

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TYNDALL			STREET ADDRESS, CITY, STATE, ZIP CODE 2304 LAUREL STREET TYNDALL, SD 57066	
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F 000	INITIAL COMMENTS Surveyor: 35237 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/8/16 through 2/10/16. Good Samaritan Society Tyndall was found not in compliance with the following requirement(s): F274, F280, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/8/16 through 2/10/16. Areas surveyed included quality of care/treatment, resident safety, and facility staffing. Good Samaritan Society Tyndall was found in compliance.	F 000	*Addendums noted with an asterisk per 3/15/16 per email with facility administrator. JMY/SDDOH/EL	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Surveyor: 32355	F 274		

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

Julie B. Schenkel

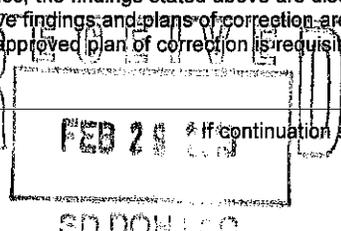
TITLE

Administrator

(X6) DATE

2/26/16

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 274	<p>Continued From page 1</p> <p>Based on observation, interview, record review, and manual review, the provider failed to identify one of one sampled resident (9) who had a significant change in condition. Findings include:</p> <p>1. Observation on 2/8/16 at 3:10 p.m. of resident 9 revealed she had been sitting in a wheelchair (w/c) and moving it down the hall without staff assistance. She had a large yellow/green colored bruise covering the right side of her face and eye.</p> <p>Interview on 2/8/16 at the time of the observation with resident 9 revealed: *She had recently fallen in her bathroom and had hit her head. That fall had required her to be transferred to the emergency department for repair of a head laceration. *Prior to her fall she had been able to: -Walk independently throughout the facility. -Get in and out of her bed without staff assistance. -Take herself to the bathroom. *Since her fall she had required staff assistance in the above areas.</p> <p>Interview on 2/9/16 at 11:00 a.m. with registered nurse (RN) F confirmed the above observations and interview with resident 9. The staff believed the resident could have returned to her previous level of independence, but since her fall she had preferred staff assistance. She had appeared to become "fearful of falling again."</p> <p>Review of resident 9's medical record revealed: *An admission date of 7/18/07. *Diagnoses of dementia (forgetfulness), osteoporosis (weakened bones), reflux, and high blood pressure. *She had fallen on 1/20/16 with an injury to her</p>	F 274	<p>In response to F274, resident number 9 has had a significant change MDS completed with an ARD date set on 2-11-16. The facility staff will continue to monitor for further significant changes through the investigation team of DNS, SSC and Administrator by daily review of the Stop and Watch alerts, incident reports and review of the 24 hour report. All staff will be educated on 3-3-16 about identifying staff of significant changes in cares. JM/SD/DH/EL</p> <p>[REDACTED]</p> <p>Upon identification of changes, MDS staff will be notified to monitor and set dates as appropriate. DNS will [REDACTED] weekly x 4 weeks, and then monthly for 3 months. This will be reported by the DNS to the QA committee monthly, the committee will determine if further auditing is needed.</p> <p>*audit randomly 10% of residents JM/SD/DH/EL</p> <p>*for condition change assessments, mobilization tool changes, care plan updates including point of care updates. JM/SD/DH/EL</p>	3-31-16

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F 274	<p>Continued From page 2 face. *Since her fall she required staff assistance with toileting, dressing, and getting in and out of bed, and walking.</p> <p>Review of resident 9's 12/8/15 quarterly Minimum Data Set (MDS) assessment revealed she had: *Been independent with transfers, walking, getting in and out of bed. *Required staff supervision with toileting. *Continent of urine. *Used a wheeled walker to get around the facility.</p> <p>Review of resident 9's 1/28/16 through 2/8/16 plan of care history revealed: *She had required staff assistance with transfers, getting in and out of bed, walking, and toileting. *She had started to become incontinent of urine.</p> <p>Interview on 2/10/16 at 8:30 a.m. with RN A regarding resident 9 revealed: *She was one of the MDS assessment coordinators. *One day a week she completed MDS assessments. *She confirmed the above observations, interviews, and record review for resident 9. *She confirmed the resident had a change in condition since her fall on 1/20/16. *The resident required an increase in staff support, and she had a change in her urine continence. *There had been no significant change in condition MDS assessment completed for the resident and one should have been done. *They had fourteen days to complete a significant change in condition MDS assessment. *They failed to identify the resident required a significant change in status assessment within</p>	F 274		
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F 274	Continued From page 3 fourteen days after her fall on 1/20/16. Interview on 2/10/16 at 8:45 a.m. with the director of nursing confirmed the above observations, interviews, and record review for resident 9. She would have expected a significant change in condition MDS assessment to have been completed on the resident. Review of the provider's October 2014 Resident Assessment Instrument manual revealed: **A significant change is a decline or improvement in the resident's status that: -"Will not normally resolve itself without intervention by staff." -"Impacts more than one area of the resident's health status." -"Requires interdisciplinary review and/or revision of the care plan." *The provider had up to fourteen days to determine whether the criteria were met for a significant change in status assessment.	F 274			
F 280 SS=D	Refer to F280, finding 1. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280			

