STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/27/22 through 6/30/22. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F584, F625, F656, F677, F725, F744, F761, F803, F835, and F880. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/27/22 through 6/30/22. Areas surveyed included Quality of Care/Treatment and Dietary Services. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F677, F725, F803 and F835.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or a greement 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 the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584	On 7/19/2022, the all mechanical lifts were cleaned the protective covering inspected and repaired as needed. On 7/21/22, the City View water fountain was taken out of service. On 7/22/2022 the wall paper in t he south elevator was repaired. Replacement is scheduled for 9/20/2022. All residents have a potential to be affected by deficient practice. By 7/29/2022 all resident rooms were inspected, cleaned and tidied. To ensure the deficient practice will not recur, on 7/14/2022, supervisor of ancillary services provided education to environmental services technicians regarding deep cleaning schedule, routine cleaning expectations, and how to report maintenance concerns. On 7/19/2022, Administrator provided education to all staff on their roles and responsibilities in providing and maintaining a pleasant home and atmosphere, and how to complete a work order. During new hire orientation, supervisor of ancillary services or designee will provide education on how to complete a work order and their duty to provide and maintain a pleasant home and atmosphere.	7/29/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/12/2022

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 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to have a system to maintain the resident environment in a neat and tidy manner with: *Cleanable surfaces and ability to maintain one of one mechanical stand lift, one water fountain on the City View hallway, and wallpaper in the south elevator. *The tidiness of resident rooms on City View and Memory Lane for 12 of 18 sampled residents (1, 9, 15, 20, 26, 46, 50, 54, 55, 57, 66, and 67). Findings include: 1. Observation on 6/27/22 at 3:46 p.m. of resident 55's room revealed:	F 584	Administrator or designee will audit by observation and resident interview 10 rooms to ensure tidiness, and audit work orders to ensure requested maintenance was completed per policy. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. Administrator or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	

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F 584	Continued From page 2 *The bed was not made, and several fitted sheets were sitting on top of the mattress in crumpled heaps. *There were many books scattered around the room; several books on top of the bed, recliner, and furniture, and books completely covering two tables in the room. 2. Observation on 6/27/22 at 3:59 p.m. of resident 9's room revealed: *There were items on the floor including at least three separate piles of food crumbs, a surgical face mask, a broken plastic medicine cup, and a stack of folded clothes. 3. Observations at the below dates and times of resident 26's room revealed: *On 6/27/22 at 4:00 p.m. there were three packages of incontinent briefs on top of a wheelchair and bedside commode in the room, two vases of dried flowers were on the dresser beside the TV, and parts of the dried flowers and leaves were on top of the dresser. *On 6/28/22 at 9:30 a.m. the packages of incontinent briefs and the dried flowers were still present. *On 6/29/22 at 10:00 a.m. the packages of incontinent briefs were still present. 4. Observations at the below dates and times of residents 46 and 66's shared room revealed: *On 6/27/22 at 4:10 p.m. there was paper litter scattered across the floor, resident personal care items were on top of the dressers, and a layer of dust was on the dressers and bedside tables. *On 6/28/22 at 9:30 a.m., the condition of the room remained the same. *On 6/29/22 at 8:30 a.m., the floor had been swept and mopped, however the rest of the room	F 584		

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F 584	Continued From page 3 remained the same. 5. Observation and interview on 6/27/22 at 4:15 p.m. with resident 54 in his room revealed: *Most of the time the staff forgot to change the bed sheets. *He had to ask someone to change the bed sheets. *The May 2022 activity calendar was still hanging on his bulletin board. *The June 2022 activity calendar was taped to the outside of his door. *There was a soggy pile of wet tissue paper on the bathroom floor. 6. Observations on the below dates and times of resident 50 revealed: *On 6/27/22 at 4:30 p.m., her wheelchair armrests were cracked, which resulted in an uncleanable surface. There were food stains on the wheelchair cushion cover. *On 6/28/22 at 12:15 p.m., the wheelchair armrests and cushion cover were noted in the same conditions and her overbed table was soiled with dried water and food spots. *On 6/29/22 at 11:10 a.m., the conditions of the wheelchair and the overbed table remained the same. Interview on 6/29/22 at 11:15 a.m., with environmental services technician (EST) H revealed she: *Explained "I didn't get in [resident 50's room] yesterday because she would not let me in her room." *Asked, "Do they have a right to do that?" *Had to "go to the social worker once before because she wouldn't let me clean." *Cleaned the overbed tables daily. She was not	F 584		

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F 584	Continued From page 4 responsible for the wheelchairs. Interview on 6/29/22 at 4:50 p.m. with supervisor of ancillary services (SAS) G revealed he was not aware of the condition of resident 50's wheelchair armrests and confirmed the nursing or housekeeping staff should have reported that. 7. Observations at the below dates and times of resident 1's room revealed: *On 6/27/22 at 4:30 p.m.: -There were personal care supplies on the dressers. -Her bulletin board was dangling on the wall by one screw. -The overbed table had an unknown sticky substance on approximately one-half of it. A partial box of gloves was on the overbed table. -Two vases of flowers were on her bedside table. The flowers were dry with petals and leaves falling on top of an oxygen concentrator which was next to the bedside table. -No other residents resided in the room, but the extra bed in the room was unmade. -A suction machine was on the bedside table. A partial roll of toilet paper was on the shelf under the suction machine. *On 6/28/22 at 8:45 a.m., resident 1's room was in the same condition. EST AA was cleaning a spill off the floor near the window. *On 6/29/22 at 9:30 a.m.: -There were personal care supplies on the dressers. -Her bulletin board was dangling on the wall by one screw. -Two vases of flowers were on her bedside table. The flowers were dry with petals and leaves falling on top of an oxygen concentrator which was next to the bedside table.	F 584		

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F 584	Continued From page 5 -The other side of the room had been cleaned and extra items were removed. 8. Observation on 6/27/22 at 5:13 p.m. in the hallway between rooms 228 and 230, the mechanical stand lift had a crumpled tissue sitting on the base, the protective covering around the base was chipped away which exposed sharp edges, and there was an unknown reddish-brown discoloration on the foot base. 9. Observation on 6/27/22 at 5:16 p.m. revealed the water fountain on City View had rust and mineral buildup around the waterspout. When the button was pressed only a small trickle of water came out from the fountain. 10. Observation on 6/28/22 at 8:21 a.m. in the south elevator revealed a 12-inch by 12-inch "L" shaped tear in the wallpaper. The wallpaper was easily pulled back which revealed an unknown blue sticky substance used to hold the wallpaper in place. 11. Interview on 6/28/22 at 8:24 a.m. with resident 9 revealed: *Staff did not fold or put away clean laundry or tidy up her room. She needed to ask staff to assist her with putting laundry away. Staff encouraged her to complete the task on her own. *The crumbs and broken plastic medicine cup were still on the floor from the previous day. *There were more stacks of folded clothes in the bathroom sink, on top of her bedside table and dresser. 12. Interviews on 6/28/22 at 8:26 a.m. and 10:41 a.m. with lead environmental services technician (LEST) Q revealed:	F 584		

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F 584	Continued From page 6 *A "full room cleaning" was done after a resident was discharged. *Necessary repairs were reported to SAS G and recorded in the maintenance book. *She would also notify maintenance if a room was "cluttered" with personal belongings on the floor. *She was responsible for cleaning the rooms on the lower level. *The housekeepers assigned to the upper-level rooms "should be tracking and scheduling rooms for full cleaning." 13. Observation and interview on 6/28/22 at 8:50 a.m. with resident 15 revealed: *The wall behind her recliner had multiple gouges and scrapes exposing the sheetrock. *She had reported her chair was "too close to the wall most of the time." Interview on 6/29/22 at 11:39 a.m. with EST H revealed she: *Reported repairs to maintenance mechanic (MM) I, or SAS G, or wrote the repair requests on the maintenance sheet. *Said, "Thank you for letting me know about [resident 15's] wall, I'll make sure to write it down." Observation and interview on 6/29/22 at 3:55 p.m. with SAS G and resident 15 revealed: *SAS G was not aware of the condition of the wall behind resident 15's recliner. *Resident 15 told him the condition of the wall was because "the chair gets pushed back too far." *He told her he would repair and paint the wall while she temporarily moved to another room until the paint vapors were gone.	F 584		

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F 584	Continued From page 7	F 584		

14. Observation and interview on 6/28/22 at 9:00 a.m. with EST AA revealed she was cleaning up the floor in resident 1's room. She stated there was a sticky spill under the window. She was in that room until approximately 10:00 a.m. She did not answer surveyor's questions regarding how often each room was cleaned and what cleaning was completed each day.

Observation and interview on 6/29/22 at 9:07 a.m. with LEST Q revealed:
*EST AA was not working that day.
*She and EST H were cleaning the rooms in the south part of City View.
*Usually, it was ESTs H and AA who worked on the second floor, and she worked on the first floor.
*She stated rooms were cleaned daily.
*She agreed that the rooms on the south part of City View looked like they had not been cleaned thoroughly for a few days.
*There was a lot of debris on the floors, under the beds, and the floors had been mopped.
*She stated, "Need to talk to [name] SAS G" about duties the ESTs were supposed to do. She continued with, "The room cleaning has been a problem for a while now."

An interview on 6/29/22 at 9:17 a.m. with certified nursing assistant (CNA) O revealed the EST assigned to the south part of City View was not particularly good. The rooms always looked bad.

Interview on 6/30/22 at 6:00 p.m. with SAS G and administrator A revealed:
*They were aware of the cleaning problems with EST AA.
*SAS G stated he did not complete any audits to ensure resident rooms were cleaned per policy.

