STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/28/25 through 1/30/25. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F657, F658, F677, F684, F686, F692, F755, F758, F761, F812, F880, and F919. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/28/25 through 1/30/25. Areas surveyed included resident to resident abuse and admission, transfer, and discharge rights. Good Samaritan Society New Underwood was in compliance.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657	Resident 2 and 35's care plan has been updated to reflect all current interventions. All residents are at potential risk for deficient practice due to non-compliance with care plan interventions. Education will be provided by the Director of Nursing to all nursing staff regarding care plan interventions that are determined by the clinical meeting with the interdisciplinary team. New internal tool was established to communicate all updates in resident's plan of care. Director of nursing or designee will audit care plan for timely interventions. Director of nursing or designee will audit care plans for compliance weekly x3, every other week x3 and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paul Hubbeling	LNHA	2/23/25

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 657	Continued From page 1	F 657		

not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and policy review the provider failed to ensure the care plans were reviewed and revised to reflect the current care needs for two of fourteen sampled residents (2 and 35). Findings include:

1. Observation on 1/28/25 at 10:40 a.m. of resident 2 revealed:
*She was sitting in the hallway on a bench.
*She had a four-wheel walker in front of her.
*She loudly requested staff to remove another resident that was talking to her, stating, "She is bothering me".
*She got up from the bench and walked to an exit door.
*She pushed on the door but did not exit.

Observation on 1/28/25 at 3:38 p.m. of resident 2 revealed she had a Wander guard (wearable door alarming device) on her left ankle.

Interview on 1/29/25 at 4:34 p.m. with certified nursing assistant (CNA) T regarding resident 2 revealed:
*Interventions for behaviors and falls were included in her care plan.
*When she exhibited behaviors staff were to offer her picture books, assist her to call her daughter,

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F 657	Continued From page 2 and turn on old country music. *Interventions in place for her falls included a pressure call light under hip to alert staff when she was getting up. *She recently was on a one-to-one staff monitoring because when she was left alone, she tried to get up and she was unsteady. *She had been working with physical therapy. Review of resident 2's electronic medical record (EMR) revealed: *She was admitted on 11/11/24. *Her 11/13/24 Brief Interview of Mental Status (BIMS) assessment score was 5, which indicated she had severe cognitive impairment. *Her diagnoses included Alzheimer's disease and other specified depressive episodes. *A 1/15/25 physician's order for lorazepam injection solution 2 mg(milligrams)/ml(milliliters) with instructions to inject 2 mg intramuscularly every 24 hours as needed for "anxiety, aggressive behavior". Review of resident 2's 1/29/25 care plan revealed: *An intervention, initiated on 11/18/24, within the cognitive function focus area indicated, "Wander Guard applied to walker due to wandering and difficulty with direction." *A focus area initiated on 11/1/24 of "at risk for altered mood/psychosocial well-being r/t [related to] SNF [skilled nursing facility] placement, change in environment, loss of independence, depression and anxiety. *On 12/10/24 it was revised to include "Deer Oaks [a psychological service utilized by the provider] for psychological services in place." *A focus area of "The resident has potential for elopement R/T [related to] Hx. [history] leaving	F 657		

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F 657	Continued From page 3 building during night hours R/T [related to] Alzheimer's, Dementia" *Interventions for this focus included: -"Attempt non-pharmacological interventions." -"Wander guard used to alert staff to resident's movements." -"Minimize potential of resident behavior problems by modifying environmental factors and daily routine." --The modifications were not specified. *A focus area for "falls r/t [related to] Alzheimer's Disease, Dementia, Wandering behavior's, E/B [evidence by] Confusion, Wander Guard in place, Exit seeking, hx [history] of falls prior to admission." *The interventions for falls did not include a pressure call light under hip to alert staff when she was getting up. *Interventions that staff identified were not addressed in the care plan. 2. Observation on 1/28/25 at 9:39 a.m. of resident 35 in her room revealed: *The door on her room was closed. *After being invited to enter, resident 35 was crouched behind her lift chair. *Her walker was not near her. *She was pulling cords out of the back of the partially lifted lift chair. *She walked to the bathroom without her walker. *There was a sign on the wall above her bed that said, "CALL DON'T FALL". *Resident 35 then stood beside the lift chair, lowered the chair to a reclined position and turned on the heat and massage function of the chair. *Her call light was attached to the lift chair. *She returned to the back of the lift chair and pulled on the cords. *When she was asked if she could turn her call	F 657		

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F 657	Continued From page 4 light on for assistance, she moved from behind the lift chair and pressed the call light to turn it on. *She then walked to her room door, without her walker. *Multiple unidentified staff walked past resident 35 standing at the door of her room without her walker. *When CNA U answered the call light she removed the remote for the heat/massage from the lift chair. *Resident 35 continued to walk in her room without the use of her walker. CNA U did not give the walker to resident 35 or encourage her to use it. Observation on 1/28/25 at 3:38 p.m. of resident 35 in her room revealed: *The door to her room was open. *She was walking in her room without her walker. *There was a gold gait belt hanging on the bathroom door. Observation on 1/29/25 at 10:49 a.m. of resident 35 revealed: *She was walking in the hall with her walker. *Staff were not assisting. *She was not wearing a gait belt. Interview on 1/29/25 at 4:36 p.m. with CNA T regarding intervention for resident 35's falls revealed: *Staff visualized her frequently. *Staff were to ensure she had her walker when she was ambulating, and she used it correctly. *Staff were to ensure her call light was near her when she is in her room. *A gait belt was not used because she walked independently with her walker.	F 657		

