regarding resident 14's above dining experiences revealed: *She would have expected the resident be positioned in the dining room so she could interact with others if desired. *Agreed that CNA C should have assisted her</p>	F 241	<p>F 241 Dignity &amp; Respect of Individuality</p> <p>Resident 14 has a wheelchair that sits higher which is why some employees were standing to assist with dining. We will be purchasing a higher stool so that staff can be seated at an appropriate height to assist resident 14 with dining. All staff were reminded during an all staff meeting on 2/18/16 to sit while assisting residents with eating.</p> <p>Nursing was educated on 2/24/16 and dietary staff members educated on 3/2/16 on policy and procedures on Dignity and Dining Room Service which include information on social isolation, promoting self-esteem and sitting with residents when assisting. All staff will be educated by 3/11/16 on dignity and respect per our policy.</p> <p>We will provide education on dignity at least yearly and all new employees will be educated during general orientation.</p> <p>The DNS or designee will audit all dining rooms to identify concerns with Dignity per our policy and procedure. These audits will be done weekly X4 then monthly X3. DNS or designee will report findings to the QAPI committee monthly. QAPI committee will determine need for ongoing monitoring.</p>		

\*NK/SDC/HL

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F 241	<p>Continued From page 2 with eating at her level instead of remaining in a standing position.</p> <p>Review of the provider's February 2013 Resident Dignity policy and procedure revealed: *Dignity was to be maintained for all residents. *The purpose for maintaining dignity was to support, encourage, and enhance the resident's self-esteem. *Promoting resident independence and dignity in dining was necessary.</p> <p>Surveyor: 29354 B. Based on observation, interview, and policy review, the provider failed to provide dinnerware for two of three observed meals in two of five dining rooms (main dining room and Selles dining room). Findings include:</p> <p>1. Observation and interview on 2/9/16 at 11:40 a.m. in the main dining room and with dietary aide (DA) K revealed small styrofoam bowls were being used for the residents' fruit.</p> <p>Interview at the above time with DA K confirmed: *They had used small styrofoam bowls in place of regular bowls to serve the residents' dessert and fruit in. *There had not been enough regular bowls, so they used styrofoam bowls when they had to.</p> <p>Observation on 2/9/16 from 12:20 p.m. through 12:30 p.m. in the Selles dining room revealed small styrofoam bowls had been used during the meal service.</p> <p>Observation and interview on 2/9/16 at 6:16 p.m. in the main dining room and with DA/receptionist N revealed:</p>	F-241	<p>Education was provided on improper use of Styrofoam dishes while surveyors were still in the building. Nursing was educated on the use of Styrofoam dishes on 2/24/16. On 3/2/16 additional education was provided to dietary staff on our policy and procedure which states "avoiding the use of plastic cutlery or paper or Styrofoam cups, plates or bowls". We have ordered and received additional dinnerware which is currently being used in place of Styrofoam. <i>*We will use Styrofoam plates and cups only in emergency, social hours and family picnic situations. NRISDDOTTEL</i></p> <p>We will monitor the inventory of the dinnerware to ensure there is enough in each dining room.</p> <p>Director of Dining Services or designee will audit each dining room for compliance with following our policy and procedure. These audits will be completed weekly X4 then monthly X3. Director of Dining Services or designee will report findings to the QAPI committee monthly. QAPI committee will determine the need for further action.</p>	4/1/2016	

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F 241	<p>Continued From page 3</p> <p>*Small styrofoam dishes had been used for the residents' fruit and dessert.</p> <p>*The dietary staff had used styrofoam dishes for the above meal service.</p> <p>*Styrofoam dishes were used when there had not been enough regular dishes.</p> <p>Interview on 2/10/16 at 2:50 p.m. with certified dietary manager O and the registered dietitian revealed:</p> <p>*They had been unaware the staff had been using styrofoam dishes for serving the residents.</p> <p>*It had not been a normal practice to have used styrofoam dishes.</p> <p>Review of the provider's February 2013 Residents Dignity policy revealed "Dietary staff will promote resident independence and dignity in dining by avoiding the use of plastic cutlery or paper or styrofoam cups, plates or bowls."</p>	F 241		
F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on record review, interview, and social work objectives review, the provider failed to ensure counseling services were provided for 1 of 22 sampled residents (12). Findings include:</p>	F 250	<p>F 250 Provision of medically related social service</p> <p>Referral to psychological services for resident 12 was made on 2/23/16. Psychological services have begun for resident 12 as of 3/1/16. <i>*All other residents were reviewed for need of this service. NR/SS/DIC</i></p> <p>Residents in need of psychological services will be identified and monitored at monthly quality of life meetings.</p> <p>Residents who have been referred to psychological services will be discussed</p>	