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F 584	Continued From page 8 *Administrator A stated more training needed to be completed. 15. Observation and interview on 6/28/22 at 9:36 a.m. with resident 67 revealed: *His recliner was reclined as far back as it could go against the wall. *He explained the "nurses move the chair" too close to the wall. *He kept shifting in his chair during the conversation and said he would be more comfortable if his chair would recline more. Observation and interviews on 6/29/22 at 3:55 p.m. with SAS G and resident 67 revealed, *The recliner was away from the wall at that time. *Resident 67 confirmed, "it gets pushed back too far." *SAS G said he would find a way to prevent the chair from sliding back too far. *He confirmed either housekeeping or nursing staff should have reported this as a concern. 16. Observation and interview on 6/28/22 at 10:47 a.m. with resident 20 in her room revealed: *There was no toilet paper on the toilet paper holder next to the toilet. *There were three toilet rolls which were wrapped and in a holder under the sink. *The resident stated: -The toilet paper holder had been that way "for days" and she had discussed this with director of nursing (DON) B and received the reply "I'll watch that." -She regularly attended resident council meetings and had mentioned concerns repeatedly. After discussion of the provider's response, the resident stated, "nothing ever gets done."	F 584		

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F 584	Continued From page 9 17. Observation on 6/28/22 at 12:58 p.m. of resident 57 in his room revealed: *A phone cord was laying across the floor from his dresser to his overbed table. The phone cord was in the walking space. *Books were stacked on the bedside table, and several books fell to the floor when he reached for a book. -He almost fell out of his wheelchair when he tried to catch the falling books. *Several books were sitting on the bed, in a box on the floor, and stacked in piles on the floor next to the box of books. *A used plastic medicine cup, an unknown black substance, and his denture brush were found sitting in his bathroom sink. *Red stains which looked like blood were on his pillowcase. 18. Interview on 6/29/22 at 11:34 a.m. with EST H revealed: *If she saw a problem, she would write the issue in the maintenance request book, or directly inform SAS G or MM I of the issue. *The CNA cleaning tasks included cleaning catheter bags, sanitizing lift equipment and resident wheelchairs, and cleaning/removing urine and feces. *The housekeepers sanitized the areas and surfaces that had urine or feces on them. *The housekeeping department: -Was responsible for smaller cleaning, like wiping down the overbed tables, and cleaning spills/crumbs/stains on the floors or furniture. -Rotated which rooms were deep cleaned. She selected two or three of the dirtiest rooms and deep cleaned those each week. She indicated she tried to deep clean each resident's room at least two to three times per month.	F 584		

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F 584	Continued From page 10 -Did not have a system for tracking which rooms had been deep cleaned or when the room was deep cleaned. *SAS G or MM I wrote maintenance issues and requests in their logbooks. Interview on 6/29/22 at 3:54 p.m. with SAS G revealed: *They did not have a system of tracking which rooms had been deep cleaned. *He mentioned he was going to implement a tracking form after the survey was completed. *Staff would verbally let him know if something needed to be repaired in a resident's room and he wrote the concerns in his logbook. *Each housekeeper picked two of the dirtiest rooms on their assigned floor and deep cleaned the rooms once per week. On 6/29/22 on the requested facility information form, surveyors requested a deep cleaning policy for resident rooms and a schedule for deep cleaning. However, neither was provided by the end of the survey on 6/30/22. 19. Review of the policy and procedure for work orders dated 1/14/22 revealed: *Under background, "efficiency in work can only be achieved if all work that needs to be done is identified...work orders provide a source for collecting and analyzing this information." *Under policy, "management will document work orders" on a specific form or software system. *Under procedure: -"Encourage residents to request maintenance work using" one of two forms. A verbal request "should be transferred" to a work order form or software system. -"Staff members should submit maintenance	F 584		

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F 584	Continued From page 11 requests on" a work order form or software system. *Under assigning work orders and follow-up: -"Prioritize the work orders based on the type of work and whether the request was generated by the resident. Give consideration to work orders that are more than 72 hours old." -"Respond to all resident requests within 24 hours with either a fix or a plan of action." 20. Review of the provider's revised 10/19/21 Environmental Cleaning Principles policy revealed: *The policy mainly reviewed cleaning related to infection control. *It defined high touch areas, low touch areas, semi-critical items, and non-critical items. *Roles and responsibilities of environmental cleaning in the infection control program. -"Environmental cleaning plays an important role in an infection control program. While most infections result from person-to-person transmission, the spread of infections from contaminated surfaces is significant and supports the need for good procedures and practices related to cleaning and disinfecting of surfaces." -"All staff members play a role and should be aware of the general principles of environmental cleaning and safety." *There were no procedures on how to or how often to clean resident rooms and common use areas. *The was no procedure on how often to complete deep cleaning of each resident's room.	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

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F 625	Continued From page 12 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and document review, the provider failed to provide bed-hold written notice at the time of transfer for one of one sampled resident (69). Findings include: 1. Review of the electronic medical record for resident 69 revealed: *She was sent to the hospital on 4/3/22. *There was no documentation that she or her	F 625	On 7/15/22, Social Services director updated transfer packets to include bed hold notice to be provided at the time of transfer and provided education to floor nurses. Any resident who transfers to the hospital or goes on therapeutic leave has the potential to be affected by the deficient practice. To ensure the deficient practice will not recur, on 7/19/22, social services director updated the facility protocol for issuing and follow-up on bed-hold notices. On 7/19/22, social worker and Administrator provided education on protocol to licensed nurses. During orientation for new hire nurses, social services director or designee will educate on how to issue written bed-hold notice in the event of a transfer. Administrator or designee will audit by documentation review the chart of any resident who transferred or went on therapeutic leave, in the prior 7 days, to ensure written bed hold notice was provided at the t ime of transfer. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. Administrator or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/19/2022

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F 625	Continued From page 13 representative had been offered a bed-hold. Interview on 6/30/22 at 2:18 p.m. with social services supervisor C regarding bed-holds when a resident was sent out of the facility revealed: *The social service employees were responsible to issue the bed-hold notices. *They did not usually issue bed-hold notices because usually the bed would just be held for the resident until their return. *If a resident had Medicaid as a payer source the bed would have been held for five days and then the family would have been contacted regarding the bed-hold. *If a resident was private pay the bed would be held and the family would have been contacted. *She did not expect the charge nurses to issue a bed hold notice when transferring a resident out as they had a lot of contracted nurses and their workload was already too busy. A bed-hold policy had been requested on 6/30/22 from administrator A but had not been received by the end of the survey.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656	On 7/22/2022, IDT met with front-line staff to review and updated care plans for residents 9, 13, 30, and 50. All residents have the potential to be affected by deficient practice. By 7/29/2022 the interdisciplinary team will review all resident care plans to ensure they accurately reflect the residents current condition. To ensure the deficient practice will not recur, on 7/19/2022 the Administrator provided education to all staff about their roles and responsibilities for identifying individual needs and implementing appropriate individual interventions or approaches to care including accessing the kardex, reporting changes, where to find information about care plan updates. During new hire orientation, MDS coordinator or designee will provide education on accessing the kardex, reporting changes, and where to find information on care plan updates. DNS or designee will audit by documentation review, resident observation and staff interview, 5 residents to ensure care plans reflect current needs and	7/29/2022

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F 656	Continued From page 14 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to develop, revise, or implement person-centered care plans for 4 of 15 residents (9, 13, 30, and 50) reviewed. Findings include: 1. Observation and interview on 6/28/22 at 8:43 a.m. of resident 30 revealed:	F 656	interventions. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. DNS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions	

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F 656	Continued From page 15 *He was standing up between his wheelchair and the front of his recliner leaning forward towards his bed. *Wet underwear was hanging on a folded walker in the corner of the room next to the dresser. *He reported he was "looking for shorts [underwear]" that he had put on the bed "last night to put them on today." Interview on 6/28/22 with certified medication assistant (CMA) Z revealed: *At 8:47 a.m.: -Resident 30 had told her he was going to dress himself. -She was not aware he could not find his underwear. -She explained, "we let him do what he can." *At 8:57 a.m., after she helped him get dressed: -She did not find any clean underwear for him to wear. -He told her he liked to wash his underwear because they have been lost when he sent them to laundry. -He agreed to put on incontinence briefs. Observation and interview on 6/29/22 at 11:23 a.m. with resident 30 revealed he was wearing the same "pajamas" (sweatpants) as yesterday. It was the only pair he had. Review of resident 30's medical record revealed: *The 5/19/22 5-day Medicare Minimum Data Set (MDS) assessment noted that he: -Had memory problems, disorganized thinking, poor decision-making. -Needed supervision for decision-making and weight-bearing assistance for transferring and dressing. -Had a urinary catheter.	F 656		

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F 656	Continued From page 16 *The care plan directed staff to: -Cue and supervise tasks related to his cognitive impairment, initiated on 4/7/22. -Provide one staff assist for dressing, initiated on 3/30/22, and a stand-by assist for transferring between surfaces, initiated on 5/25/22. -Empty Foley catheter every shift, initiated on 5/25/22. *A 5/25/22 incident progress note documented the catheter had been removed during a urology appointment that day. Interviews with staff confirmed the care plan had not been implemented and revised: *On 6/29/22, laundry technician (LT) F reported: -At 11:53 a.m., she "wasn't aware he was missing underwear, but I thought he didn't wear them." She also did not know about his missing pants. -At 1:30 p.m., she and CMA Z confirmed he had only one to two pairs of underwear, and they found three pairs of soiled long pants in his dresser drawer. *On 6/30/22: -At 2:20 p.m., certified nursing assistant (CNA) S confirmed he needed at least one person to supervise his dressing and transferring, "He acts like he can be more independent, but he doesn't remember to call for help and do things safely." -At 4:40 p.m., clinical care leader (CCL) U reported: --Staff should have been supervising him, but "I don't recall what is on the care plan. The standard is for staff to round every 2 hours." --He was "not the safest with transfers," and they had "posted reminders for him to use the call light. Sometimes those help." --"Originally, the thought was that he would return home after therapy, and staff were to encourage him to do for himself. He now is for sure	F 656		

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long-term care."
--The care plan should have been revised once the catheter was removed.
-At 6:15 p.m., social worker (SW) W agreed he needed to be more supervised.

2. Observation and interview on 6/28/22 at 8:40 a.m. revealed:
*Resident 50 laying on her bed in a relaxed curled position on her right side with her back facing the door.
*Her door was partially open, and she did not respond to a gentle knock on the door.
*CMA Z walked by at that time and commented she had been awake most of the night.

Observation and interview on 6/28/22 at 12:00 p.m. revealed:
*Resident 50 was heard yelling loudly behind her closed door.
-Staff voices were also heard talking.
*Upon leaving her room, CMA Z reported resident 50 had been yelling while she and another staff member changed and dressed her.
-CMA Z had "woke her up for lunch," and "she could sleep 24 hours."
-Her hair was not combed, and her demeanor appeared angry.
*When resident 50 was asked about combing her hair and whether she was hungry, she replied with a series of words that did not form complete sentences and did not relate to the topics posed to her.
-CMA Z then commented that she refused to have her hair combed and did not agree to go to lunch.