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F 657	Continued From page 5 Review of resident 35's EMR revealed: *She was admitted on 10/9/24. *Her 1/6/25 BIMS assessment score was 8, which indicated she had moderate cognitive impairment. *Her diagnoses included dementia, depressive episodes, and anxiety. *There was no assessment completed for resident 35's safe use of the lift chair. Review of resident 35's 1/29/25 care plan revealed: *Her care plan did not address the use of a lift-chair with heat and massage features. *Within the activities of daily living focus area the ambulation intervention indicated, "Resident 1 assist to ambulate with walker or at least supervised with ambulation, gait belt on if resident allows, as safety measure. Resident will not remember to use call light or wait for assist [assistance] to walk. Respect residents right to self ambulate." *The focus falls area indicated, "The resident is at risk for falls R/T [related to] reported by resident and [family member] that [resident 35] has fallen frequently in the past few months E/B [evidence by] Bruises present to buttocks and right elbow/forearm when admitted." *One of her fall interventions indicated, "Obtain gold gait belt for increased compliance and use." *The interventions for frequent visualizations and ensuring resident 35 had her walker and was using it properly were not included in her care plan. Interview on 1/30/25 at 9:19 a.m. with Minimum Data Set (MDS) registered nurse (RN) K revealed: *Care plans gave direction for staff to care for the	F 657		

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F 657	Continued From page 6 residents and should be person-centered. *Each morning there was a "stand up" meeting, where the falls were reviewed, and interventions were determined. *After the meeting the interventions were to be entered in the resident's care plan. *The updates were to be in the care plan, at the nurse's station, and in the breakroom. *CNAs could also refer to the resident's Kardex (a report of residents' care needs and interventions) to view the interventions. *New residents had a baseline care plan for falls, pressure ulcers, and pain. *Sometimes specific falls were put included in the care plan. *She stated if she was not aware of a specific fall it would not be entered into the care plan. *She indicated multiple staff would enter information into the residents' care plans. *MDS RN K indicated the injuries identified in resident 35's care plan were no longer present. *When asked to clarify if resident 35 was to use a gait belt with the assistance of one staff or was to walk independently she replied, the staff should know if someone was walking independently and a gait belt did not need to be used. *When asked about the gold gait belt for resident 35, MDS RN K indicated she was not aware of that intervention. *She stated staff should know how to care for the residents and their interventions, because the facility is small. *She agreed that resident 35's improper use of her walker and the interventions should be included under her risk for falls in her care plan. Review of the provider's 12/2/24 Care Plan policy revealed: *"Each resident will have an individualized,	F 657		

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F 657	Continued From page 7 person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs." *"The plan of care will be modified to reflect the care currently required/provided for the resident."	F 657	Resident 88 – pain assessment completed. Notification to physician to clarify parameters related to pain medication administration and resident cognition. Resident 11 – resident has since discharged. Residents who receive narcotics are at risk for deficient practice. Residents who smoke are at risk for deficient practice. Education will be provided by the Director of Nursing to all nursing staff regarding pain management scale and resident's cognitive ability to determine a pain scale. Staff also educated on the smoking and tobacco use policy. Director of nursing or designee will audit residents who receive narcotic analgesics for appropriate direction related to cognitive deficits and new admissions for tobacco use. Director of nursing or designee will audit residents who receive analgesics for appropriate direction related to cognitive deficits and new admissions for tobacco use for compliance weekly x3, every other week x3 and monthly x3.	2/27/25
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to adhere to professional standards of practice for: *Following a physician-ordered pain assessment scale prior to the administration of narcotic pain medication for one of one sampled resident (88). *Obtaining physician clarification regarding the type of pain scale assessment ordered by that provider for use with one of one sampled resident (88). *Completing a safety smoking assessment for one of one sampled resident (11) who smoked. Findings include: 1. Observation on 1/28/25 at 10:00 a.m. of resident 88 in her room revealed: *The resident was transferred from her wheelchair to her bed by two caregivers. -She wore a sling on her left arm and verbalized "Ow" when that arm was touched or moved by	F 658		

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F 658	Continued From page 8 the caregivers during the transfer process. Review of resident 88's electronic medical record (EMR) revealed: *She was admitted on 1/15/25 and her diagnoses included a left humerus (the long bone in the upper arm extending from the shoulder joint to the elbow) fracture and vascular dementia. *Her 1/16/25 Brief Interview for Mental Status (BIMS) assessment score was 1. That indicated her cognition was severely impaired. Review of resident 88's January 2025 medication administration record (MAR) revealed: *Her physician-ordered pain medications included oxycodone HCl (5 mg) which to be given every four hours as needed (PRN). "Give 1 capsule by mouth every 4 hours as needed for pain 8-10/10 scale [a numerical rating of pain based on a scale of zero (no pain) through 10 (severe pain) as reported by the resident]." *Oxycodone was administered 12 times between 1/16/25 and 1/29/25. -Seven of those times it was administered for a pain level less than 8: once for a pain level of zero, twice for a pain level of 1, and once each for pain levels of 2, 4, 6, and 7. -Four different licensed nursing staff had been responsible for those same oxycodone administrations. Interview on 1/29/25 at 2:50 p.m. and review of resident 88's above MAR with licensed practical nurse (LPN) F revealed: *The resident was not able to have rated her pain based on a numeric scale because of the level of her cognitive impairment. -LPN F used a faces pain assessment scale. That included a series of face pictures with	F 658	Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25