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F 280	<p>Continued From page 4</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident's (9) care plan had been reviewed and revised to reflect the resident's significant change in condition. Findings include:</p> <p>1. Observation on 2/8/16 at 3:10 p.m. of resident 9 revealed she had been sitting in a wheelchair (w/c) and moving it down the hall without staff assistance. She had a large yellow/green colored bruise covering the right side of her face and eye.</p> <p>Interview on 2/8/16 at the time of the observation with resident 9 revealed: *She had recently fallen in her bathroom and had hit her head. That fall had required her to be transferred to the emergency department for repair of a head laceration. *Prior to her fall she had been able to: -Walk independently throughout the facility. -Get in and out of her bed without staff assistance. -Take herself to the bathroom. *Since her fall she had required staff assistance</p>	F 280	<p>*Care team members and nurses will update care plans as needed on a daily basis. JM/SDD/HJL</p> <p>In response to F280, resident number 9 care plan has been updated to reflect changes in care requiring more assistance on 2-10-16.</p> <div style="background-color: black; width: 100%; height: 100px; margin: 5px 0;"></div> <p>This will be monitored by the MDS Coordinator or designee → *will randomly audit 10% of residents weekly X4 and then monthly X3 and will be reported to the QA committee monthly, the committee will determine if further auditing is needed. JM/SDD/HJL</p> <p>*All staff were educated on 3/3/16 regarding updating of care plans, including care team members, charge nurses, and MDS coordinator.</p>	3-31-16

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F 280	<p>Continued From page 5 in the above areas.</p> <p>Interview on 2/9/16 at 11:00 a.m. with registered nurse (RN) F confirmed the above observations and interview with resident 9. The staff believed the resident could have returned to her previous level of independence. She had appeared to become "fearful of falling again."</p> <p>Review of resident 9's medical record revealed: *An admission date of 7/18/07. *Diagnoses of dementia (forgetfulness), osteoporosis (weakened bones), reflux, and high blood pressure. *She had fallen on 1/20/16 with an injury to her face. *Since her fall she required staff assistance with toileting, dressing, getting in and out of bed, and walking. *She had been continent of urine.</p> <p>Review of resident 9's 1/28/16 through 2/8/16 plan of care history revealed: *She had required staff assistance with transfers, getting in and out of bed, walking, and toileting. *She had started to become incontinent of urine.</p> <p>Review of resident 9's current comprehensive care plan revealed: *She had been independent with walking, toileting, and getting in and out of bed. *It failed to identify her: -Change in condition with required staff assistance in the above areas. -Change in urine continence status.</p> <p>Interview on 2/10/16 at 8:40 a.m. with the director of nursing and RN A regarding resident 9 revealed:</p>	F 280		
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F 280	Continued From page 6 *The interdisciplinary care team and nursing staff had been responsible for the reviewing and revising of the care plans. *They agreed all the above areas of concern and change for the resident should have been on her care plan. *Her care plan should have identified her change in status and condition. *The care plan for the resident had not reflected her current required level of care.	F 280			
F 441 SS=E	Review of the provider's August 2015 Comprehensive Care Plan policy and procedure revealed "Care plans must be revised as the resident's needs/status changes." 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 prevent the spread of infection, the facility must	F 441			