Observation and interview on 06/29/22 at 11:10 a.m. revealed:

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F 656	Continued From page 18 *Resident 50 sitting in a wheelchair just inside her room. *Hair was combed but oily. *She smiled and carried on a conversation that was mostly not understandable due to a mixture of words and phrases that did make a complete sentence. Review of resident 50's assessment revealed: *The 12/02/21 annual MDS noted: -She had severe cognitive impairment and physical and verbal behaviors 1-3 days a week. -It was very important for her to choose her bedtime. -She needed weight-bearing assistance of 1-2 persons for most daily tasks. *The 6/1/22 quarterly MDS noted an increase in most daily behaviors that interfered with care. *The 6/1/22 MDS physical and verbal behaviors interfere with care and reject care 4-6 days, wandering 1-3 days interferes with residents. Memory problems, no recall. Extensive assist of 2+ person for need mobility, transfers, dress, toilet, and hygiene. Behavior CAA implications and rationale for care plan decision not documented, only decrease physical aggression. Review of resident 50's care plan revealed: *The goal for behaviors due to cognitive function, revised on 12/10/21, for "no further episodes of physical aggression." *The interventions for behaviors had not been revised and were not specific to her cognitive functional capabilities, including: -Revised on 12/10/21, provide "necessary cues-stop and return later if agitated. ALWAYS LET HER KNOW WHAT YOU PLAN TO DO, USE SLOW/CALM APPROACH." -Initiated on 12/17/18, "Break tasks into one step	F 656		

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F 656	Continued From page 19 at a time." -Revised on 6/5/20, "Cue, reorient and supervise as needed." -Revised on 1/28/22, "Redirect/reassure as needed. Requires much redirection while at meals and often wheels away from table." *The goal for activities of daily living (ADL) performance deficit, revised on 12/10/21, was to improve her level of self-performance without consideration to her cognitive capabilities. *The interventions for ADLs did not provide person-centered approaches to honor her preferences in keeping with her cognitive capabilities, including: -For bathing, revised on 3/4/22, directed, "She is often resistive to cares, refuses baths often. Don't say 'Bath' - just tell her to come along with you - bring into the tub room backwards. Reapproach later if needed. If [resident] is in a good mood try to give Bath even if it is not her scheduled day." There were no person-centered alternatives for the resident to bathe. -For eating, revised on 3/2/22, directed, "RESIDENT HOARDS FOOD IN ROOM - CHECK Q [every] SHIFT .... Encourage to come to DR [dining room] for meals." *The care plan did not address her preference for choosing when to sleep. Interviews with staff on 6/30/22 revealed: *At 2:20 p.m., CNA S said resident 50: -Resists most cares, is sometimes asleep all day and will then be awake during the night and may let her brief be changed while she stays in bed, but she usually rejects that. -She does not eat a meal when it is delivered to her room. She plays with it and mixes other things into it. When she doesn't eat her meals, she will look for food when she decides she is	F 656		

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hungry.
*At 5:07 p.m., CCL U confirmed resident 50 resisted care but:
-Had no response when asked how staff should accommodate her person-centered routines to reduce the frequency of behaviors.
-Did not respond when asked about bringing resident 50 into the tub room backwards.
-Agreed staff should follow her lead with routines for the least amount of aggression.
---Did not like letting her sleep without being changed.
*At 5:33 p.m., LPN E said:
-Resident 50 will put her foot down to keep from going into the tub room.
-Other methods for baths could be offered.
-Staff should offer care to resident 50 but not make her do them when she is unwilling, like waking her up for lunch.
*At 6:15 p.m., SW W affirmed that:
-Waking her up was not good.
-Going backwards into the tub room was not appropriate and there were other ways for her to keep clean.
-Letting resident 50 lead the timing of task activity was better than trying to convince her to do things, including going to the dining room and eating.
3. Review of resident 13's 6/20/22 care plan revealed she:
*Was admitted to the facility on 7/24/20.
*Had moderately impaired cognition with a brief interview for mental status (BIMS) score of 9 out of 15.
*Had started taking an antipsychotic medication on 1/10/22 while in the hospital, which had been prescribed for agitation.
*Had experienced numerous fractures from falling since her comprehensive, annual

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F 656	Continued From page 21 assessment on 7/28/21: -Left arm (humerus bone) fracture on 11/14/21. -Right arm (humerus bone) fracture on 1/8/22. -Right leg (femur bone) fracture on 3/13/22. *Needed assistance to complete her activities of daily living: -Required extensive assistance of two staff persons to assist her with bed mobility. -Required extensive assistance with dressing and personal hygiene. --The number of staff needed was not clarified. -Required the assistance of one staff person with bathing, toileting, and transferring. --The amount of assistance was not clarified. -Required set-up assistance and cueing with oral care and eating. A review of resident 13's most recent Omnibus Budget Reconciliation Act (OBRA) required MDS assessment, her third quarterly review assessment dated 4/20/22 revealed she had required extensive assistance of two staff persons for transfers, dressing, toilet use, and personal hygiene. A review of resident 13's OBRA comprehensive annual assessment, dated 7/28/21, revealed she: *Had needed limited assistance of one staff person for bed mobility, dressing, and toileting. *Had needed only supervision of one staff person for personal hygiene and walking in her room. Interview on 6/30/22 at 1:40 p.m. with CCL L revealed: *She had worked at the provider for the past 23 years. *She was one of the provider's two registered nurses responsible for completing both types of MDS assessments of residents:	F 656		

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F 656	Continued From page 22 -The required OBRA MDS assessments. -The Prospective Payment System (PPS) MDS assessments required for Medicare payment purposes. When discussing the MDS assessment process and how a significant change in a resident's status was identified, CCL L stated: *A significant change must have been identified in more than one area. *The change was not the result of a short-term illness. She stated the provider had a "Quality of Life (QOL)" meeting every month, which included the interdisciplinary team (IDT) and the medical director. She revealed the monthly QOL meeting tended to "cover it all," including a review of current residents': *Status, activity level, and any significant changes. *Who had experienced a fall. *Behaviors that affected others. *On psychotropic medications. CCL L stated the QOL meeting ended with a review of those residents identified by the IDT team as "frequent fallers." Continued interview with CCL L regarding resident 13 revealed: *She was "very confused." *The IDT team had identified her as a "frequent faller." *Confirmation she had broken both her arms and her right leg in the last year. -She declined with her first fracture, her broken left arm, in November 2021. -Since January 2022's second fracture, her broken right arm, she has been "going downhill." -Since March 2022's right broken hip, she further declined.	F 656		

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F 656	Continued From page 23 -Before these fractures, she had been doing crafts and crocheting in her room. --She no longer did these activities. *She was hospitalized following each of the three fractures. Continued interview with CCL L regarding resident 13's MDS assessments revealed CCL L: *Agreed resident 13's level of assistance with most of her ADLs had significantly changed from limited assistance with one staff person on her OBRA 7/28/21 comprehensive annual MDS assessment to extensive assistance requiring two staff persons on her most recent OBRA 4/22/22 quarterly review MDS assessment. *Was not sure if one of the Medicare PPS five-day MDS assessments completed after each of her three hospitalizations was also an OBRA significant change assessment. *Agreed that each of the three quarterly review MDSs, completed in the last year had changes in her status but stated the IDT team anticipated resident 13's therapy services would have recovered those losses and she would "bounce back" to her prior level. *Stated scheduling the OBRA quarterly review MDSs and the PPS Medicare five-day MDSs "throws us off." *CCL L stated she would discuss this resident's status with the IDT team and determine when the significant change had occurred. A subsequent review of resident 13's scheduled MDSs revealed that none of the MDSs completed after the OBRA 7/28/21 comprehensive annual MDS assessment had been identified as a significant change in status assessment. 4. Observation and interview on 6/28/22 at 10:35 a.m. with resident 9 revealed:	F 656		

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F 656	Continued From page 24 *She was seated in her electric wheelchair with a seatbelt secured loosely around her waist. *She had a below-the-knee amputation of her right leg. *She usually wore a prosthetic, but her doctor told her not to wear it for two weeks due to an abrasion on the amputated limb. Review of resident 9's medical orders confirmed: *A doctor's order for "No RLE [right lower extremity] prosthetic use for 2 weeks" which started on 6/17/22 and had an expiry date of 7/1/22. Review of resident 9's care plan did not indicate that her prosthetic should not be worn for two weeks.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure activities of daily living (ADL) had been provided for 9 of 18 sampled residents (1, 13, 16, 26, 30, 46, 50, 66, and 67) on Memory Lane and City View. Findings include: 1. Observation on 6/27/22 at 3:45 p.m. of resident 26 revealed she was lying in bed. She had bruising to her entire face along with a large bump on her right forehead. That bump had dried blood on it. Her hair was noted to be very tangled	F 677	By 7/22/2022, residents 1, 13, 16, 26, 30, 46, 50, 66 and 67 have received proper ADL care including oral and nail care. Resident 16 has since passed away. Residents who are dependent of staff for ADLs have the potential to be affected by deficient practice. To ensure the deficient practice will not recur, on 7/19/22, the Administrator provided education to all staff about their roles and responsibilities for identifying individual needs, implementing appropriate interventions, and ensuring needs are consistently being met. During new hire orientation, DNS or designee will provide education for expectations for consistently meeting residents ADL needs. DNS or designee will audit by documentation review, resident observation and staff interview, 10% of ADL dependent residents to ensure consistent delivery of ADL care. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. DNS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/29/2022

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F 677	Continued From page 25 and matted on the back of her head. Observation on 6/28/22 at 8:35 a.m. revealed resident 26 with the head of the bed raised. She attempted to eat her breakfast but was struggling as she was leaning to the left. Restorative nursing aide (RNA) N came to assist her after the surveyor notified the nurse. After she was repositioned, she was able to eat her breakfast with no difficulty. She still had the dried blood on the bump on her right forehead, her hair had not been combed and was still matted in the back. One of the pillows used to reposition her had a dollar bill size red stain on the pillowcase. Her face had not been washed and her toothbrush bristles were dry. Observation on 6/28/22 at 10:17 a.m. of certified nursing assistant (CNA) O and RNA P when they provided personal care to resident 26 revealed they changed her incontinence brief. RNA P attempted to comb her hair but only combed a little in the front. No oral care was provided. Observation on 6/29/22 at 8:58 a.m. revealed an unidentified contract CNA had combed and braided resident 26's hair. She had not completed any other personal care. Observation of her toothbrush indicated the bristles were dry. The pillow with a red stain on the pillowcase was still in use. Observation on 6/30/22 at 10:35 a.m. revealed resident 26 had the head of her bed up and was leaning slightly to the left. Her eyes were closed, and she had dried blood on the right side of her face. The blood had run down from the scabbed area on her forehead. The pillow with the red-stained pillowcase was noted in her recliner.	F 677		

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F 677	Continued From page 26 The bristles of her toothbrush were dry. 2. Observations on 6/28/22 at 8:15 a.m., 6/29/22 at 8:45 a.m., and on 6/30/22 at 10:30 a.m. of residents 1, 16, 46, and 66 revealed each time the bristles on their toothbrushes were dry. Interview on 6/29/22 at 9:17 a.m. with CNA O revealed: *Oral care was sometimes completed after breakfast and some of the residents refuse oral care. She was not able to state which residents usually refused oral care. *Night shift put hot water and soap in a large cooler. CNAs took a washcloth, got it wet, put it in a plastic bag, and then wrapped a hand towel around it. Those washcloths and towels were used to provide personal care to the residents in the morning. *It was not easy to get all the residents' ADLs completed each morning with two staff on the City View unit. *Some residents took more time than others to assist up in the morning, so some ADL care was completed after breakfast. *She agreed not all residents had been getting oral care consistently. Interview on 6/30/22 at 3:00 p.m. with director of nursing (DON) B revealed she expected that all residents received at least daily personal hygiene, grooming, and oral care. She was not aware residents had not received ADL assistance consistently. 3. Observation of resident 13 in her wheelchair on 6/28/22 at 9:05 a.m. revealed long fingernails that appeared dirty with brown matter under them. Observation of resident 13 on 6/29/22 at 8:08	F 677		

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F 677	Continued From page 27	F 677		

a.m. in the dining room revealed she was eating her breakfast. Her fingernails with longer lengths were dirty with brown matter underneath.
The resident was pleasant and stated, "I don't know what's going on around here." She continued to talk about her mother and father and wondered where they were.