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F 658	Continued From page 9 different expressions that provided her with a way to understand what level of pain the resident may have been experiencing. *She agreed the PRN oxycodone order was not administered according to the physician's order. for 7 of 12 administrations. Interview on 1/29/25 at 3:05 p.m. and review of resident 88's above MAR with director of nursing (DON) B revealed: *PRN oxycodone was not administered per the physician's order for 7 of 12 administrations. -Those administrations were considered to have been medication errors. *Nursing staff failed to notify the physician the resident was unable to verbally rate her pain and a pain scale appropriate for someone with a severe cognitive impairment was needed instead. Review of the provider's 2/2/24 Pain Management policy revealed: *"The licensed nurse will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological [without medication], as well as pharmacological [medication]. The licensed nurse will review response to medication intervention and work closely with the physician to assist in the individualized pain management plan." Review of the provider's revised 4/1/24 Physician/Practitioner Orders policy revealed: *Physician/Practitioner Orders Content: "1. Clarification orders are needed when reviewing any type of physician/practitioner orders that are incomplete or raise questions." "If any question arises, nursing services are responsible for obtaining clarification."	F 658		

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F 658	Continued From page 10 2. Interview during the entrance conference on 1/28/25 at 8:30 a.m. with DON B revealed the facility was a non-smoking facility. Observation and interview on 1/28/25 at 9:02 a.m. with resident 11 revealed: *She entered her room. *Her daughter was already in the room. *Resident 11 stated she was going to go out of the facility with her daughter. Review of resident 11's EMR revealed: *Her admission date was 3/28/24. *Her 12/23/24 BIMS assessment score was a 14, which indicated her cognition was intact. *Her diagnoses included: diabetes, chronic kidney disease, COPD, Hypertension, Major Depressive Order, Alzheimer's Disease, Post Traumatic Stress Disorder, Chronic pain, fibromyalgia, heart disease, and anxiety. *A 9/26/24 physician order's indicated "Resident may go out on pass with family. She may not smoke on the facility grounds. She may not go out to smoke unless a responsible party is with her. Daughter must sign resident out at the Nurses Station before she can leave [the] facility to visit. May not go out overnight." *Her nurse progress notes included: *On 9/26/24 resident 11 stated she was "going outside to smoke". -The nurse read the "new order pertaining to leaving facility to resident." -Resident 11 became upset and stated that she has two friends who were "coming over to check her out." -The nurse explained the "MD [medical doctor] order specified "daughter" is who the resident could leave with.	F 658		

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F 658	Continued From page 11 Review of resident 11's 1/28/25 care plan included: *A 7/12/24 focus area that indicated, resident 11: -" Is a smoker and expresses the desire to smoke despite ongoing education from facility staff and provider regarding the risks of continued smoking with her current health status." -"Will demonstrate compliance with the facility nonsmoking policy e/b [evidenced by] not smoking in facility, on facility grounds or off property (unless taken out on pass by family)." -"Has been offered a referral for smoking cessation and staff will continue to counsel her on the detrimental effects of continued smoking." -"Per provider: [Resident 11] lacks the safety awareness to sign herself out to go off [the] property to smoke, [resident 11] has an active order that she can only go out on pass/off facility grounds with a family member." -"And her family are aware of the tobacco free facility policy and their responsibility to abide by those rules." Interview and review of EMRs on 1/29/25 at 1:49 p.m. with DON B regarding resident smoking assessments revealed: *The admission/re-admission assessment included a question about whether a resident smoked or not." -If this question was marked 'positive' it would trigger a smoking assessment to be completed. *Resident 11's 11/4/24 return from the hospital readmission assessment revealed: -Her current use of tobacco was marked positive which indicated she smoked. -There was no documented safe smoking assessment completed.	F 658		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 12 Continued interview on 1/29/25 at 2:00 p.m. with DON B revealed a safe smoking assessment should have been completed for resident 11 after she was re-admitted from the hospital. Review of the provider's 4/27/22 Tobacco Free policy revealed: *"Residents who smoke must not pose a safety hazard to themselves or others."	F 658		
F 677 SS=F	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 interview and record review, the provider failed to ensure bathing was provided to 13 of 16 sampled residents (2, 7, 10, 11, 12, 17, 23, 27, 29, 30, 32, 34, and 35), in a census of 36 residents while certified nursing aide (CNA)/bath aide N was not at the facility. Findings include: 1. Interview on 1/29/25 at 1:40 p.m. with CNA L revealed: *Residents were to be bathed at least once per week. Some residents preferred two baths. *CNA/bath aide N was in charge of bathing residents and making the bathing schedule. *He stated that all CNAs were trained and capable of bathing residents. *He was able to show this surveyor the bathing schedule and the completed bath sheet. Interview on 1/29/25 at 2:30 p.m. with licensed practical nurse (LPN) F revealed:	F 677	Resident 7, 10, 11, 12, 17, 23, 27, 29, 30, 32, 34, and 35 have all received a bath. All residents are at potential risk by not receiving proper bathing. Bathing schedule was revised for consistency and changes was made in staffing to accommodate bathing. Director of Nursing or designee will educate all nursing staff on new process. Education will be provided by the Director of Nursing to all nursing staff regarding proper bathing, and auditing of proper bathing to ensure compliance. Director of nursing or designee will audit completion of bathing schedule weekly x3, every other week x3 and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 677	Continued From page 13 *Residents were to be bathed at least once per week. *CNA/bath aide N was in charge of bathing residents. *If CNA/bath aide N was ill or unable to work, another CNA would be given the task of bathing residents that day if staffing permitted. *If staffing did not permit, the resident would be offered their bath on a different day that week. Interview on 1/30/25 at 1010 a.m. with CNA/bath aide N revealed: *She is scheduled to work every week from Sunday through Thursday, 8 hours per day. *She recently missed two weeks period work due to a scheduled hand surgery. *It was her expectation residents would still have received their baths during her absence. *She reported that she had trouble keeping up with the bathing schedule by herself. *The other CNAs help as much as they can. *She had asked management for help but has not received it. Interview on 1/30/25 at 10:30 a.m. with director of nursing (DON) B revealed: *She was aware CNA/bath aide N was recently on leave from work. *She expected residents to be bathed at least once per week. *She reported that registered nurse (RN) E made the CNA schedule. *She had assumed RN E would have scheduled other staff to complete the bathing task in CNA/bath aide N's absence, but she did not. Interview on 1/30/25 at 12:35 p.m. with resident 10 revealed: *She preferred to have two baths per week.	F 677		