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F 441	<p>Continued From page 7 isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to maintain sanitary conditions for: *One of three observed storage rooms (100 wing) that had clean and soiled items mixed together. *Four of five randomly observed oxygen concentrator filters that had dust and foreign particles on them. *One of one crash cart containing emergency use equipment and supplies that was not clean and ready for emergency use. Findings include:</p> <p>1. Random observations from 2/8/16 through 2/10/16 of the storage room on the 100 wing revealed: *The door remained open at all observed times. *Inside of the storage room were various items including:</p>	F 441	<p>*DNS or designee will audit 100 bath room, oxygen concentrators and crash cart for proper cleaning/storing procedures weekly & then monthly x3.</p> <p>In response to F 441, the oxygen filters and crash cart cleaning have been set up on a weekly cleaning schedule. The 100 bathroom will be cleaned and will be used only for storage of clean supplies by March 4, 2016. Wheelchair cleaning will be relocated. All staff will be educated on 3-3-16 on infection control procedures and monitoring that will take place.</p> <p>Audit will be reported monthly to the QA committee by the DNS, the committee will determine if further auditing is needed.</p> <p>*Charge nurses will check and clean oxygen filters weekly. Staffing coordinator will clean crash cart weekly. Charge nurses and staffing coordinator were educated at all staff inservice JM/SDO/HJL</p>	3-4-16

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F 441	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Soiled linen and garbage carts. -Two clean commodes. -A clean over-the-bed table. -A bath tub covered with a wooden board. Attached to the tub was mechanical equipment used to clean wheelchairs (w/c). -Three transfer aides (mechanical lifts used to transfer residents). Those transfer aides were pushed up against the bath tub and the soiled linen and garbage carts. -Three cardboard boxes of pillows with one box sitting directly on the floor. <p>Interview on 2/8/16 at 4:42 p.m. with certified nursing assistant (CNA) B confirmed the storage room was used for both clean and dirty items.</p> <p>Interview on 2/9/16 at 8:00 a.m. with CNA G regarding the storage room revealed "Everything is clean that comes in here. The only thing that is dirty is the garbage and linen barrels."</p> <p>Interview on 2/10/16 at 9:00 a.m. with the director of nursing (DON) regarding the above storage room revealed she confirmed:</p> <ul style="list-style-type: none"> *The storage room was considered a room to store clean items. *The over-the-bed table and commodes were clean. *The staff had cleaned soiled wheelchairs in that room. *The transfer aides, garbage, and soiled linen carts had been stored in that room when not in use. *The box of pillows should not have been placed directly on the floor and should have been placed on a platform. *The storage room should not have contained both clean and dirty items and equipment. 	F 441		

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F 441	<p>Continued From page 9</p> <p>*The cleaning of wheelchairs had not been considered a clean task.</p> <p>*There had been potential for cross-contamination of bacteria to the residents.</p> <p>2. Random observations from 2/8/16 2:30 p.m. through 2/9/16 3:15 p.m. throughout the facility revealed:</p> <p>*Residents 2, 6, 8, and 12 had oxygen concentrators in their rooms.</p> <p>*The oxygen concentrator filters were dusty with a whitish powder noted on them.</p> <p>*Some of those oxygen concentrator filters had white particles attached to them.</p> <p>Interview on 2/9/16 at 2:10 p.m. with the DON revealed:</p> <p>*She had not realized the filters on the oxygen concentrators had required cleaning.</p> <p>*She would have expected the company who serviced the oxygen concentrators to clean the filters.</p> <p>*The company who serviced the oxygen concentrators came to the facility quarterly and as needed.</p> <p>*She confirmed the oxygen concentrator filters were dirty and needed cleaning.</p> <p>*The staff had not been expected to clean the filters.</p> <p>*She had no documentation to support when the last time the oxygen concentrators had been cleaned.</p> <p>Review of the provider's September 2015 Oxygen Concentrator policy and procedure revealed "Filter and humidifier (if used) should be cleaned once a week."</p> <p>3. Observation on 2/9/16 at 1:30 p.m. of the crash</p>	F 441		