Observation of resident 13 on 6/30/22 at 10:23 a.m. in her room revealed she was not feeling well, and her fingernails were long and dirty with brown matter underneath. The resident stated, "I just got into the dirt," regarding her dirty fingernails.

Interview on 6/30/22 at 10:26 a.m. with CNA O regarding how residents' nails were cared for revealed:
*Residents were showered once a week and nail care was performed at this time.
*At other times if a resident's nails appeared dirty, then nails should have been cleaned at that time.
*CNA O reviewed the provider's electronic health record point of care documentation and stated "nail care" was not a specific task for all residents.
-She stated for specific residents there was a task to "Clean and trim nails with bath."
*Resident 13 did not have a specific task for nail care.

Interview on 6/30/22 at 11:13 a.m. with CNA/certified medication aide (CMA)/bath aide AB revealed:
*She had given resident 13 a shower earlier that morning, 6/30/22.
*She thought she had cleaned her fingernails at that time.
*Resident 13 had no agitation with her showers or

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F 677	Continued From page 28 nail care. Observation of resident 13 on 6/30/22 at 11:30 a.m. in her room with CNA/CMA/Bath Aide AB revealed her fingernails were long and appeared dirty with brown matter underneath. CNA/CMA/Bath Aide AB stated she would clean resident 13's fingernails right away. 4. Review of provider's 4/25/22 policy "Activities of Daily Living" revealed: *Policy "Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene." *"ADLs are those necessary tasks conducted in the normal course of a resident's daily life. Included in these are the following:" -"General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin, nails and oral care." -"Bathing: . . ." -"Dressing: Selecting, obtaining and putting on, fastening and taking off items of clothing including braces and prostheses." -"Toileting: Transferring on and off toilet; use of bedpan, urinal or commode; cleansing after elimination; changing any protective pads; adjusting clothing after toileting." 5. Observations and interviews with resident 30 and staff and review of resident 30's medical record revealed supervision of dressing and transferring was not provided as care planned, which resulted in the lack of clean underwear and clothes. Refer to F656, finding 1. 6. Observations and interviews with resident 50 and staff and review of resident 50's medical record revealed ADL care was not care planned	F 677		

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F 677	Continued From page 29 with person-centered approaches consistent with her cognitive capabilities. Refer to F656, finding 2. Review of the June 2022 bathing record revealed baths were documented only three days that month: June 1, June 15, and June 29. 7. Interview on 6/28/22 at 9:36 a.m. with resident 67 revealed: -"I had to wait until 6:30 a.m. to get up" but he had told them he wanted to get up at 5:00 a.m. every morning as that was what he did on the farm every day. -He had not had a bath "since the first one when I came here." He would like to have them about 12:30 or 1:00 p.m. "They were going to come get me pert near [almost] a week ago but they never did." Review of a care conference note dated 6/22/22 at 5:02 p.m. revealed "a PCC [point click care] communication note about [resident] wanting to get up at 5 a.m." Interviews with staff on 6/30/22 revealed: *At 5:00 p.m., clinical care leader U replied, "I remember putting that [getting up at 5 a.m.] on the care plan." She offered no explanation for the reason he was not assisted until 6:30 a.m. on Tuesday morning nor why he had not received another bath since he moved in. *At 5:21 p.m., licensed practical nurse E reported that "usually overnights [CNAs] gets him up." She was not aware of any reports from the CNAs to explain the reason he was not assisted up by them on Tuesday morning. *At 6:15 p.m., social worker W noted resident 67 had informed her "he was not happy about getting	F 677		

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F 677	Continued From page 30 up late on Tuesday" but did not explain the delay.	F 677		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure sufficient personnel and resources to meet the needs of the 58 residents on Memory Lane, Country View, and Magnolia Heights with specific	F 725	On 7/20/2022, resident 30's care plan has been revised to reflect his current needs of assist of one with transfers and dressing. On 7/20/2022 resident 50's care has been revised to reflect person-centered approaches consistent with her cognitive capabilities. On 7/20/2022 resident 67s care plan was updated to reflect preferred routine. On 7/21/2022, DNS and administrator met with resident 68 regarding her concerns for environmental tasks. On 7/21/2022 administrator met with resident 9 regarding her staffing concern and to any unmet needs. All residents have the potential to be affected by deficient practice. To ensure deficient practice will not recur, on 7/21/2022 available radios were provided to front-line staff. Additional radios were ordered on 7/20/2022 to ensure leaders have a radio as well. On 7/21/2022, DNS implemented new process for shift change huddles to facilitate communication and provide regular forum for updates on resident changes, and accountability for routine tasks and to lift up environmental needs. Administrator or designee will audit by documentation review, staff observation and interview, and resident observation, to ensure compliance with radios being on and staff responding properly; linen, water, and snack pass completion; nurse leader participation in huddles and support assignments, and consistent delivery of ADLs. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. Administrator or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/29/2022

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F 725	Continued From page 31 unmet needs identified for 5 of 18 sampled residents (9, 30, 50, 67, and 68). Findings include: 1. Observations, interviews, and record review of three Memory Lane residents (30, 50, and 67) revealed unmet resident needs: a. Observations and interviews with resident 30 and staff and review of resident 30's medical record revealed supervision of dressing and transferring was not provided as care planned. Refer to F656, finding 1. b. Observations and interviews with resident 50 and staff and review of resident 50's medical record revealed activities of daily living (ADL) care was not provided using a person-centered approach consistent with her cognitive capabilities. Refer to F656, finding 2. c. Observations and interviews with resident 67 and staff and review of resident 67's medical record revealed his preferred morning routine was not honored on 6/28/22. Refer to F677, finding 7. 2. Interview on 6/28/22 at 6:00 p.m. with two nurses on the day shift and two nurses on the night shift at the same time (registered nurse (RN) X, RN T, licensed practical nurse (LPN) V, and LPN Y) revealed consensus on the following comments: *The staff to resident ratio was not good. *They did not know how ratio was determined. *Management told them the staffing ratio was the amount allowed. *They "rarely, if ever, see management on the floor."	F 725		

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F 725	Continued From page 32 *The "MDS [Minimum Data Set] nurses [clinical care leaders (CCL)] stay in their offices." *Communication between staff was a challenge because they do not have radios. *The call light bells can only be heard when they are close to the nurse's station. *The nurses would help the certified nursing assistants (CNAs) with transfers and provide personal care for residents when the CNAs are not available or within sight. *They are not able to oversee the care provided by the CNAs during the shift because they are so busy getting their tasks completed. *RN X reported she would "punch out for her break but continue working just to get the work done." Interviews with CNA S revealed: *On 6/29/22 at 4:55 p.m.: -There were "not enough staff." -They had to "turn on the emergency call light or call out for someone to help" when a second staff was needed. -They used to have radios. *On 6/30/22 at 2:20 p.m.: -The CNAs have a shift-to-shift report, and the evening shift was "supposed to pass information from the morning report to the night shift CNAs." -Staff were "supposed to turn on the green [call] light [button] when they are assisting a resident" to let the other staff know where they are. Review of the provider's "Safety Rounds" for CNA shift changes revealed: *The 14 bulleted tasks included "last time of rounds" and "times last repositioned," and "who is dressed from nights to days." *"Also utilize: PCC [Point Click Care] Communication tab, nurse to nurse shift change	F 725		

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F 725	Continued From page 33 report, and daily stand-up: huddle." Review of the provider's CNA "Duties and Routine" revealed: *"Communication is key! Work as a team to get everything done." *Day shift CNAs: -Start at 6:00 a.m. rounding with the overnight CNAs and begin getting residents up. -Between 7:30 a.m. and 9:00 p.m., "Encourage all residents to go down [to the dining room (DR)] after they are up. Assist in DR when you have all your residents up. Help all residents out of DR back to room, toilet it needed." -Between 9:00 a.m. and 11:00 a.m., "work together to decide who does what," including passing out water, emptying garbage, exchanging the linen carts, and taking breaks. -Between 11:00 a.m. and 12:45 p.m., get residents up for lunch, assist with lunch, and take residents back to rooms. -Between 1:00 p.m. and 2:00 p.m., "toilet residents, lay down, or take them to activity." -Between 2:00 p.m. and 2:15 p.m., rounding with evening CNAs. *Evening shift CNAs: -After rounding with day shift CNAs, between 2:15 p.m. and 4:30 p.m., pass supplies to resident rooms, "get residents toileted and up for activities/supper." -Between 5:00 p.m. and 7:00 p.m., assist residents to DR, "pass trays," assist resident back to room, and "take turns with breaks." -Between 7:00 p.m. and 10:00 p.m., provide evening cares, "2nd [second] rounds on those that went to bed early," and pass snacks. -Between 10:00 p.m. and 10:30 p.m., rounding with overnight CNAs. *Overnight shift CNAs:	F 725		

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F 725	Continued From page 34 -After rounding with evening shift CNAs, pass supplies to resident rooms and exchange linen cart. -Starting at midnight, "1st [first] rounds" to check every resident and provide care as needed. -At 4:00 a.m., "last rounds" and "Start getting residents dressed on lists - at least 2!" *Float CNA: -"Take the spot of the one [CNA] missing if absent..." -"Get list of which residents you are doing cares for on each hallway. Even it out! Make sure your co-workers know who you are taking." -"Floats on overnights you need to dress on from each hallway." -"Take a task from each hallway to help them out." -"Floats will help the other staff get their break in and then take their break after." -"Help with answering lights on all halls and try to split your time evenly." -"Communicate with the other staff to let them know when you are leaving the hallway and going to the next." -"Let the staff member doing rounds know anything that needs to be shared to next shift." 3. Interview on 6/29/22 at 9:02 a.m. with resident 9 revealed: *She had been asked three times by staff members how her breakfast was. -That was not a normal occurrence. -"I just have to laugh and shake my head because you see how many people are running around today? This is not normal. They are putting on a show for you." 4. Interview on 6/30/22 at 9:46 a.m. with RN M regarding staff-to-staff communication revealed if she needed help with a task, she would see if an	F 725		

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F 725	Continued From page 35	F 725		

aide or another nurse was walking by, otherwise she would leave the resident's room to walk around and find someone to assist her.