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GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 677	Continued From page 14 *She recalled when CNA/bath aide N was not working recently, she was not receiving her baths as scheduled. Interview on 1/30/25 at 12:45 p.m. with resident 29 revealed: *She preferred to have two baths per week. *She recalled she recently was not getting her baths as scheduled. "It's because [CNA/bath aide N] was gone". *"We really missed her". Review of the provider's "Suggestion or Concern" form completed by resident 17's daughter on 1/22/25 revealed she had concerns about resident 17 missing his scheduled baths. Review of documentation in Point Click Care (PCC) (documentation system used by the provider) regarding resident baths revealed: *Resident 2 received a bath on 1/15/25, then did not receive a bath until 1/29/25, 13 days in between baths. *Resident 7 received a bath on 1/15/25, then did not receive a bath until 1/28/25, 12 days in between baths. *Resident 10 received a bath on 1/9/25, then did not receive a bath until 1/27/25, 17 days in between baths. *Resident 11 received a bath on 1/8/25, then did not receive a bath until 1/29/25, 20 days in between baths. *Resident 12 received a bath on 1/7/25, then did not receive a bath until 1/23/25, 15 days in between baths. *Resident 17 received a bath on 1/9/25, then did not receive a bath until 1/23/25, 13 days in between baths. *Resident 23 received a bath on 1/9/25, then had	F 677		

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F 677	Continued From page 15 not receive a bath through the time of the survey on 1/29/25. *Resident 27 received a bath on 1/7/25, then did not receive a bath until 1/20/25, 12 days in between baths. *Resident 29 received a bath on 1/9/25, then did not receive a bath until 1/26/25, 16 days in between baths. *Resident 20 received a bath on 1/13/25, then did not receive a bath until 1/23/25, 9 days in between baths. *Resident 32 received a bath on 1/13/25, then did not receive a bath until 1/27/25, 13 days in between baths. *Resident 34 received a bath on 1/13/25, then did not receive a bath until 1/27/25, 13 days in between baths. *Resident 35 received a bath on 1/7/25, then had not received a bath through the end of the survey on 1/29/25.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to: *Implement and document physician-ordered bowel management interventions for one of one	F 684		

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F 684	Continued From page 16 sampled resident (88). *Follow a physician-ordered therapeutic diet for one of one sampled resident (88). Findings include: 1. Observation on 1/28/25 at 10:00 a.m. of resident 88 in her room revealed: *The resident was transferred from her wheelchair to her bed by two caregivers. -She wore a sling on her left arm and verbalized "Ow" when that arm was touched or moved by the caregivers during the transfer process. Review of resident 88's electronic medical record (EMR) revealed: *She was admitted on 1/15/25 and her diagnoses included a left humerus (the long bone in the upper arm extending from the shoulder joint to the elbow) fracture and vascular dementia. *Her 1/16/25 Brief Interview for Mental Status (BIMS) assessment score was 1. That indicated her cognition was severely impaired. Review of resident 88's 1/16/25 through 1/27/25 medication administration record (MAR) revealed: *Her pain medication included physician orders for: -Extra-strength acetaminophen (500 milligram [mg]), acetaminophen (650 mg), and oxycodone HCl (5 mg). *A side effect of those pain medications was constipation. Her ordered medications to mitigate the risk for constipation included: -Docusate Sodium (stool softener) which was to be administered twice daily. -A fiber powder (makes stools bulkier/softer) mixed in liquid which was to be administered daily. *Her ordered PRN (as needed) constipation	F 684	Resident 88 has been assessed for proper bowel management. All residents are at potential risk if bowel management protocols are not followed for resident who use narcotic pain medications, and documentation for supporting non –pharmacological interventions. Bowel management interventions in Point Click Care electronic medical record reviewed and activated. Director of Nursing provided education to Health Information Manager to ensure new admission orders include activating bowel management protocol. Education will be provided by the Director of Nursing to all nursing staff regarding proper bowel management protocol. Director of nursing or designee will audit bowel management interventions for non-compliance weekly x3, every other week x3 and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25

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F 684	Continued From page 17 medications included: -Dulcolax suppository. "Insert 1 application rectally as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM [bowel movement]." -Fleet enema. "Insert 1 application rectally as needed for constipation. One time daily as needed. Contact provider/practitioner if there are three days without a significant BM." -Milk of Magnesia. "Give 30 ml [milliliters] by mouth as needed for constipation. Give daily as needed. Contact provider/practitioner if there are three days without a significant BM." *None of those PRN constipation medications had been administered to her in January 2025. Continued review of resident 88's EMR revealed: *The resident's bowel continence, amount, and consistency from 1/16/25 through 1/27/25 was documented on a user-defined assessment (UDA). -That UDA documentation indicated there had been two instances when resident 88 had gone without having a BM for at least three days. Those dates were 1/18/25 through 1/21/25 and from 1/25/25 through 1/27/25. *Review of resident 88's interdisciplinary progress notes revealed no mention of her having had constipation symptoms, requiring any constipation-related interventions, or that her physician was notified she had not had a BM for three days. Interview on 1/29/25 at 2:50 p.m. with licensed practical nurse F regarding resident 88's bowel management program revealed she: *Confirmed the UDA documentation above was completed throughout the day by certified nurse	F 684		

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F 684	Continued From page 18	F 684		

aides to document a resident's bowel activity. Nursing staff were to review and implement bowel management interventions based on that documentation.
*Thought resident 88 had received non physician-ordered constipation interventions such as prune juice when she had not had a BM in three days. She confirmed there was no documentation to support that had occurred. There was no documentation to support the physician's order to have been contacted if the resident had no significant BM in three days was followed.