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F 250	Continued From page 4 1. Review of resident 12's medical record revealed: *She had diagnoses of depression, dementia, and psychosis. *She had been seen for psychological counseling services by a behavioral health organization on 6/11/15. *The 6/11/15 psychological services progress note stated: -She had depression and anxiety. -Her long therapy goal progress score was a three indicating moderate progress. -The session goal progress score was a two indicating more than minimal but less than moderate progress. -The plan of care was for her to have been counseled four times per month for four months. *The 7/6/15 counseling services discharge summary stated "NH [nursing home] staff report dementia progressing to where client no longer benefits from services." *There was a physician's order to discontinue counseling services on 7/8/15. *The 8/6/15 Minimum Data Set (MDS) assessment revealed a score of four which indicated minimal depression. *The 11/3/15 MDS revealed a score of twelve which indicated moderate depression. *A care plan review note on 11/10/15 stated she had been crying more often. *A physician's order on 11/10/15 for the behavior health organization to provide services. -No documentation was found she had been seen or evaluated by the behavioral health organization after that referral. *A mood and behavior note on 12/2/15 at 8:30 a.m. by licensed nurse G revealed she had stated: -"Everyone thinks that she is a bother and that	F 250	at social services weekly meeting. Social services will also develop a spreadsheet to track who has a referral. Director of Social services or designee will provide education on new process for tracking referrals that have been made and the policy and procedure Providing Medically Related Social Service to the social services team. DNS or designee to provide education to nursing. Education will be completed before April 1, 2016  The DNS or designee will audit whether referrals have been made and the use of the new referral spreadsheet weekly X4 then monthly X3. The DNS or designee will report findings to the QAPI committee monthly and QAPI committee will determine if further action is needed.	4/1/2016	

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F 250	<p>Continued From page 5</p> <p>she is very unhappy." -"Everyone thinks I'm better off dead." *A shift note on 12/30/15 at 10:55 p.m. by certified medication aide R revealed she: -Was in a "bizarre mood." -Had stated "gett [get] the [profanity] out of here I want my privacy and I will call the cops." -Has refused medication, bed time care, and most treatments. *A care plan review note on 2/5/16 at 1:50 p.m. by social worker H revealed: -Her behavior status had worsened. -She had rejected cares. -She was no longer being seen by the behavioral health organization.</p> <p>Interview on 2/11/16 at 8:30 a.m. with the social services director revealed: *She had mailed forms for consent for services from behavioral health to the resident's daughter. *The consent forms had not been returned. *She had not followed-up with the daughter regarding the consent forms for services. *She agreed the resident had not received the psychological services her physician had intended.</p> <p>Interview on 2/11/16 at 9:00 a.m. with the director of nursing revealed she agreed the resident had not received the psychological services her physician had intended.</p> <p>Review of the provider's revised December 2014 Social Work Philosophy and Objectives revealed social services was to have: *Provided "The leadership of a qualified social worker in organizing, coordinating, evaluating and providing or arranging for the medically-related social service needs of each resident."</p>	F 250			

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F 250	Continued From page 6	F 250	F 272 Comprehensive Assessments		
F 272 SS=D	<p>*Addressed the psychological needs and challenges for each resident.</p> <p><b>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</b></p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and                      Documentation of participation in assessment.</p>	F 272	<p>Resident 7 is deceased, unable to correct assessment.</p> <p>For resident 17 we are not able to go back to fix this MDS section dated 8/27/15. Another MDS was submitted on 11/24/15 and we verified that section C was completed correctly. <i>*All other residents MDSs, section C's, were reviewed for accuracy. All 100% correct</i></p> <p>Per policy and procedure MDS 3.0/RAI "each discipline will be responsible for completing its section(s) of the MDS in PCC". Social Workers will ensure that their section of the MDS has been completed accurately.</p> <p>Director of Social Services and DNS or designee will educate MDS Coordinators and Social Service staff on policy and procedures by 4/1/16.</p> <p>Social Services Director will audit section C on the MDS that questions have been answered appropriately and in a timely manner. This will be done weekly X4 then monthly X3. Social Services Director will report findings to the QAPI committee monthly. The QAPI committee will determine ongoing monitoring.</p>	4/1/16	