Observation on 6/30/22 from 10:20 a.m. to 10:30 a.m. revealed:
*Surveyor was looking for CNA J on the first floor hallway.
*Surveyor asked purchasing assistant K for help locating CNA J. She was in the central supply room which was on the first floor hallway. Purchasing assistant K indicated that she did not know where CNA J was.
*She:
-Walked down the hallway saying, "I'm looking for the green light [above the resident's door] but I don't see one on."
-Asked an unidentified staff member if he knew where CNA J was. He said that CNA J was in resident 56's room.
--The unidentified staff member was in the nurse's office with the door open just a crack. It was not initially apparent that there was anyone in the nurse's station due to the door being almost shut.
-Checked the resident's room and confirmed that CNA J was in there.
--The light above the resident's door was not turned on, creating a lack of communication among the staff.

Interview on 6/30/22 at 11:11 a.m. with CCL L revealed:
*The facility had radios before the COVID-19 pandemic, but the radios disappeared quickly.
*She thought the radios may have been stolen or staff forgot to return them.
*The facility used the lights above the resident's doors to indicate when a staff member was in the

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F 725	Continued From page 36	F 725		

room with the resident.
-The lights were color-coded for different tasks.
-If the light was on above a resident's door, a light would also turn on at the main board in the nurse's station.

Interview on 6/30/22 at 12:15 p.m. with CNA J revealed:
*She did not have a consistent area in which she worked.
*Sometimes she was pulled to another area.

Interview on 6/30/22 at 2:23 p.m. with administrator A and director of nursing (DON) B revealed:
*The facility had communication radios before the pandemic started.
*They removed the radios from use after several radios went missing, and they had to spend money to replace the lost radios.
*They could not remember when the radios were discontinued.
*They understood the importance of effective communication amongst staff members.
*The leadership team were in discussions to bring back the communication radios.

5. Review of resident 68's grievance dated 3/23/22 on the provider's "Suggestion or Concern" form regarding her concern with getting towels to her bathroom included a notation to "(see attached sheet also)". The attached sheet had five three inches by three inches sticky notes that revealed:
*"3/20 Sun[day:]"
-No washcloth and hand towel had been delivered to her room or trash removed that morning.
-No hand towel had been delivered to her room

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F 725	Continued From page 37 that evening. *"3/21 Mon[day:]" -No washcloth or hand towel had been delivered to her room that morning. -No bedtime snack had been offered. -After she had asked, a hand towel had been delivered to her room that evening. She "had 2 min discussion about whether they should do it or not & whether it was nessesary [sic]". *"3/22 Tue[sday:]" -No washcloth, hand towel, or water mug had been delivered to her room that morning. -"Call light on 45 min[utes] 8:55 - 9:40 a.m." before it had been answered. -No bedtime snack had been offered. -No water mug or hand towel had been delivered to her room that evening. *"3/23 Wed[nesday:]" -No washcloth or hand towel had been delivered to her room or trash removed that morning. -No water mug had been delivered to her room that evening. *"3/24 Thur[sday:]" -No washcloth or hand towel had been delivered to her room that morning. -After she had asked, a hand towel had been delivered to her room that evening. *All the notes had been signed with the resident's first name. The provider's "Suggestion or Concern" form included the resolution of having reviewed the concern at CNA and nurses' meeting and provided coaching to the eleven CNAs that had worked the shifts noted on the concern and was signed "Completed by" director of nursing B on 3/30/22. This form was also reviewed and signed by administrator A on 3/31/22 and social services supervisor C on 4/7/22.	F 725		

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F 725	Continued From page 38 Review of a document completed by resident 68 of daily environmental tasks revealed three separate sheets of paper labeled "April 2022", "May 2022", and "June 2022" (the June 2022 sheet had been completed up to the date the survey started, 26 days). Over those three months, the resident's documentation revealed out of 84 opportunities (the resident had been out of the facility three days): *The morning washcloth and hand towel had been passed 1% of the time, once on 5/14/22. *The morning water mug had been passed 60% of the time (51 days). *The bedtime snack had been offered 37% of the time (31 days). *The evening water mug had been passed 2% of the time, on two days, 5/2/22 and 5/26/22. *The evening hand towel had been passed 33% of the time (28 days). Interview on 6/28/22 at 12:53 p.m. with resident 68 regarding her tracking of environmental tasks revealed she: *Had given these to DON B who said she would review them. *She had not received a response to her concern. 6. Interview on 6/30/22 at 10:56 a.m. with CNA O and CNA S regarding staffing revealed: *They had been assigned to provide care to the section of the unit that included 30 beds. -Two of those beds had been unoccupied. -They had been responsible to provide care for 28 residents from 6:00 a.m. to 2:00 p.m., the day shift. *The staffing pattern for this section had been like this "for the past year." *CNA O stated "We could use more [CNAs]" as not all the tasks assigned could get done with two	F 725		

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F 725	Continued From page 39 CNAs for 28-30 residents on the day shift. -CNA S had agreed with CNA O's statement. 7. Interview on 6/30/22 at 3:00 p.m. with administrator A and DON B revealed: *Communication with staff on the care needs of the residents were completed by: -Having stand-up meetings on weekday mornings. -Staff that attended those meetings included the management, supervisory, clinical care coordinators, and the charge nurses. -Any changes in a resident's care or other communication was placed on the electronic medical record (EMR) dashboard. -When a staff person logged into the EMR a note would pop-up with the new information. -There was no monitoring if staff had checked the dashboard or not.	F 725		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure staff understood how to provide services for two of two sampled residents (49 and 50) with dementia. Findings include: 1. Observation of resident 49 on 6/27/22 at 4:59 p.m. in her room revealed she was laying on her bed wearing dark gray sweatpants and a light gray sweatshirt with the word "Tommy" on the	F 744	On 7/14/22, social services director met with front line staff to review and update behavioral and dementia care plan interventions for residents 49 and 50. Residents with dementia have the potential to be affected by deficient practice. By 7/14/22, interdisciplinary team will review dementia and behavioral care plan interventions of cognitively impaired residents ensure they reflect best interventions to meet the resident's needs. To ensure deficient practice will not recur, on 7/14/2022, social services director implemented behavior management committee, involving the IDT and front line staff to review needs of residents with dementia and behaviors and ensure interventions are in the care plan and communicated to staff. The committee will meet twice a month. On 7/19/2022, IDT will provide education to all staff on dementia care, discuss those residents identified with cognitive deficits and dementia and how to appropriately implement and alter approach and interventions to provide person centered care. Going forward, new hires will meet with social services director or designee, to learn about dementia care and specific needs of residents. DNS or designee will audit by documentation review, care observation and staff interview, 5 residents with	7/29/2022

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F 744	Continued From page 40 front of the sweatshirt. She did not verbally respond to questions asked. Interview of resident 21 at the same time, who was in the room along with other persons that asked to remain unidentified, revealed: *He and resident 49 were married and shared the same room. *He expressed his concern that she had often gone two to three weeks without her clothes being changed. *The dark gray sweatpants and light gray "Tommy" sweatshirt had been on for a week. *She often refused to change her clothes due to her dementia. *Resident 49 would not allow resident 21 to change her clothes. *He was especially concerned that her underwear did not get changed daily. -She did not wear incontinence protection. -She toileted herself. -She had not wiped her private parts well in the past. *Resident 49 was supposed to have a shower once-a-week, but she often refused due to her dementia. Review of resident 49's quarterly Minimum Data Set from 5/28/22 revealed she had diagnoses of Alzheimer's disease and dementia. Observation of resident 49 on 6/28/22 at 10:43 a.m. with a nurse surveyor revealed she was laying on her bed with the same clothes on from yesterday, dark gray sweatpants and a light gray "Tommy" sweatshirt. The underwear she had on was the same pair as the previous day, 6/27/22. Observation of resident 49 on 6/29/22 at 8:03	F 744	cognitive deficits to ensure the care plan reflects current behavioral needs and intervention, staff understand how to implement person-centered interventions, staff interact with resident appropriately, and behavior management committee met and addressed any changes in resident needs. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. DNS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions	

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F 744	Continued From page 41	F 744		

a.m. revealed she was laying on her bed. She was wearing the same clothes from 6/27/22, dark gray sweatpants, light gray "Tommy" sweatshirt, and underwear.

Observation of resident 49 on 6/30/22 at 9:57 a.m. revealed the resident standing in the hallway with a change in clothing, a beige sweatshirt with "Victorian Cape May" on front and black pants.

Interview on 6/30/22 at 9:57 a.m. with resident 21 revealed resident 49 had received a shower and change of clothes yesterday afternoon on 6/29/22.

Interview on 6/30/22 at 10:36 a.m. with certified nursing assistant (CNA) O regarding how often a resident's clothing is changed revealed she changed the resident's clothing routinely every morning.

Continued interview with CNA O regarding resident 49 and training on dementia care revealed:
*CNA O will change resident 49's clothes "when she lets us."
*Staff are assigned computerized training in the provider's "Learning Center" which included computer modules in dementia.