Interview on 1/29/25 at 3:05 p.m. with director of nursing B regarding resident 88 revealed:
*The interdisciplinary team met on weekday mornings to discuss resident-related information including residents identified through UDA documentation who had no BM after three days. That same documentation also prompted an "alert" on the EMR dashboard that notified the nursing staff of the same information.
-It was expected nursing staff had documented a response and/or nursing intervention in response to that alert before they "cleared" it from the dashboard. That had not occurred.
*There was no documentation to support acknowledgement of resident 88 having had no BM in three days or that physician-ordered bowel management interventions had been implemented for her.

Review of the provider's revised 5/21/24 Bowel & Bladder policy revealed:
*Purpose: "To assess bowel and bladder function appropriately. To identify appropriate bowel or bladder management programs."
Policy: "Based on the resident's comprehensive

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F 684	Continued From page 19 assessment, the location will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as possible."	F 684	Resident 23 had a wound RN assessment, user defined assessment completed. Notification to Genteel wound consultant for assessment and treatment recommendations placed. All residents with pressure related injury are at risk for improper wound documentation and assessment. Education will be provided by the Director of Nursing to all nursing staff regarding care plan interventions that are determined by the clinical meeting with the interdisciplinary team. New internal tool was established to communicate all updates in resident's plan of care. Director of nursing or designee will audit care plan for timely interventions. Director of nursing or designee will audit care plans for compliance weekly x3, every other week x3 and monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to prevent one of one sampled resident (23) from developing a facility-acquired pressure ulcer and to assess and document that facility-acquired pressure ulcer accurately. Findings include: 1. Observation and interview on 1/28/25 at 9:20 a.m. with resident 23 revealed: *She was in bed lying on her back. -She stated, "I have a blister on my butt, so they wanted me to lay here a little longer to help it heal, but I hate it." -Resident 23 agreed to the observation of her	F 686		

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F 686	Continued From page 20 wound care and stated that her dressing changes were usually done in the morning. 2. Observation and interview on 1/28/25 at 3:43 p.m. with resident 23 revealed: *She was sitting up in her chair. -She stated that the staff uses a sling to move her from her bed to her chair and she eats all of her meals sitting in her chair in her room. 3. Observation of wound care on 1/29/25 at 10:03 a.m. revealed a pressure ulcer on resident 23's left buttock that had already been cleaned and covered with zinc oxide. -The nurse applied a Mepilex dressing (a foam dressing used to treat pressure ulcers) over the sacral area (a bony structure at the base of the lumbar spine). 4. Interview on 1/30/25 at 9:20 a.m. with certified nursing aide (CNA)/unlicensed medication aide (UMA) L about pressure ulcer prevention for residents revealed he would use the following interventions: frequent position changes, offloading (removing pressure from the site), and keeping skin clean and dry. -He stated he would know which interventions to use for each resident by looking at the resident's care plan. -If he had any concerns about a resident's skin or noticed any changes, he would report it to the nurse. -When asked specifically about interventions for resident 23, he stated that she prefers female care providers, so he did not often work with her and was unsure of specific interventions ordered for her. 5. Interview on 1/30/25 at 9:26 a.m. with	F 686		

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F 686	Continued From page 21 registered nurse (RN) J about preventing pressure ulcers revealed the interventions she would use included: providing good skin care by keeping skin clean and dry, and using barrier cream, good nutrition, pressure relieving mattresses, and weekly skin assessments. *She stated CNAs should report any changes in skin integrity to the nursing staff immediately, and then the nursing staff would contact the physician for specific wound care orders. 6. Interview on 1/30/25 at 10:45 a.m. with director of nursing (DON) B revealed the interventions she would expect her staff to provide to prevent pressure ulcers would include using cushions in chairs/wheelchairs, pressure relieving mattresses, dietary/nutrition assessment, turning or repositioning every two hours, good skin care and using a barrier cream to protect the skin. *She stated: -Residents' weekly skin assessments were to be completed following each resident's bath. -CNAs would not know which interventions to use if they were not listed on the care plan. -Documentation for pressure ulcers was to include weekly measurements of the pressure ulcer by the infection preventionist/wound care RN, and the treatment orders were to be reviewed every two weeks for efficacy. -When asked specifically about resident 23's pressure ulcer, she stated she would be surprised if no measurements were documented because that was the expectation. -She reviewed the documentation and agreed that the required pressure ulcer measurements were missing. 7. Review of resident 23's medical record revealed:	F 686		

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F 686	Continued From page 22 *She was admitted on 11/4/22. *She had a Brief Interview for Mental Status (BIMS) assessment score of 13, which indicated she was cognitively intact. *Her diagnoses included hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness that affects one side of the body) following cerebral infarct (a stroke) affecting the left non-dominant side, essential (primary) hypertension, deficiency of other specified B-group vitamins, vitamin D deficiency, neuromuscular dysfunction of the bladder (nerves controlling the bladder are damaged, leading to disrupted communication between the brain and bladder), and polyneuropathy (multiple peripheral nerves are damaged, leading to problems with sensation and coordination). *A 10/12/24 nursing-to-physician communication note indicated resident 23 had a "small opening on her left buttock"; the area was cleaned, and zinc oxide was applied, "encouraging her to offload." *An order received was on 10/15/24 for "wound care to left buttock. Cleanse, apply zinc oxide until healed." *On 10/15/24, a family communication note said, "Summary of discussion/notification and any education provided: Shearing to resident's left buttock." *A 10/20/24 nursing note indicated she had a "Left buttock open sore." *A care plan focus revised on 11/11/24 indicated: "The resident has potential for pressure ulcer development R/T [related to] hx [history] of Cerebral Infarction, Polyneuropathy; E/B [evidenced by] Left hemiparesis, Left side neuropathy, Extensive assistance with Bed Mobility, Total Lift for all transfers." -The associated goal revised on 11/11/24	F 686		