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F 272	Continued From page 7  This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and procedure review, the provider failed to include a cognitive screening with each Minimum Data Set (MDS) assessment for 2 of 22 sampled residents (7 and 17). Findings include:  1. Review of resident 7's 1/21/16 admission MDS assessment revealed section C (a review of brain functioning) had not been completed.  2. Review of resident 17's 8/17/15 quarterly MDS revealed section C had not been completed.  3. Interview on 2/10/16 at 11:30 a.m. with MDS coordinator D regarding resident 7 revealed: *Social worker H had been responsible for completing section C. *She was not sure why section C had not been completed.  Interview on 2/10/16 at 1:00 p.m. and again at 4:00 p.m. with social worker H revealed: *She was to have completed section C of the MDS. *She was not sure why she had not completed section C for residents 7 and 17. *She had written a social services assessment in resident 7's chart, but it had not contained a review of brain functioning. *Her expectation was section C would have been completed for all residents with each MDS.	F 272			

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F 272	Continued From page 8  Interview on 2/11/15 at 9:00 a.m. with the director of nursing revealed her expectation would have been all residents should have a completed section C with each MDS assessment.  Review of the provider's August 2015 MDS 3.0/Resident Assessment Instrument (RAI) procedure revealed: *The Brief Interview for Mental Status was to have been completed for the MDS during the observation period. *Social services was responsible for completing section C. *The MDS coordinator was to have completed a validation verification of the entire MDS after each discipline had coded and signed their sections.	F 272			
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278	F 278 Assessment Accuracy/Coordination/Certified  The MDS for residents 1,3,8,13 and 20 will be corrected by 3/4/16. The DNS provided re-education to the MDS coordinator, who completed all five of the MDS assessments, on toileting plan vs toileting program per our procedure on Toileting Programs. All MDS coordinators and nurses were re-educated by the DNS on 2/24/2016 on the Toileting Program policy and the difference between a toileting program and toileting schedule. <i>*All other MDS's were audited and modified as needed. NE/SDH/EL</i>		

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F 278	<p>Continued From page 9</p> <p>\$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on record review, interview, and policy review, the provider failed to ensure the Minimum Data Set (MDS) assessment had been completed accurately for five of twenty-two sampled residents (1, 3, 8, 13, and 20). Findings include:</p> <p>1. Review of resident 20's medical record revealed: *She had a Foley catheter. *The 1/20/16 MDS assessment indicated she was: -On a urinary toileting program that had resulted in no improvement. -Always continent. *The 2/3/16 care plan review note had no mention of toileting. *The 2/3/16 care conference note had no mention of toileting. *The current care plan stated "Toileting schedule: Offer toileting before and after meals, mid-PM [evening], HS [bedtime], Nocs [nights] during rounds and PRN [as needed]."</p> <p>2. Review of resident 3's medical record revealed:</p>	F 278	<p>MDS coordinators will print out a report to identify which residents are on a toileting program prior to the Quality of Life (QOL) meeting each month. QOL team will identify whether or not this resident is appropriate for this program.</p> <p>The DNS or designee will audit residents on a toileting program at each quality of life meeting monthly X3. DNS will report findings to the QAPI committee monthly. The QAPI committee will determine if further monitoring is needed.</p>	4/1/2016	

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F 278	<p>Continued From page 10</p> <p>*The 1/5/16 MDS assessment indicated she was: -On a urinary toileting program that had resulted in being completely dry. -Always continent of urine.</p> <p>*The 2/8/16 care plan change note stated a toileting schedule had been added to toilet resident every two to three hours.</p> <p>*Current care plan stated "Toileting schedule: Assist resident with toileting every 2-3 hours."</p> <p>Surveyor: 34030 3. Review of resident 13's medical record revealed: *She lived on the memory care unit.</p> <p>The 11/17/15 quarterly Minimum Data Set (MDS) assessment revealed: *A Brief Interview for Mental Status (BIMS) assessment of 3, which shows severe mental impairment. *Sometimes required assistance with toileting and other times took herself to the bathroom. *Coded yes for current toileting program.</p> <p>The care plan with a 8/26/14 initiated date revealed "Toileting schedule: before and after meals, mid-pm (afternoon), HS (hour of sleep), NOCS (nights) during rounds, and PRN (when necessary). *There was no documentation resident 13's toileting schedule had been monitored and evaluated.</p> <p>Surveyor: 29354 4. Review of resident 1's medical record revealed she lived in the memory care unit.</p> <p>The 7/27/15 annual MDS assessment for resident 1 revealed:</p>	F 278		