Interview on 6/30/22 at 11:06 a.m. with CNA/certified medication aide/bath aide AB regarding showering resident 49 and training in dementia care revealed:
*Resident 49 often refused her showers.
*The resident "freaks out" when staff start to remove her pants.
*She had asked another CNA to assist with her showers, as the resident resisted undressing and

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F 744	Continued From page 42 hair washing. *This week, the resident had refused Monday and Tuesday, but she was able to get the resident showered yesterday afternoon, 6/29/22. *She asked, "Do you want to see my war wounds?" and showed her forearms on both arms and explained the resident caused the broken skin and discoloration during her shower on 6/29/22. *She stated the provider had training assigned "every so often" on the computer. 2. During an interview on 6/30/22 at 12:15 p.m. with CNA J revealed: *She: -Had not had specific training on dementia care other than what was provided in the provider's online learning modules. -Offered an example of a situation with resident 49 who had a diagnosis of dementia: --She would ask the resident to undress herself for her bath by asking her to pull her pants down. She stated the staff try to allow the resident be as independent as possible. --Resident 49 did not understand the directions so CNA J had to assist the resident with pulling her pants down. CNA J suggested that resident 49 was no longer able to remember how to undress herself. Despite this statement, staff members continued to ask the resident to undress herself. Review of the provider's post-acute care required annual training 2022 calendar revealed: *The annual required training topic for the month of June was dementia management and care of the cognitively impaired. -The title of the course was "pc-2035 Supporting Individuals with Dementia."	F 744		

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F 744	Continued From page 43 -The length of the training was 13 minutes. *The annual required training topic for the month of October was behavioral health. -The length of the training was 31 minutes. -The provider's required training for "June 2022" included "Supporting Individuals with Dementia" -The provider had not conducted in-person training on creative approaches that could help reduce challenges and minimize resistance for the provider's residents with dementia. 3. Observations and interviews with resident 50 and staff and review of resident 50's medical record revealed activities of daily living (ADL) care was not care planned nor provided using a person-centered approach consistent with her cognitive capabilities, which had resulted in behavioral reactions. Refer to F656 finding 2, and F677 finding 6. Further review of resident 50's record revealed 6 of 30 days in June 2022 had physical behaviors directed towards others documented as having occurred. 4. Observations and interviews with resident 30 and staff and review of resident 30's medical record revealed supervision of dressing and transferring was not provided as care planned, which resulted in the lack of clean underwear and clothes. Refer to F656, finding 1, and F677, finding 5. Further review of resident 30's record revealed he had unwitnessed falls on 4/3/22, 5/22/22, and 5/25/22, resulting from his attempts to transfer independently. 5. Review of provider's 2/17/22 "Dementia Care	F 744		

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F 744	Continued From page 44 Guidelines" revealed: *"Purpose: To outline how to provide care and support to residents living with dementia." *"Guidelines:" -"Provide care and support in a way that is respectful, preserves the resident's identity and maintains dignity." -"Remain calm and provide a supportive approach that is individualized to the resident." -"All behavior has meaning and is a means to communicate an unmet need." -"Approach is everything, Caregivers can cause a behavior is we don't use the right approach." -"A resident with dementia can misunderstand what is happening and perceive activities of daily living (ADL) care as traumatic and/or frightening, resulting in resistance to care." -"Partnering with the resident to complete and ADL task and using creative approaches can help reduce challenges and minimize resistance." -"General tips include:" --"Promote independence by encouraging the resident to do as much as possible." --"Focus on the resident's current abilities and encourage involvement that matches the resident's skill level." --"Modify the action steps involved with the task to match the resident's cognitive and/or physical limitations." --"Incorporate the resident's former routine, rituals and preferences." *References included the "Alzheimer's Association website: https.//www.alz.org/" -"cc-9566-Handling Aggressive Behavior[.]" -"cc-8745-Module 3: Being a Person with Dementia: Actions and Reactions[.]"	F 744		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761	On 7/12/2022, a new temp log was posted to capture twice daily temperature monitoring.	7/29/2022

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F 761	Continued From page 45 §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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: Based on observation, interview, and policy review, the provider failed to ensure temperatures of refrigerators that stored temperature sensitive medications were checked and documented for two of two medication fridges (first floor and second floor) in the facility. Findings include: 1. Observation and interview on 6/29/22 at 5:03 p.m. of the refrigerator used to store medications on the first floor with licensed practical nurses (LPN) D and E revealed:	F 761	Residents with refrigerated medications have the potential to be affected by the deficient practice. To ensure deficient practice will not recur, on 7/19/2022 DNS provided education to licensed nurses on medication storage and twice daily documentation of refrigerator temps. DNS or designee will audit medication refrigerators to ensure temperatures are documented twice a day. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. DNS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	

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F 761	Continued From page 46 *A log form taped to the front of the refrigerator to document the temperature each day for the month of June 2022. *The temperature of the refrigerator had only been documented on nine of the twenty-nine days. *The night nurse was responsible to document the refrigerator temperatures. Observation and interview on 6/30/22 at 10:40 a.m. of the refrigerator used to store medications on the second floor with LPN E revealed: *A log form taped to the front of the refrigerator to document the temperature each day for the month of June 2022. *The temperature of the refrigerator had only been documented on 24 of the 30 days. *The night nurse was responsible to document the refrigerator temperatures. Review of the provider's 2/8/22 Medications: Acquisition Receiving Dispensing and Storage policy revealed: "Check refrigerator temperatures once in the morning and once in the evening." Interview on 6/30/22 at 4:37 p.m. with administrator A and director of nursing B regarding the above observations and interviews revealed: *The same observations had been identified during a mock survey in May 2022. *The responsibility for ensuring the refrigerator temperatures had been moved from the unlicensed assistive personnel to the night nurses. *It had been brought to their attention on the evening of 6/29/22 that it was still not completed daily. *Neither of them had been aware that the	F 761		

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F 761	Continued From page 47 provider's policy had required the temperature to be checked twice a day.	F 761		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the provider failed to ensure palatability of food taste and consistency of food served following the posted menu were addressed adequately for five of five interviewed residents (11, 15, 21, 43, and	F 803	Starting 7/19/22, dietary supervisor will email central kitchen manager twice a week to confirm upcoming menu. By 7/29/2022, selective menu will be available for residents. All residents have the potential to be affected by the deficient practice. To ensure deficient practice will not recur, on 7/19/22 two additional freezers were acquired to store supplies for selective menu/"Blue Basket" specials. On 7/19/22, Administrator will provide education to all staff about their roles and responsibilities for a thoughtful and pleasant meal delivery. Starting 7/28/2022, weekly for 4 weeks and then monthly during resident group, dietary supervisor designee and administrator will meet with residents to address concerns, ask about preferences and get quick feedback on if corrective actions are improving the dining experience. Administrator or designee will audit by menu review, meal tasting, and resident interview to ensure palatability of food taste and consistency of food served follows the posted menu in a 7 day look-back. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. DNS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/29/2022

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 803	Continued From page 48 68), four of four concerns documented on suggestions or concern forms, and one of one resident council meeting attended by nine residents (3, 8, 10, 20, 23, 31, 35, 43, and 68). Findings include: 1. Interview on 6/27/22 at 4:22 p.m. with dietary supervisor R revealed: *She had worked the past 48 years for the provider. *The provider's meals were cooked offsite at a central kitchen and transported to the facility. *The meals that were transported to the provider did not always follow the provider's posted menu. *Problems with the meals had started nine months ago when the new manager started at the central kitchen. Interview on 6/27/22 at 4:59 p.m. with resident 21 revealed: *The food served at the noon and evening meal were "terrible!" *He stated you "can't eat it." *He stated the food was "roadkill" and was over cooked. *He had asked for something different but stated "it's usually not any better." Interview on 6/28/22 at 8:36 a.m. with resident 68 revealed: *The food served by the provider was "not good." *Food was "mushy" at times. *There were problems with the menus posted and what was served. -"Mushroom chopped steak" was on the menu recently and what was served was different either "a sandwich or macaroni & cheese." *She attended resident council meetings and had made her concerns known.	F 803		

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F 803	Continued From page 49 Review of provider's "Suggestion or Concern" form completed on 2/18/22 by Clinical Care Leader L on behalf of four residents revealed: *The concerns reported: -"Evening meals are terrible." -"They [four residents] feel like they don't matter." -"They say they can't even eat some of the things they are served." -"Frequently 'starving' by breakfast." *The investigation of the concern was "[dietary supervisor's first name] discussed with [central kitchen] staff[.]" *There was no resolution documented on the form. *There was no documented follow-up with the four residents. *Adhered to the concern was a 3" by 3" sticky note: -"Action plan?" -"Follow up?" Review of provider's "Suggestion or Concern" form completed on 5/23/22 by dietary supervisor R on behalf of a previous resident revealed: *The concern expressed: -"Upset about supper meals being subpar." *There was no investigation documented. *There was no resolution documented. *Dietary supervisor R had documented a follow up with the resident regarding the supper meals. -"I let her know that the [name of central kitchen] is continuing to work on improvements." *The concern form was reviewed and signed by the following staff: -Administrator A. -Director of nursing B. -Social services supervisor C. -Dietary supervisor R.	F 803		

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F 803	Continued From page 50 Review of provider's "Suggestion or Concern" form completed 5/25/22 by social services supervisor C on behalf of resident 35's family member revealed: *The concern expressed included: -"We still have concerns with the food that is being given [resident 35's first name] that is inadequate, dried out food, tough to chew, and often times cold." -"This has been addressed several times saying that this is going to get better, not so far!!!" *The investigation was completed by administrator A on 5/27/22. *The resolution was completed by administrator A on 5/27/22 noting an action plan to improve food quality would be forthcoming in the "next couple weeks." *The follow up was documented as "Admin and dietary manager to provide future follow-up to resident and family and also resident council group." *The concern form was reviewed and signed by the following staff: -Administrator A. -Social services supervisor C. -Dietary supervisor R. Review of provider's "Suggestion or Concern" form completed 6/6/22 by [staff initials] on behalf of three residents revealed: *The concern expressed was "Reported @[at] Res. [Resident] Council today that the tater tot hotdish that was served last evening (6/5/22), was 'terrible."... *The investigation was completed by dietary supervisor R on 6/7/22 which consisted of an email to the central kitchen regarding this concern.	F 803		

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F 803	Continued From page 51 *The resolution was completed on 6/10/22 by administrator A. -"[Central kitchen] continuing to work on dietary solutions." *There was no follow-up documented. *The concern form was reviewed and signed by the following staff: -Administrator A. -Director of nursing B. -Social services supervisor C. -Dietary supervisor R. Interview on 6/30/22 at 4:50 p.m. with dietary supervisor R confirmed: *There was a problem with the provider's posted menu and the meal delivered to the provider from the central kitchen the provider used. *Monday evening, 6/27/22 the meal delivered from the central kitchen was "French dip sandwich and coleslaw." -The posted menu for the evening meal was "scalloped potatoes and ham." -Monday evening's posted meal "scalloped potatoes and ham" was delivered Tuesday, 6/28/22 for the noon meal. *The meal delivered being different from the posted menu happened routinely. -She was frustrated with this problem. -She stated the consultant registered dietitian was aware of the problems in general with the menu and the meals served. Interview on 6/30/22 at 5:48 p.m. with dietary supervisor R regarding the pervasiveness of the problems revealed: *For the problem with meals following the provider's menu there was only a slight improvement over the past nine months. -It "could be days in a row not following the	F 803		

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F 803	Continued From page 52	F 803		

menu."
-There could be days the meals served were following the posted menu.
*For the problem with the quality of the meals served she noted no improvement over the past four months.
2. Interviews with residents regarding food quality revealed:
*On 6/27/22 at 5:19 p.m., resident 11 said the cooked style meats are repetitive during the week and could use more flavor.
*On 6/28/22 at 9:10 a.m., resident 43 said the food was "so so" and provided no further comment.
*On 6/28/22 at 12:15 p.m., resident 15 said:
-She had a bowl of "minced and moist beef" that looked the color of chicken while seated at a dining room table.
-A bowl of mashed potatoes was delivered at that time.
-When informed by surveyor that some residents had beets, she replied she did not know that.
-She would like to choose food from the menu but did not know what was available.
*On 6/29/22 at 3:00 p.m., nine residents (3, 8, 10, 20, 23, 31, 35, 43, and 68) who regularly attended monthly resident group meetings agreed:
-Food was delivered from the Good Samaritan Society Sioux Falls (GSS SF) Village, already cooked.
-The food served was "never" what was written on the menu.
-They want to go back to selecting their food choices on a meal slip.
-The choice of meals stopped around the time when COVID started.