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F 686	Continued From page 23	F 686		

indicated: "[Resident 23] will maintain intact skin integrity, free of redness, blisters or discoloration through the review date."
*A 12/4/24 nursing note indicated "Left buttock with shearing, with 2 open areas on right buttock, zinc and mepilex applied."
*A care plan focus area revised on 1/23/25 indicated: "The resident has potential for impairment to skin integrity R/T [related to] incontinence, bed/chair bound."
*Care plan goals revised on 1/23/25 indicated:
-"Resident will be free from skin injury through the review date."
-"Resident will have no complications R/T [related to] skin injury through the review date."
*Wound assessments were documented by a licensed practical nurse (LPN) but were incomplete and lacked measurements to document the size of the wound and description of wound bed.
*A care plan intervention revised on 1/23/25 indicated she was to be repositioned every two hours.

8. In an interview on 1/30/25 at 12:35 p.m. with infection preventionist/wound care RN E regarding pressure ulcers she stated, "Here's our wound care policy. According to our policy, we don't have to measure shearing."

9. Review of the provider's 6/5/24 "Pressure Ulcer/Wound Care Resource Packet-Rehab/Skilled" policy revealed:
*Introduction
-"Promotion of healing, pain management and prevention of complications is extremely important, as well as accurate assessment and documentation."
*Forms:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

(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 686	Continued From page 24 -Wound RN Assessment UDA (user-defined assessment) "is required every seven days and as needed when skin integrity is impaired or open area is present." This assessment includes measurement of the wound to document improvement or worsening of the wound. *"Best Practices for Wound Management" -The Wound Care Education Institute (WCEI) is listed as a resource for comprehensive training and education. --A review of WCEI education indicates a "shearing wound damages the skin on a deeper level" and "shearing can only contribute to and compound the damage created by pressure."	F 686	Dietary interventions processed and initiated for resident 6 Residents at risk are those who trigger for weight loss per CMS regulations. All residents have dietary recommendation initiated as ordered. Education will be provided by the Director of Nursing to all nursing staff regarding care plan interventions that are determined by the clinical meeting with the interdisciplinary team. New internal tool was established to communicate all updates in resident's plan of care. Education will be provided by the Director of Nursing to all nursing and dietary staff in collaboration regarding interventions regarding to weight loss and timely interventions. Dietary manager will continue to update dietary staff of ongoing needs IDT team will meet every other week to identify dietary recommendations and ensure proper follow up. Dietary manager, or designee will audit recommendations for proper follow up and completion, every other week x 3, monthly x 3, quarterly x 3. Dietary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Dietary Manager, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	2/27/25
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 692	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a registered dietician's (RD) recommendations had been implemented for one of one sampled resident (6) at nutritional risk related to her weight loss. Findings include: 1. Observations on 1/28/25 at 10:09 a.m. and 12:15 p.m. of resident 6 in her room revealed: *She had been asleep in her bed. *There was an opened bottle of Boost + (a nutritional supplement) with a straw inside of it, a lidded plastic mug with eight ounces of water and a straw inside of it, and an unopened container of Medtrition Gelatein (a jello-type protein supplement) on her nightstand beside her bed. Interview on 1/28/25 at 10:15 a.m. with director of nursing (DON) B regarding resident 6 revealed: *She was hospitalized mid-January 2025 with an upper respiratory infection. During her hospital stay, she developed a COVID-19 infection. -The resident had a physical decline and a decline in behaviors (slapping, kicking, biting, and pinching) since her return from the hospital. Review of resident 6's electronic medical record (EMR) revealed: *Her Brief Interview for Mental Status assessment score was 2. That indicated her cognition was severely impaired. *A 1/12/25 Nutritional Status progress note completed by registered dietician (RD) V: -Resident weights: 125 lbs. (8/6/24), 118.5 lbs. (11/6/24), and 113.4 lbs. (12/31/24). That weight loss was considered to have been unavoidable related to her poor oral intake. Her nutritional goal	F 692		

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F 692	Continued From page 26 was to avoid further weight loss and improve her oral intake. -Her diet order was for a regular diet with minced and moist texture food textures. *Nutritional plan recommendations staff were to provide the resident included: -Continue Boost + three times a day at meals. -Continue eight ounces of whole milk three times per day at meals and offer chocolate milk or hot chocolate made with milk to assist with intake if the resident accepted that. -Offer puddings, yogurt, ice cream, hot cereal, or other smooth foods at each meal for extra calories if she accepted that. *RD V's 1/24/25 post-hospitalization Nutritional Status progress note indicated: -The resident's weight on 1/23/25 was 104.4 lbs. and the resident's diet order was changed to a regular diet with pureed texture. -"Discussed resident with dietary manager this morning and to consider re-starting the Mighty Shakes [liquid nutritional supplement] tid [three times a day] at meals, along with the Boost +." *Nutritional Plan recommendations for staff were to: -Offer Gelatein trial and, if accepted, obtain an order and continue it. ,-Continue eight ounces of whole milk tid at meals. -Continue offering puddings, yogurt, ice cream, hot cereal, or other smooth foods at each meal for extra calories if she accepts. Observations on 1/27/25 between 5:30 p.m. and 5:35 p.m. in resident 6's room and of resident 6 in the dining room revealed: *The above observed water and supplements remained untouched on resident 6's nightstand. *The resident was seated in the dining room for the evening meal at a table where staff were	F 692		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