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F 278	<p>Continued From page 11</p> <p>*A Brief Interview for Mental Status (BIMS) assessment had not been documented.</p> <p>*Had long and short term memory impairment.</p> <p>*Required extensive assistance with toileting and personal hygiene.</p> <p>*Was frequently incontinent of bladder and bowel.</p> <p>*Was coded yes for current toileting program or trial for urinary incontinence.</p> <p>The 12/21/15 quarterly MDS assessment for resident 1 revealed:</p> <p>*The BIMS score had not been documented.</p> <p>*Long and short term memory had not documented.</p> <p>*Required extensive assistance with toileting and personal hygiene.</p> <p>*Was frequently incontinent of bladder and bowel.</p> <p>*Was coded yes for current toileting program or trial for urinary incontinence.</p> <p>The care plan with a 7/10/14 initiated date and 7/10/14 revision date revealed "Toileting schedule: before and after meals, mid-pm [afternoon], HS [hour of sleep], NOCS [nights] during rounds, and PRN [when necessary]. There was no documentation in resident 1's medical record a toileting schedule had been monitored and evaluated.</p> <p>Interview on 2/10/16 at 8:10 a.m. with CNA P regarding resident 1 confirmed she usually took the resident to the bathroom after breakfast and after lunch.</p> <p>Interview on 2/10/16 at 8:37 a.m. with RN Q regarding resident 1 confirmed she was on a toileting program.</p> <p>5. Review of resident 8's medical record</p>	F 278			

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F 278	<p>Continued From page 12 revealed:</p> <ul style="list-style-type: none"> <li>*He lived in the memory care unit.</li> <li>*Had a diagnosis of urinary retention.</li> <li>*He had a Foley catheter (tube inserted into the bladder).</li> </ul> <p>The 7/27/15 significant change MDS assessment for resident 8 revealed:</p> <ul style="list-style-type: none"> <li>*A BIMS score of six indicating severe cognitive impairment.</li> <li>*Required extensive assistance of two staff for toileting and personal hygiene.</li> <li>*Had an indwelling (foley) catheter.</li> <li>*Was coded yes for current toileting program or trial for urinary incontinence.</li> <li>*Urinary continence was not rated.</li> <li>*Was frequently incontinent of bowel.</li> <li>*Was coded no for toileting program for bowel continence.</li> </ul> <p>The 1/21/15 quarterly MDS assessment for resident 8 revealed:</p> <ul style="list-style-type: none"> <li>*A BIMS score of three indicating severe cognitive impairment.</li> <li>*Required extensive assistance of two staff for toilet use and personal hygiene.</li> <li>*Had an indwelling catheter.</li> <li>*Urinary continence was not rated.</li> <li>*Was frequently incontinent of bowel.</li> <li>*Was coded yes for current toileting program or trial for urinary incontinence.</li> <li>*Was coded zero for bowel toileting program.</li> </ul> <p>The care plan with a 6/20/14 initiated date and 7/20/16 revision date revealed "Toileting schedule: toilet resident before and after meals, mid-PM, HS, and during rounds NOCS." There was no documentation resident 8's bladder and bowel toileting schedule had been monitored</p>	F 278			