Interview on 6/29/22 at 4:24 p.m. with dietary supervisor R revealed:

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F 803	Continued From page 53 *"Select menus went away when the GSS SF Village started preparing the meals." *"Many, many, many times, the menus don't match what is served." *That problem started when a new dietary director and staff started at the Village "about 3-4 months ago." *She was not aware resident 15 would like to select her food preferences from the menu but will begin doing that. *A couple of times a week, meal trays may not be delivered timely to resident rooms. *The certified nursing assistants (CNAs) pass trays in the dining room. *When the CNAs are ready to assist residents with eating, then those trays are served. *The CNAs then let the kitchen know when they are ready for room trays. The kitchen staff do not dish up the room trays until then.	F 803		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, anonymous complaint review, and policy review, the provider failed to ensure the facility was operated and administered by administrator A, director of nursing (DON) B, and supervisor of ancillary services (SAS) G, in a manner that ensured the safety and overall well-being of all sixty-eight residents in the facility. Findings	F 835	Individual resident findings are addressed as specified in the referred tags. Administrator, DNS, and SAS will meet with Regional Clinical services director by 7/29/2022 to create individual performance improvement plans. All residents have the potential to be affected by the deficient practice. To ensure deficient practice will not recur, the Administrator, DNS, and SAS will have bi-weekly performance improvement meetings during August and September. By 7/29/2002, administrator will set up weekly meetings with each department supervisor to communicate updates, receive feedback, and hold supervisors accountable to expectations, including but not limited to, department training, supporting front-line staff, communication, and follow-up on assigned staff/resident concerns. On 7/21/2022, DNS implemented new process for shift change huddles to facilitate communication and provide regular forum for updates on resident changes, and accountability for routine tasks and to lift up environmental needs. By 7/29/2022, SAS will establish weekly meetings with maintenance mechanic and lead environmental services tech to set priorities and ensure timely resolution of environmental concerns. Going forward, all staff	7/29/2022

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F 835	Continued From page 54 include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey revealed administrator A, DON B, and SAS G had not ensured the safe management and overall well-being of all the residents who lived in the facility. There was a widespread system breakdown to ensure the facility was safe, clean, comfortable, and had a homelike environment. Resident rooms and other common use areas had not been maintained in a manner to ensure the homelike environment. Staff had concerns in regards to the lack of communication available to them to ensure prompt care of the residents. There was not enough staff to ensure residents received person-centered care on a daily basis. Staff did not have knowledge of how to provide care for those residents with dementia. Refer to F584, F677, F725, F744, and F803. 2. Interview on 6/29/22 at 3:54 p.m. with SAS G confirmed they did not have a system of tracking which rooms had been deep cleaned but was going to implement a tracking form after the survey was completed. 3. Interview on 6/30/22 at 2:23 p.m. with administrator A and DON B revealed: *The facility used to have communication radios before the pandemic started. *They had removed the radios after several radios went missing, and they had to spend money to replace the lost radios. *They could not remember when exactly the radios were discontinued. *They understood the importance of effective communication amongst staff members. *The leadership team was in discussions to bring	F 835	meetings will include time to review QAPI initiatives, roles each staff member plays in the safety and well-being of all residents, and to receive feedback on communication strategies. Regional clinical services director or designee will audit by staff interview, resident interview, observation, and review of meeting minutes to ensure the corrective actions outlined in the prior paragraph are properly implemented. Audits will occur weekly x4, every other week x2, monthly x2, and quarterly x1. Regional clinical services director or designee will report audit findings to QAPI committee monthly, and to regional leaders to include Executive Director, Human Resources Advisor and Quality Advisor monthly. The Quality Advisor will determine ongoing monitoring and interventions.	

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F 835	Continued From page 55 back the communication radios, however, they revealed they were in the process of researching what kind of radio to purchase. 4. Interview on 6/30/22 at 4:37 p.m. with administrator A and DON B regarding the storage of temperature sensitive medications revealed: *The same observations had been identified during a mock survey in May 2022. *The responsibility for ensuring the refrigerator temperature checks had been moved from the unlicensed assistive personnel to the night nurses. *It had been brought to their attention on the evening of 6/29/22 that it was still not completed daily. *Neither of them had been aware that the provider's policy had required the temperature to be checked twice a day. *Refer to F761. 5. Interview on 6/30/22 at 10:56 a.m. with certified nursing assistant (CNA) O and CNA S regarding staffing and administration revealed: *They had been assigned to provide care to Memory Lane that included 30 beds. -Two of those beds had been unoccupied. -They had been responsible to provide care for 28 residents from 6:00 a.m. to 2:00 p.m. on the day shift. *The staffing pattern for this section had been like that "for the past year." *CNA O stated, "We could use more [CNAs]" as not all the tasks assigned could get done with only two CNAs for 28-30 residents. CNA S agreed with CNA O's statement. *They both stated DON B "does help out" but administrator A and other managers had not provided assistance. -They had seem them "once in a while" when	F 835		

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F 835	Continued From page 56 they had come out of their office(s). -They had not helped in the dining room with meal service. 6. Interview with SAS G on 6/29/22 at 3:55 p.m. revealed: *He was not aware of needed repairs for residents 15, 50, and 67, but those should have been reported by housekeeping or nursing staff as work orders. (Refer to F584, findings 13, 14, and 15). *His daily routine was to conduct rounding tours at the beginning of each day and then plan out the tasks to be completed with maintenance mechanic I. *Often staff would stop him during the rounding tours to report repairs that needed their attention.	F 835		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880	Infection Prevention & Control Directed Plan of Correction Good Samaritan Society Sioux Falls Center F880 Corrective Action: 1. For the identification of lack of: *Appropriate infection prevention and control practices for disinfecting re-usable medical equipment. *Appropriate maintenance of laundry carts to ensure covers are intact and free of tears and holes. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Please do read 2567 findings. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 7/19/22 by the Administrator. 2. Identification of Others: ALL residents and staff have the potential to be affected by lack of: *Appropriate care and maintenance of re-usable	7/29/2022

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F 880	Continued From page 57 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880	medical equipment and laundry transport carts. areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by Administrator on 7/19/22. System Changes: 3. Root cause analysis conducted answered the 5 Whys: During our root cause analysis, it was identified in regards to replacing covers on the laundry carts that cost and budget was a factor. It was identified that no matter the cost with some of these items, if they pose an infection control or safety concern, these items need to purchased upon identification. In regards to the cleaning and disinfecting of re-useable medical equipment, the nurse identified was a transfer and it was unclear as to how much on-site instruction was given regarding proper infection control practices. It was identified that going forward, infection prevention/control education will be completed onsite to all new employees, including those employees that are internal transfers. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 7/21/22 and discussed our 5 Why's Root Cause Analysis. QIN will be providing additional resources for environmental rounding as well. Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 58 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were maintained for disinfecting re-usable medical equipment by one of one licensed practical nurse (LPN) (D). Findings include: 1. Observation on 6/29/22 at 8:30 a.m. of LPN D obtaining vital signs for resident 220 revealed: *She had removed a thermometer, oximeter, and blood pressure cuff from her shirt pocket and set them on top of the medication cart. *Prepared his medications and put the equipment back in her shirt pocket. *Walked into resident 220's room. *Put the equipment down on the bedside table. *Used the equipment to obtain his vitals and then put them back in her pocket. *Walked out of the room and put them back on top of the medication cart. *Did not clean or disinfect the items. *She also had a set of keys and portable phone in her shirt pocket. Interview on 6/29/22 at 5:00 p.m. with LPN D regarding the above observation revealed: *Her pockets were not clean. *Did not know she should have cleaned the care items with a disinfecting wipe between residents. *She agreed setting them on a surface in a	F 880		

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F 880	Continued From page 59 residents room could be dirty. Review of the provider's 10/19/21 Environmental Cleaning Principles policy revealed the blood pressure cuff, thermometer, and oximeter should have been disinfected after each use. Interview on 6/30/22 at 5:23 p.m. with administrator A and director of nursing (DON) B revealed: *Staff may not have been educated on carrying resident care items in their pockets. *Staff had been educated to disinfect re-usable equipment between uses. *Clothing pockets were not clean. B. Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices were maintained for four of four laundry carts used to transport resident's personal laundry from the laundry room to the resident's rooms by ensuring the covers were intact and free of tears and holes. Findings include: 1. Observation and interview on 6/30/22 at 11:20 a.m. with laundry technician F of four laundry carts that held resident's clean personal clothing revealed: *There were four carts in the laundry room that had covers over them used to deliver resident's personal clothing to their rooms. *All four covers had tears and holes. *She had told her supervisor about the covers and was told they had been too expensive to replace. *She was not sure how long the tears and holes had been in the covers.	F 880		

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 880	Continued From page 60 Interview on 6/30/22 at 1:46 p.m. with supervisor of ancillary services G regarding the four laundry cart covers revealed: *He was not aware they had tears and holes in them. *With the holes the laundry could become contaminated. Interview on 6/30/22 at 5:23 p.m. with administrator A and DON B revealed: *They had not been aware the four laundry cart covers had tears and holes in them. *Clothing within carts would have had the potential to become contaminated.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/30/2022

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 6/27/22 through 6/30/22. Good Samaritan Society Sioux Falls Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Marvin Tordoff | Administrator | 7/25/22

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/28/22. Good Samaritan Society Sioux Falls Center Building 1 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K300, K321 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 300 SS=E	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to protect five separate storage areas (resident rooms 241, 242, 243, 244, and 249 being used as storage) by providing a door closer as required. Findings include: 1. Observation on 6/28/22 at 11:30 a.m. revealed resident room 241 was over 100 square feet and	K 300	By 7/29/22, resident rooms 241, 242, 243, 244 and 249 will be cleaned of non-essential combustibles and will no longer be used for storage. All other resident rooms have the potential of being deficient. By 7/29/22, all other resident rooms identified of being used for storage will be cleaned of non-essential combustibles. SAS or designee will audit each empty resident room to ensure the room is clear of non-essential combustibles. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit findings to QAPI committee monthly,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Tordoff	Administrator	7/25/22

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	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2022