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F 692	Continued From page 27 available to encourage her to eat. -She was served a four-ounce cup of water and an eight-ounce cup of lemonade. *She independently drank the lemonade. *There were no nutritional supplements, whole milk, or other food items such as pudding or yogurt served to the resident with that meal as recommended by RD V. *Her menu card identified her diet texture but had not indicated any nutritional supplements, whole milk, or any of the above smooth foods recommended by RD V that she was expected to have been either served or offered with her meals. Observations on 1/28/25 at 10:10 a.m. and 12:30 p.m. of resident 6 and at 6:00 p.m. in resident 6's room revealed: *She was in the hallway, awake, and in her wheelchair near the nurses' station. *She ate her noon-time meal in the dining room. -With her meal she was served a four-ounce cup of water and an eight-ounce cup of fruit juice. *There were no nutritional supplements, whole milk, or other food items such as those recommended by RD V served to the resident with that meal. *The above observed water and supplements remained untouched on resident 6's nightstand. Observation on 1/30/25 at 8:15 a.m. in resident 6's room revealed: *The above observed water and Gelatein cup remained on the resident's nightstand but the Boost + was gone. *The resident reached out for and held the surveyor's hand in silence. Interview on 1/30/25 at 8:30 a.m. with unlicensed	F 692		

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F 692	Continued From page 28 medication aide W regarding resident 6 revealed she: *Provided the resident Boost + at each meal when she had worked. -Offered the resident four ounces of the supplement at a time. The resident "likes Boost +." -Boost + intake or refusal was to be documented daily on the resident's medication administration record. Interview on 1/30/25 at 8:50 a.m. with RD V regarding resident 6 revealed: *After she had completed her resident assessments she would meet with dietary manager (DM) D to discuss her findings and her recommended dietary interventions (Mighty Shakes, Gelatein cups, whole milk, yogurt, pudding etc.) the food and nutritional services (FNS) department was responsible for implementing. -She would communicate with DON B her recommended dietary interventions (physician-ordered supplements such as Boost +) the nursing department was responsible for implementing. Interview on 1/30/25 at 9:00 a.m. with DM D regarding RD V's 1/24/25 FNS-related recommendations for resident 6 revealed: *Each resident's menu card was expected to list individualized dietary interventions including those recommended by RD V. It was his responsibility to ensure the FNS staff had been educated on those recommendations. *He had not updated resident 6's menu card to reflect RD V's recommendations for: -Serving her whole milk at all meals, restarting Mighty Shakes at all meals, or adding Gelatein	F 692		

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F 692	Continued From page 29 cups with the noon-time meal. *He agreed the nutritional and caloric value of the mealtime fluid recommendations made by RD V (Mighty Shakes and whole milk) surpassed the mealtime fluids (water and juice) resident had been served by the FNS staff. Interview on 1/30/25 at 9:50 a.m. with FSA (food service assistant) H revealed: *There was a list she reviewed to know which residents received nutritional interventions provided by FNS staff. -Resident 6's name was not listed under the "Mighty Shake" section of that list so she would not have been served that supplement. -Her name was listed in the "Gelatein Cup" section. The cup was to be served with her noon-time meal. FSA H had not known why the resident had not received that cup at either of her 1/28/25 or 1/29/25 noon-time meals. -Resident 6's name was not listed under the "Milk Served with Meals" section of that list so she would not have been served whole milk. *A side-by-side refrigerator outside of the kitchen was stocked with Mighty Shakes, Gelatein cups, milk, and food items such as puddings, and yogurt that were accessible to the FNS staff to have been served to any resident. Observation on 1/30/25 at 12:40 p.m. of resident 6 in the dining room during the noon-time meal revealed: *She was served a four-ounce cup of water, an eight-ounce cup of pink juice, and a container of Gelatein. -There were no nutritional supplements, whole milk, or other food items such as those recommended by RD V served to the resident with that meal.	F 692		

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F 692	Continued From page 30 Interview on 1/30/25 at 1:30 p.m. with DON B regarding resident 6 revealed: *She would not have been able to access and consume the water, Boost +, or Gelatein cup left on her bedside stand without assistance from staff. -The palatability and safety of consuming those items after they had been left out at room temperature for the above amount of time was compromised. A Weight Loss policy was requested from DON B on 1/30/25 at 2:30 p.m. She stated the facility had no Weight Loss policy. A 10/15/24 revised Weight and Height policy was provided instead. It only had described the procedures for weighing and measuring residents and not a procedure staff were expected to follow regarding residents at nutritional risk related to having weight loss.	F 692	Unable to instruct or create missing documentation from deficient practice. Residents with narcotic medications are at potential risk Education will be provided by the Director of Nursing to all nursing staff regarding appropriate documentation of narcotic log and compliance with professional nursing standards. Director of Nursing, or designee will audit narcotic administration log to ensure documentation compliance and maintenance of professional standards. Director of nursing or designee, will narcotic administration log for compliance weekly x 3, every other week x 3, monthly x 3. Director or Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Director of Nursing, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee.	2/27/25
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		

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F 755	Continued From page 31 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to follow their policy for: *Maintaining a physical inventory count of controlled substances at each shift change by two qualified staff for two of two medication carts. *Maintaining a system of receipt for controlled medications (medications that risk abuse or addiction)received from the pharmacy to ensure accurate medication reconciliation of those medications for four of four (2, 6, 17, and 25) residents. Findings include: 1. Review on 1/29/25 of the January 2025 Narcotic Control Sheet (sheet used to document the count of controlled medications between shifts) and the Controlled Drug Records located in the 100-hall medication cart revealed: *The form indicated: -"When signed at each change of shift by off-going and on-coming nurse of medication	F 755		