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F 278	<p>Continued From page 13 and evaluated.</p> <p>Interview on 2/9/16 at 4:17 p.m. with unlicensed assistive personnel (UAP)/CNA L regarding resident 8 confirmed he was toileted during the day for bowel movements.</p> <p>Interview on 2/10/16 at 8:10 a.m. with CNA P regarding resident 8 confirmed: *He usually had a bowel movement at night. *He had a Foley catheter.</p> <p>6. Interview on 2/10/16 at 8:37 p.m. with RN Q regarding resident 8 confirmed he had been on a toileting schedule for bowel movements. He was toileted in the morning upon rising, after meals, and during the night.</p> <p>Interview on 2/10/16 at 10:10 a.m. with the director of nursing and MDS coordinator M regarding residents 1 and 8's toileting programs revealed: *They were not on a toileting program. *They were on a toileting schedule. *Residents were assessed if they were able to be on a toileting schedule that included if a resident could remember, needed assistance, or needed cueing. *Residents on the memory care unit usually needed cueing and reminding. *A toilet schedule considered the best time when residents were up, before and after meals, middle of the afternoon, bed time, and night time with rounds. *Residents were assessed on admission for toileting. *There was no formal documentation for assessing a resident for a toileting schedule. *If a resident was not receptive with the current</p>	F 278		
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F 278	<p>Continued From page 14</p> <p>toileting schedule she would talk to the staff and see what worked best for the resident.</p> <p>*A toileting schedule included a resident's level of care and changes.</p> <p>*Resident 8 had an indwelling Foley and was not on a toileting program.</p> <p>*Resident 8 was on a bowel program.</p> <p>*MDS coordinator M used the MDS 3.0 version to code each MDS.</p> <p>Interview on 2/10/16 at 8:40 a.m. with the DON revealed:</p> <p>*The facility used the MDS 3.0 version.</p> <p>*She agreed resident's 1 and 8's MDS assessments had been coded incorrectly for being on a scheduled toileting program.</p> <p>Review of the provider's revised September 2015 Toileting Programs policy revealed:</p> <p>**"An appropriate toileting program should be implemented based on the type of incontinence and information obtained and evaluated through the use of the Bladder Assessment and completion of the Care Area Assessment."</p> <p>**"To be considered a scheduled toileting program according to the RAI Manual, the following criteria must be met:</p> <ul style="list-style-type: none"> <li>-Scheduled.</li> <li>-Toileting.</li> <li>-Program: a specific approach that is organized, planned, documented, monitored, and evaluated."</li> </ul> <p>Review of the Version 1.13, October 2015, Resident Assessment Instrument (RAI) Manual, pages 1 through 5, revealed:</p> <p>**"The purpose of this manual is to offer clear guidance about how to use the RAI correctly and effectively to help provide appropriate care.</p> <p>*The RAI helps nursing home staff look at</p>	F 278			

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<p>F 278</p> <p>F 281 SS=D</p>	<p>Continued From page 15 residents holistically as individuals for whom quality of life and quality of care are mutually significant and necessary."</p> <p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Three of thirty resident's (31) randomly observed blister-seal medication cards had listed accurate times for administering the medication. *One of three observed residents (28) requiring medications to have been crushed had a physician's order to crush them. Findings include:</p> <p>1. Observation on 2/9/16 at 12:40 p.m. during a medication pass for resident 31 revealed: *The pharmacy label on a blister seal card of PV methylcellulose (for constipation) indicated the tablets were to have been given at 8:00 a.m. *The pharmacy label on a blister seal card of donepezil HCl (for dementia) indicated the tablet was to have been given at 8:00 a.m. *The pharmacy label on a blister seal card of Namenda XR (for dementia) indicated the tablet was to have been given at 8:00 a.m.</p> <p>Interview with unlicensed assistive personnel (UAP) F regarding resident 31 at that time revealed:</p>	<p>F 278</p> <p>F 281</p>	<p>F 281 Services Provided Meet Professional Standards</p> <p>For resident 31 a new sticker was immediately put on her medication card with correct time for administration and the pharmacy was notified to change time on future cards.</p> <p>All med carts were checked by 3/4/16 and verified that times on MAR and the stickers matched.</p> <p>For resident 28 DNS educated staff member on Crushing Medication policy and where to look for orders to crush meds. *UAP E received individual education on the procedure by DON on 3/2/16. The DNS provided education on procedure Medication - Change of Direction Stickers and Crushing Medications to nursing staff on 2/24/16.</p> <p>Staff development or designee will audit med administration and verify that the stickers match the MAR/TAR and that Crushing Medications procedure was followed. [REDACTED] staff development or designee will report to the QAPI committee monthly. The QAPI committee will determine the need for further monitoring.</p>	<p>4/1/16</p>
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*\*WE WILL audit one nurse or UAP, per shift, monthly for 3 months. NR400048*