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F 441	<p>Continued From page 10</p> <p>cart revealed:</p> <ul style="list-style-type: none"> *It had been stored in a clean room underneath multiple mechanical boxes and wires. *It had not been covered to ensure the equipment and supplies on the cart remained clean and free from dust. *It had three shelves covered with dust. This surveyor had been able to leave a finger mark and line in that dust. *On the top shelf there was a suction machine. Attached to the suction machine was an unpackaged single-use plastic tubing and yankauer (device to remove secretions from the mouth during suctioning). The tip of the yankauer was resting on top of the suction machine leg. *On the bottom shelf there was an unpackaged ambu bag (device to assist residents with breathing). Attached to the ambu bag was an unpackaged single-use mask and plastic tubing. <p>Interview on 2/9/16 at 1:40 p.m. with CNA C revealed she agreed:</p> <ul style="list-style-type: none"> *The crash cart should have been covered to ensure the equipment and supplies remained clean. *All of the plastic tubing and yankauer should have been packaged and not attached to the suction machine or ambu bag. *The ambu bag should have been placed in a plastic bag to ensure cleanliness. *Any single-use equipment not sealed in their original packages had been considered contaminated. *All supplies should have remained sealed in their original packages until they were used. <p>Interview on 2/9/16 at 1:50 p.m. with licensed practical nurse D revealed:</p> <ul style="list-style-type: none"> *She confirmed the crash cart had always been 	F 441			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TYNDALL			STREET ADDRESS, CITY, STATE, ZIP CODE 2304 LAUREL STREET TYNDALL, SD 57066		
(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	<p>Continued From page 11</p> <p>stored underneath the mechanical equipment. *She would have expected to find the crash cart and equipment covered to ensure cleanliness. *She could not remember the last time the suction machine and ambu bag had been used. *She would not have expected to find the single-use supplies out of their original packages and attached to the suction machine and ambu bag. Those items would have been considered contaminated. *No staff had been responsible for checking the crash cart to ensure it was clean, properly stored, covered, and ready for emergency use. *The person who had last used the crash cart would have been responsible to ensure it was properly set-up and ready-to-use for the next emergency.</p> <p>Interview on 2/9/16 at 2:10 p.m. with the DON revealed she confirmed: *The above interview information. *The crash cart was dirty and should have been covered. *All single-use supplies should have remained sealed in their original packages until they were used. *Those supplies would have been considered contaminated. *There was potential for cross-contamination and the spreading of bacteria from one resident to another.</p> <p>The provider had no policy or procedure for the staff to follow when using single-use supplies.</p> <p>The provider had no policy or procedure in place for the staff to follow to ensure the crash cart had been properly stored, covered, clean, and ready for emergency use.</p>	F 441			

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

PRINTED: 02/16/2016
FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TYNDALL			STREET ADDRESS, CITY, STATE, ZIP CODE 2304 LAUREL STREET TYNDALL, SD 57066		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

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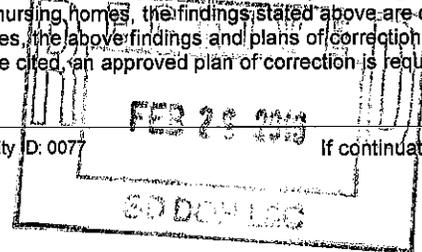
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TYNDALL			STREET ADDRESS, CITY, STATE, ZIP CODE 2304 LAUREL STREET TYNDALL, SD 57066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/9/16. Good Samaritan Society Tyndall 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
Julie B. Schenkel

TITLE
Administrator

(X6) DATE
2/26/16

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.



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/10/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TYNDALL	STREET ADDRESS, CITY, STATE, ZIP CODE 2304 LAUREL ST TYNDALL, SD 57066
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S 000	Compliance/Noncompliance Statement Surveyor: 35237 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/8/16 through 2/10/16. Good Samaritan Society Tyndall was found not in compliance with the following requirement(s): S169 and S236.	S 000	*Addendums noted with an asterisk per 3/15/16 per email with facility administrator. JM/SDDOH/EL	
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: 32331 Based on observation, interview, testing, and policy review, the provider failed to ensure the safety of residents from possible burns and/or fire for one of one portable space heater (dietary manager's [DM] office. Findings include: 1. Observation and interview on 2/9/16 at 8:20	S 169		