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K 300	Continued From page 1 was being used to store combustible items. The door was not equipped with a closer. 2. Observation on 6/28/22 at 11:31 a.m. revealed resident room 242 was over 100 square feet and was being used to store combustible items. The door was not equipped with a closer. 3. Observation on 6/28/22 at 11:32 a.m. revealed resident room 243 was over 100 square feet and was being used to store combustible items. The door was not equipped with a closer. 4. Observation on 6/28/22 at 11:33 a.m. revealed resident room 244 was over 100 square feet and was being used to store combustible items. The door was not equipped with a closer. 5. Observation on 6/28/22 at 11:40 a.m. revealed resident room 249 was over 100 square feet and was being used to store combustible items. The door was not equipped with a closer. Interview with the maintenance supervisor at the times of the observations confirmed those findings. The deficiency affected one of numerous requirements for protection of rooms.	K 300	and the committee will determine ongoing monitoring and interventions.	7/29/22
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing	K 321	By 7/22/22, the ceiling opening in the first floor boiler room will be enclosed with and sealed with approved fire-stop material. By 7/29/22, all other ceiling openings in Main Building 1 have the potential to be	

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	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2022

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K 321	Continued From page 2 system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain two separate hazardous areas (first floor boiler room and lower level boiler room) a one-hour separation in Building 1 as required. Findings include: 1. Observation on 6/28/22 at 10:15 a.m. revealed the first floor boiler room was over 100 square feet, contained combustible items, and did not maintain a one-hour fire separation to the second floor. The ceiling separation had a two-inch by seven-feet opening made when cabling was pulled to other areas and not repaired as required.	K 321	deficient. Any other potential penetrations through fire barriers will be inspected to ensure those enclosures are sealed with fire-stop material. SAS or designee will audit each empty resident room to ensure the room is clear of non-essential combustibles. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/29/22

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	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2022

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K 321	Continued From page 3 2. Observation on 6/28/22 at 1:15 p.m. revealed the lower level boiler room had two four-inch penetrations of the one-hour fire-rated ceiling for computer cabling. The penetrations should have been sealed with an approved fire-stop material such as intumescing fire caulk. Interview with the maintenance technician at the times of the observations confirmed those findings. The deficiency affected one of numerous requirements for hazardous rooms and could have affected all of the occupants of each affected smoke zone.	K 321		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918	On 7/21/22, SAS followed up and called Cummins Central Power to schedule the load bank testing and to receive an estimated delivery date for new batteries. Once we receive notification back from Cummins, this will be performed as soon as possible. Facility has no additional generators that could potentially be out of compliance. SAS or designee will audit generator compliance weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit findings to QAPI committee monthly,	

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	435046	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2022**

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	**401 WEST SECOND STREET SIOUX FALLS, SD 57104**

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K 918	Continued From page 4 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the provider failed to perform generator maintenance as required (monthly load runs, load bank testing, and battery testing and replacement) for the Cummings diesel generator in 2022. Findings include: 1. Observation on 6/28/22 at 11:50 a.m. revealed generator batteries were last changed in September, 2018. Three years was an acceptable life interval for generator batteries. Interview with the maintenance supervisor at the time of observation revealed he was not aware of the appropriate interval for change out. 2. Record review on 6/28/22 at 3:30 p.m. revealed documentation of generator load runs were for fifteen minutes (0.25 hours) each week. No thirty minute load tests were performed. Interview with the maintenance supervisor at the time of the record review confirmed that finding. The monthly load runs must be for thirty minutes	K 918	and the committee will determine ongoing monitoring and interventions.	7/21/22

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K 918	Continued From page 5 (0.5 hours) plus a minimum five minute (0.1 hour) cool down time. 3. Record review on 6/28/22 at 3:45 p.m revealed there was no documentation the monthly load runs had met or exceeded thirty percent (30%) of the generator's name plate capacity in order to avoid an annual load bank test for a diesel generator. No load bank testing had been performed. Interview with the maintenance supervisor at the time of the record review confirmed these findings. These deficiences have the potential to affect all staff and residents within the facility.	K 918		

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	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING	06/28/2022

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/28/22. Good Samaritan Society Sioux Falls Center Building 2 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K225, K226, K321, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain conforming exit stairs for one of four stair enclosures (stairwell descending from the solarium area). Items were stored in the stair enclosure. An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit. Findings include: 1. Observation on 6/28/22 at 10:30 a.m. revealed a wheelchair, a box, and an extension cord were stored in the stair enclosure at the first level of the	K 225	On 6/28/22, all stored items in the stairway were removed. All other stairways have the potential of being deficient. On 6/28/22, all other stairways were been inspected and are clean and clear of any storage items. SAS or designee will ensure all stairways remain clean and clear from objects. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/20/22

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Marissa Tordoff | Administrator | 7/25/22

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	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING	06/28/2022

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

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K 225	Continued From page 1 solarium stair enclosure. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated he was unaware those items could not be kept in the stair enclosure. 2. Observation on 6/28/22 at 1:35 p.m. revealed a box stored on the landing of the solarium stair enclosure. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated he was unaware those items could not be kept on the stair landing. The deficiency has the potential to affect all staff and residents within the facility.	K 225		
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire-resistive design of one of one horizontal exit and building separation walls (between the original building and the 1972 addition). Findings include: 1. Observation on 6/28/22 at 12:45 p.m. revealed the two-hour, fire-rated separation wall between	K 226	On 7/18/22, both sets of wooden 90-minute fire rated doors identified have been modified to close properly. All other wooden 90-minute fire rated doors have the potential of being deficient. On 7/18/22, all wooden 90-minute fire rated doors were inspected to make sure they close properly. SAS or designee will ensure all stairways remain clean and clear from objects. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/18/22

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K 226	Continued From page 2 the original building and the addition had ninety-minute, fire-rated wood doors that did not latch. The the pair of cross corridor doors were too swelled to close completely. Interview on 6/28/22 at 12:45 p.m. with the maintenance supervisor confirmed that condition. He verified the door would need to be sanded in order to have complete closure. The deficiency could affect 100% of the occupants of the smoke compartments on each side of the pair of doors.	K 226		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321	By 7/22/22, the ceiling opening in the first floor boiler room will be enclosed with and sealed with approved fire-stop material. By 7/29/22, all other ceiling openings in Main Building 2 have the potential to be deficient. Any other potential penetrations through fire barriers will be inspected to ensure those enclosures are sealed with fire-stop material. SAS or designee will audit each empty resident room to ensure the room is clear of non-essential combustibles. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit	

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K 321	Continued From page 3 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain a hazardous area (second floor maintenance area known as the Doghouse) in Building 2 with a one hour separation as required. Findings include: 1. Observation on 6/28/22 at 11:45 a.m. revealed the second floor maintenance area known as the Doghouse was over 100 square feet and did not maintain a one-hour fire separation. The ceiling separation had six four-inch holes cut to provide access for piping and pipe hangars. The space between the piping or pipe hangars were not provided with an approved fire-stop material such as intumescing fire caulk. Interview with the maintenance technician at the times of the observations confirmed those findings. The deficiency affected one of numerous requirements for hazardous rooms and could have affected all of the occupants of each affected smoke zone.	K 321	findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/29/22
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918	On 7/21/22, SAS followed up and called Cummins Central Power to schedule the load bank testing and to receive an	

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GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 918	Continued From page 4 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the provider failed to perform generator maintenance as required (monthly load runs, load bank testing, and battery testing and replacement) for the Cummings diesel generator	K 918	estimated delivery date for new batteries. Once we receive notification back from Cummins, this will be performed as soon as possible. Facility has no additional generators that could potentially be out of compliance. SAS or designee will audit generator compliance weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/21/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING 02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION B. WING _____	06/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 918	Continued From page 5 in 2022. Findings include: 1. Observation on 6/28/22 at 11:50 a.m. revealed generator batteries were last changed in September, 2018. Three years was an acceptable life interval for generator batteries. Interview with the maintenance supervisor at the time of observation revealed he was not aware of the appropriate interval for change out. 2. Record review on 6/28/22 at 3:30 p.m. revealed documentation of generator load runs were for fifteen minutes (0.25 hours) each week. No thirty-minute load tests were performed. Interview with the maintenance supervisor at the time of the record review confirmed that finding. The monthly load runs must be for thirty minutes (0.5 hours) plus a minimum five minute (0.1 hour) cool down time. 3. Record review on 6/28/22 at 3:45 p.m revealed there was no documentation the monthly load runs had met or exceeded thirty percent (30%) of the generator's name plate capacity in order to avoid an annual load bank test for a diesel generator. No load bank testing had been performed. Interview with the maintenance supervisor at the time of the record review confirmed these findings. These deficiences have the potential to affect all staff and residents within the facility.	K 918		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 W 2ND ST SIOUX FALLS, SD 57104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/27/22 through 6/30/22. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement: S169.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to ensure an electrically audible alarm on all unattended exit doors was provided on two of six exit doors to the exterior (east door and door to the smoking area). Findings include: 1. Observation on 6/28/22 at 10:10 a.m. revealed the door alarm at the east door to exit the facility was not working. Currently the door was locked	S 169	The door at the east to exit the facility and the exit door to the smoking area are alarming properly as of 7/21/2022. Additionally, new magnetic locks have been purchased awaiting shipment to facility to replace when delivered. All other exit doors have the potential to be deficient. By 7/20/22, all other exit doors are either monitored, locked or alarmed for resident and facility safety. SAS or designee will audit all exit doors to ensure they are either monitored, locked or alarmed. Audits will occur weekly x4, every other week x2, monthly x1, and quarterly x1. SAS or designee will report audit findings to QAPI committee monthly, and the committee will determine ongoing monitoring and interventions.	7/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Marsha Tendoff — Administrator — 7/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 W 2ND ST SIOUX FALLS, SD 57104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 169	Continued From page 1 for entry to the facility, but exit could occur without alarm. Due to layout and location of those exit access doors the doors could not be considered easily seen by staff. Record review on 6/28/22 at 3:20 p.m. revealed the alarm had not been working since 4/14/22. Interview at on 6/28/22 at 4:15 p.m. with the maintenance supervisor and administrator confirmed the above condition. 2. Observation on 6/28/22 at 12:15 p.m. revealed the door alarm at the smoking area exit was not working. The door had swollen and could not close, and no alarm was heard. This allowed any person to enter or leave at will. Those exit access doors they could not be considered attended by staff unless the activities room was in use. Interview at on 6/28/22 at 12:15 p.m. with the maintenance supervisor confirmed the door had swollen and could not close	S 169		
S 000	Compliance/Noncompliance Statement 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 6/27/22 through 6/30/22. Good Samaritan Society Sioux Falls Center was found in compliance.	S 000		