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F 281	<p>Continued From page 16</p> <p>*The above medication order times had changed for the resident.</p> <p>*She used a pharmacy that was different from most of the other residents.</p> <p>*She thought nursing staff had probably attempted to get the pharmacist to change the medication times on the resident's medication cards, but the pharmacist had not made those changes.</p> <p>*She was not sure if the provider had stickers to place on the cards that would alert those passing medications of the inaccurate medication times listed on those cards.</p> <p>Interview on 2/11/16 at 9:00 a.m. with the director of nursing revealed her expectation was:</p> <p>*The nurses should have contacted the pharmacist to change the medication times on the above medication cards.</p> <p>*Stickers should have been used on the medication cards to alert those passing medications of the incorrect time on the current medication cards.</p> <p>Review of the provider's December 2015 Acquisition, Receiving, Dispensing, and Storage of Medications policy revealed:</p> <p>*"The pharmacy needs to be kept up to date on any order changes."</p> <p>*"The medication orders/changes are communicated to the pharmacy."</p> <p>2. Observation on 2/9/16 at 12:15 p.m. of UAP E during a medication pass to resident 28 revealed:</p> <p>*UAP E removed two acetaminophen (for pain) from her medication card and crushed those pills.</p> <p>*She gave the crushed medication to the resident.</p> <p>*When asked how she would know the</p>	F 281			

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F 281	<p>Continued From page 17</p> <p>acetaminophen should have been crushed she stated:</p> <ul style="list-style-type: none"> <li>-The medication administration records (MAR) did not list who required to have their medications crushed.</li> <li>-The UAPs and nurses passing medications normally had a nursing paper that listed which residents required their medications to have been crushed.</li> <li>-There were no more nursing papers left when UAP E came to work on that day.</li> <li>-The nurse in charge would have been able to check the residents' physicians' orders to find out who could have their medications crushed.</li> </ul> <p>Review of resident 28's 1/7/16 physician's orders revealed no order to crush the acetaminophen or any other medications.</p> <p>Interview on 2/11/16 at 9:00 a.m. with the director of nursing regarding crushing medications without a physician's order revealed her expectation was the UAP would have had the med crush information available to her while she passed the medications.</p> <p>Review of the provider's September 2015 Medication Administration and Scheduling policy revealed "Follow the "six rights": right medication, right dose, right resident, right route, right time and right documentation."</p>	F 281		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p>	F 332		