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

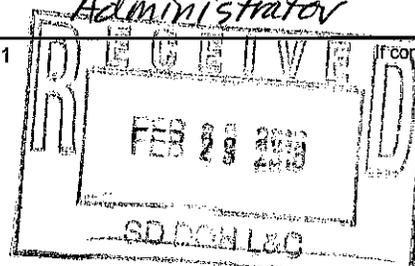
Julie B. Schenkue

TITLE

Administrator

(X8) DATE

2/26/16



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10695	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/10/2016
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S 169	<p>Continued From page 1</p> <p>a.m. with the DM in the her office revealed: *A Lasko portable space heater located on the floor next to an open, filled wastepaper basket. *That space heater was plugged into an outlet and operating. *The DM stated she had needed the space heater, because it had been cold in her room. *She had not been aware space heaters were not allowed in nursing facilities.</p> <p>Observation, testing, and interview on 2/10/16 at 8:40 a.m. with the DM and maintenance assistant E in the DM's office regarding the portable space heater revealed: *The DM reported the space heater had been moved to the provider's garage. *Both the maintenance assistant E and the DM agreed space heaters were not to have been used in the facility as it was a safety risk for possible burns and/or fire.</p> <p>Interview on 2/10/16 at 9:00 a.m. with the director of nursing confirmed portable space heaters were not to have been used in the facility, as it was a safety risk for possible burns and/or fire.</p> <p>Interview on 2/10/16 at 9:25 a.m. and 9:35 a.m. with the maintenance supervisor revealed: *He confirmed portable space heaters were not to have been used in the facility. *The provider had no policy on the usage of space heaters in the facility except during a blizzard.</p> <p>Interview on 2/10/16 at 10:00 a.m. with the administrator confirmed: *Portable space heaters were not to have been used in the facility, as it was a safety risk for possible burns and/or fire. *She stated the only exception for usage of space</p>	S 169	<p>In response to S169, the space heater has been removed from the Dietary office on 2-9-16. An existing wall heater for that area is being repaired to provide proper temperatures. On 3-3-16, all staff will be educated that the use of space heaters is prohibited in nursing facilities. Staff will be educated and asked to report any questionable pieces of equipment to the Maintenance Director. The Maintenance Director will audit the monthly preventive maintenance checks and report to the Safety committee for the next 4 months. Safety committee will report to QA committee monthly and determine if further auditing is needed.</p>	3-4-16

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY TYNDALL	STREET ADDRESS, CITY, STATE, ZIP CODE 2304 LAUREL ST TYNDALL, SD 57066
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S 169	Continued From page 2 heaters would have been in the event of a blizzard according to the provider's policy. Review of the provider's revised January 2013 External Disasters: Blizzards policy revealed: *The purpose was to have protected residents and staff in the event of blizzard conditions. *Necessary precautions were to be taken if space heaters were being used. *Those precautions had included locating them well away from any flammable materials.	S 169		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB	S 236		

South Dakota Department of Health

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S 236	<p>Continued From page 3</p> <p>blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure two of six newly admitted sampled residents (6 and 11) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of admission. Findings include:</p> <p>1. Review of resident 6's medical record revealed: *An admission date of 8/4/15. *A one-step TB skin test had been completed on 10/29/15. *The TB skin test had not been completed fourteen days after admission.</p> <p>Interview on 2/9/16 at 2:45 p.m. with licensed practical nurse D regarding the TB screening for resident 6 revealed: *There was a documented one-step TB skin test on 10/29/15. *She had no documentation that a two-step TB skin test had been given. *She confirmed the resident had been admitted on 8/4/15. *The nursing staff were responsible for the resident's TB skin tests to have been given in a timely manner.</p> <p>Interview on 2/10/16 at 10:00 a.m. with the director of nursing (DON) regarding the TB screening for resident 6 revealed: *She was unsure why she had not received a two-step TB skin test.</p>	S 236	<p>In response to S236, for residents 6 and 11, 2-step TB skin tests have been completed on 2-25-16. The 2-step PPD will be set up on each new resident's MAR to be completed within 14 days by the HIM or charge nurse. The PPD's will be completed by the assigned nurses. [REDACTED] educated on procedure on 3-3-16. The DNS will monitor and audit all new residents for the next 4 months and report to the QA committee monthly.</p> <p><i>*All staff including charge nurses and HIM were JM/SDDO/H/EL</i></p>	3-4-16
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S 236	<p>Continued From page 4</p> <p>*She agreed she had not had a skin test within fourteen days of her admission. *That TB skin test had not followed the state guidelines for TB screenings for new admissions.</p> <p>Surveyor: 35237 2. Review of resident 11's medical record revealed: *He was admitted on 1/22/16. *His first TB skin test had been completed on 1/23/16. *There was no record a second TB skin test had been completed.</p> <p>Interview on 2/10/16 at 9:00 a.m. with the DON regarding resident 11 revealed: *She was unsure why he had not received a second TB skin test. *He should have had a two-step TB skin test within fourteen days of his admission.</p> <p>3. Review of the provider's revised November 2014 Screening of Residents for Tuberculosis policy revealed: **Prior to (within three months or per specific state regulation) or upon admission, residents will receive the two-step method for baseline screening of TB." **"A two-step Mantoux method should be used for TST [tuberculin skin test] when testing in the care center. This involves administering the initial upon admission, which is read within 48 to 72 hours by a nursing professional or a physician. If the first TST is negative, the second test should be placed one to three weeks after the placement of the first test. The second test is read 48 to 72</p>	S 236		
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S 236	Continued From page 5 hours after administration."	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 35237 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 2/8/16 through 2/10/16. Good Samaritan Society Tyndall was found in compliance.	S 000		