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F 332	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and medication insert review, the provider failed administer 2 of 30 observed residents' medications according to manufacturers' recommendations and physicians' orders for 2 of 11 randomly observed residents (29 and 30) during a medication pass. Findings include:</p> <p>1. Observation on 2/10/15 at 8:10 a.m. of LPN G administering medication to resident 30 revealed: *She administered omeprazole at the breakfast table at 8:10 a.m. *The 7/11/15 physician's order indicated it was to have been given once daily 30 to 60 minutes before her meal. *The resident already had her food and fluids in front of her.</p> <p>Observation on 2/10/16 at 8:15 a.m. of licensed practical nurse (LPN) G administering medication to resident 29 revealed: *She administered omeprazole (for stomach conditions) to the resident at the breakfast table at 8:15 a.m. *The 1/21/16 physician's order indicated it was to have been given daily. *The resident already had food and fluids in front of her.</p> <p>Interview with LPN G during the above time revealed that was how she normally administered those medications to residents 29 and 30.</p> <p>Interview on 2/11/16 at 9:00 a.m. with the director of nursing revealed her expectation was</p>	F 332	<p>F 332 Free of Medication Error Rates of 5% or More</p> <p>Residents 29 &amp; 30 we are unable to char<sup>ge</sup> the events that happened. *LPN G received individual education on the procedure by DON on 3/2/16. DNS immediately educated staff member to give omeprazole to residents 30 to 60 minutes prior to eating or drinking.</p> <p>The DNS reviewed the Medication Administration and Scheduling policy and procedure, specifically address medications given with food, with nurses and medication aides on 2/24/16.</p> <p>Staff development or designee will audit med administration to verify that Medication Adminsitration and Scheduling policy has been followed.</p> <p>Staff development or designee will report to the QAPI committee monthly. The QAPI committee will determine the need for further monitoring.</p> <p>*We will audit one nurse or UAP, per shift, per unit monthly for 3 months.</p>	4/1/16
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<p>F 332</p> <p>F 371 SS=E</p>	<p>Continued From page 19 omeprazole was to have been given at least 30 minutes before the residents were to have eaten.</p> <p>Review of the Prilosec (omeprazole) March 2014 package insert revealed "Take at least 1 hour before a meal."</p> <p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to: *Ensure food had been stored in a safe and sanitary manner in one of one dorm-size refrigerator in the main dining room and one of one activity room refrigerator. *Ensure dishes being transported from the central kitchen to the memory care unit dining room had been covered for three of three observed meals. *Maintain food beyond expiration dates for one of one dry food storage room. Findings include:  1. Observation and interview on 2/9/16 at 11:00 a.m. in the main dining room revealed a</p>	<p>F 332</p> <p>F 371</p>	<p>F 371 Food Procure, Store/Prepare/Serve- Sanitary</p> <p>All items not labeled and out dated were disposed of immediately. Activity and dietary staff members were educated immediately to date and label food as well as to make sure labels are readable. Nursing staff was educated on labeling food items with date and readable description of item on 2/24/16. Additional education on food storage policy and procedure was provided by registered dietitian on 3/2/16 to dietary staff. All departments will be educated before March 11, 2016.</p> <p>Foods that have been opened or prepared will be placed in an enclosed container, dated and labeled. Expiration dates will be checked when monitoring refrigerator temperatures, at least daily and unlabeled and/or foods/fluids that have expired dates will be discarded. Potentially hazardous foods (PHF)/time and temperature control for safety (TCS) foods will be discarded after three days in refrigerator per policy Food/Food Preparation Food Storage.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2016  
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/11/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3901 S MARION RD</b> <b>SIOUX FALLS, SD 57106</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 371	<p>Continued From page 20</p> <p>dorm-size refrigerator in the food serving area. Inside the refrigerator were:</p> <ul style="list-style-type: none"> <li>*A large package of bacon strips not labeled or dated when it had been opened.</li> <li>*A gallon freezer bag containing several pancakes.</li> <li>*The label and date on that bag were smeared, black marks that were unreadable.</li> </ul> <p>Interview at the above time with dietary aide (DA) K confirmed the food in the dorm-size refrigerator was not labeled or dated correctly.</p> <p>2. Observation and interview on 2/9/16 at 12:40 p.m. of the activity room refrigerator revealed:</p> <ul style="list-style-type: none"> <li>*A sign posted on the outside of the refrigerator read "This refrigerator is for resident/activites use only."</li> <li>*A large covered container with cold meat and cheese had not been labeled or dated.</li> <li>*A large half eaten cake had not been labeled or dated.</li> </ul> <p>Interview on 2/9/16 at 4:10 p.m. with the activities director confirmed:</p> <ul style="list-style-type: none"> <li>*Food stored in the activity room refrigerator was for residents' food.</li> <li>*Agreed the food in the refrigerator should have been labeled and dated.</li> </ul> <p>Interview on 2/10/16 at 2:50 p.m. with certified dietary manager (CDM) O and the registered dietitian (RD) regarding the above observation confirmed:</p> <ul style="list-style-type: none"> <li>*The activity room refrigerator was to be used for residents' food.</li> <li>*All opened food should have been labeled and dated.</li> </ul>	F 371	<p>New temperature sheet will be introduced to audit temps and to ensure items are labeled, labels are readable and items are dated. We will also educate staff to return all unused food to the Main Dining Room for storage.</p> <p>Dietary staff members were educated immediately about the need to have dish and food carts covered in transport to prevent contamination. Nursing staff members were also educated on 2/24/2016. Additional education provided on 3/2/16 by registered dietitian or designee to the dietary staff. All departments will be educated on covering food and dishes during transport and proper labeling and storage of food before 3/11/16.</p> <p>Expired dry foods were discarded immediately.</p> <p>The Director of Dietary or designee will audit dry food expiration dates and will discard any that are outdated each week when ordering and putting away groceries.</p>		

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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3901 S MARION RD SIOUX FALLS, SD 57106		
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F 371	Continued From page 21 Review of the provider's undated Leftover policy revealed items were to have been dated and labeled.  3. Observations on 2/9/16 at 12:15 p.m., 2/9/16 at 6:15 p.m., and 2/10/16 at 8:30 a.m. revealed a three-tiered cart with uncovered red dishes that had been transported from the central kitchen to the memory care unit.  Interview on 2/10/16 at 2:50 p.m. with CDM O and the RD agreed the dishes should have been covered when they had left the central kitchen.  Review of the provider's revised March 2014 Sanitation Dishwashing policy revealed dishes and glassware should have been protected from contamination.  4. Observation on 2/9/16 at 8:15 a.m. in the main kitchen dry food storage area revealed several seven and one-fourth ounce cans of cream of mushroom soup with the following expiration dates: 6/21/14, 4/5/15, and 5/24/15.  Interview on 2/10/16 at 2:50 p.m. with CDM O and the RD revealed: *CDM O was responsible for checking outdated food in the dry storage area. *CDM O confirmed there was a case of outdated cream of mushroom soup.  Review of the provider's revised February 2016 Food Storage policy revealed expiration dates would have been checked on a regular basis. Foods and fluids that expired would have been discarded.	F 371	Director of Dining Services or designee will audit our processes of checking refrigerators daily for labeled and out dated items; that food and dish carts are covered during transport and that dry goods are being checked for expired items. These audits will be done weekly X4 then monthly X 3. Director of Dining Services or designee will report findings to the QAPI committee monthly. QAPI committee will determine if further monitoring is needed.	4/1/16	
F 514	483.75(l)(1) RES	F 514			

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F 514 SS=D	<p>Continued From page 22</p> <p><b>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and policy review, the provider failed to identify a significant change in weight for 1 of 22 sampled residents (2). Findings include:</p> <p>1. Interview and record review on 2/11/16 at 7:30 a.m. with the director of nursing (DON) regarding resident 2 revealed: *The resident was to be weighed weekly. *The resident's weight between 7/9/15 and 2/5/16 had been between 83.6 pounds to 96.0 pounds, except for four weights that were at least 16 pounds above the range above. Those weights were: -On 8/27/15 at 9:44 a.m. 120.4 pounds. -On 8/27/15 at 2:23 p.m. 112.8 pounds. -On 1/14/16, 130.6 pounds. -On 1/21/16, 132.3 pounds. *Both weights on 8/27/15, the first weight and the</p>	F 514	<p>F 514 Records - Complete/Accurate/ Accessible</p> <p>Resident 2's incorrect weight was struck out of the record. Unable to change the events related to resident 2. <i>*All other residents' weight histories were reviewed by the dietitian. We will continue to weigh residents weekly. Nursing staff will be educated by DNS or designee on Weight and Height policy and procedure for alerting registered dietitian of significant weight change before April 1, 2016.</i></p> <p>Nursing will use our electronic system to send an alert to notify registered dietitian of significant weight changes.</p> <p>Registered Dietitian or designee will audit the process for alerting the registered dietitian of significant weight changes. The audits will be completed weekly X4 then monthly X3. The registered dietitian or designee will report to the QAPI committee on findings monthly. QAPI committee will determine if further follow up is needed.</p>	4/1/2016	

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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3901 S MARION RD</b> <b>SIOUX FALLS, SD 57106</b>		
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F 514	Continued From page 23 reweight, were out of the normal range for the resident. *The weights on 1/14/16 and 1/21/16 were not identified out of the normal range for the resident until 1/28/16. *The DON agreed the above weights out of the normal range should have been recognized and addressed.  The provider's February 2016 Monitoring Residents with Impaired Nutrition and Nutritional Risk policy revealed weight changes of three pounds in a week were to be identified and communicated to the dietary department within twenty-four hours.	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435045</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/10/2016</b>
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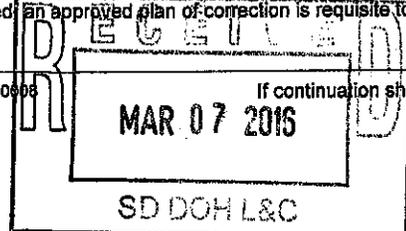
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3901 S MARION RD SIOUX FALLS, SD 57106</b>
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/10/16. Good Samaritan Society Sioux Falls Village was found not 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 and the Fire Safety Evaluation System (FSES) dated 2/10/16 upon correction of the deficiencies identified below.</p> <p>Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 032 SS=B	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain two conforming exits from the basement. Findings include:</p> <p>1. Observation at 11:00 a.m. on 2/10/16 revealed</p>	K 032		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X8) DATE <i>3-4-16</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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K 033	Continued From page 2 provider's intent to correct deficiencies identified in K000.	K 033			