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F 755	Continued From page 32 aide, verifies the correct number of schedule 2 narcotics in lock box." -"Both nurses and/or medication aides must sign." -Sign-off times on the form were "0630" (6:30 a.m.), "1430" (2:30 p.m.), and "1830/2230" (6:30 p.m./10:30 p.m.). *There were areas where signatures were not present, which included: -One signature on 1/7/25 at 1430 and one at 1830/2230. -One signature on 1/18/25 at 0630 and two at 1430. -Two signatures on 1/21/25 at 1430 and one at 1830/2230. -One signature on 1/22/25 at 0630 and one at 1430. -One signature on 1/23/25 at 1430 and one at 1830/2230. *One Controlled Drug Record did not contain the quantity, date, or nurses signature to verify the receipt of 60 Tramadol, for resident 25. 2. Review on 1/29/25 of the January 2025 Narcotic Control Sheet and Controlled Drug Records located in the 200-hall medication cart revealed: *There were areas where signatures were not present, which included: -Two signatures on 1/4/25 at 1430. -One signature on 1/5/25 at 1430. -One signature on 1/8/25 at 1830/2230. -Two signatures on 1/11/25 at 1430. *Resident 2's controlled drug record did not contain the quantity, date, or nurse's signature to verify the receipt of 10 tablets of lorazepam (anxiety medication). *Resident 17's controlled drug record did not contain the quantity, date, or nurse's signature to	F 755		

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F 755	Continued From page 33 verify the receipt of 30 tablets of oxycodone (pain medication). *Resident 6's controlled drug record did not contain the quantity, date, or nurse's signature to verify the receipt of 60 tablets of Tramadol. Resident 6's controlled drug record did not contain the quantity, date, or nurse's signature to verify the receipt of 30 half tablets of Tramadol. Interview on 1/29/25 at 11:08 a.m. with licensed practical nurse (LPN) F revealed: *When controlled medications would arrive from the pharmacy the licensed nurse on duty was to count the medications and compare that count to the amount documented on the controlled drug record. *If the controlled medication count matched the amount documented on the controlled drug form the licensed nurse would document the quantity, the date, and sign the form to verify that the information on the form was accurate. *There were missing nurse signatures on the controlled drug records. *The controlled drug form was then placed in the binder with the Narcotic Control Sheet to be used for the medication reconciliation counts between each shift. *Controlled medication counts were to be done on both carts between each shift. *The nurses'/ UMA's signatures indicated that the narcotic count had been completed. *There were missing signatures on the Narcotic Control Sheets. Interview on 1/30/25 at 10:59 a.m. with director of nursing (DON) B revealed: *It was her expectation that the narcotics were to be counted anytime there was an exchange of medication cart keys.	F 755		

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F 755	Continued From page 34 *She expected the nurse who received the controlled medications from the pharmacy to verify the medication count being received, document the quantity and date received and then sign the controlled drug record. Review of the providers 6/27/24 Medications: Controlled policy revealed: *The provider along with the consultant pharmacist will "establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation that determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled". *"Each time the keys that secure controlled medications change from one nurse/medication aide to another, the oncoming and off-going nurse/medication aide will work together to reconcile controlled medications, including all discontinued controlled medications and document the same." *"When a new controlled medication is delivered, the nurse in the skilled nursing facility will be responsible for counting the medication."	F 755	Resident 12s PRN antipsychotic was discontinued. All residents with PRN antipsychotics are at potential risk. Education will be provided by the Director of Nursing to all nursing staff regarding antipsychotic medication use and CMS guidelines as well as education regarding utilization of GSS #230F-9 to ensure compliance with stop date. Director of Nursing, or designee will audit antipsychotic medication orders to ensure documentation compliance and maintenance of professional standards per CMS regulations. Director of nursing or designee, will audit for compliance weekly x 3, every other week x 3, monthly x 3. Director or Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Director of Nursing, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates	2/27/25
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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F 758	Continued From page 35 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy	F 758		

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F 758	Continued From page 36	F 758		

review, the provider failed to ensure:
*Two of two sampled residents' (12 and 2) PRN (as needed) psychotropic medications had been discontinued after fourteen days.
*An appropriate diagnosis for the use of a psychotropic medication administered to two of two sampled residents (2 and 28).
Findings include:

1. Review of resident 12's electronic medical record (EMR) revealed:
*A 12/20/24 physician's order for .25 milligrams lorazepam (anti-anxiety/psychotropic medication) to have been administered every 24 hours PRN for combativeness with personal cares.
-The physician's order note regarding that same medication indicated: "If PRN, order stop date=14 days."

Review of resident 12's December 2024 and January 2025 medication administration records (MAR) revealed.
*She was administered PRN lorazepam on 12/23/24 and 1/7/25.
-The PRN lorazepam order had not been discontinued after 14 days.

Interview on 1/30/25 at 12:15 p.m. with director of nursing (DON) B regarding resident 12's PRN lorazepam order revealed it was the responsibility of a licensed nurse to have entered a stop date for that medication for it to have been discontinued according to the physician's order notes. That had not occurred.
2. Review of resident 2's EMR revealed:
*She was admitted on 11/11/24.
*Her 11/13/24 Brief Interview of Mental Status (BIMS) assessment score was 5, which indicated she had severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

(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 758	Continued From page 37 *Her diagnoses included Alzheimer's disease and other specified depressive episodes. *A 1/15/25 physician's order for lorazepam injection solution 2 mg/ml(milliliters) with instructions to inject 2 mg intramuscularly every 24 hours as needed. -The order did not have an end date. -The targeted behavior was indicated to be "anxiety aggressive behavior". -There was no diagnosis associated with the lorazepam order. *She did not have a diagnosis of anxiety or behavioral disturbances. 3. Review of resident 28's EMR revealed: *She was admitted on 12/4/23. *Her 1/10/25 BIMS assessment score was 3, which indicated she had severe cognitive impairment. *Her diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. *A 11/11/24 physician's order for Ativan (lorazepam) every two hours as needed. *The targeted behavior for the Ativan was anxiety. *There was not a diagnosis associated with the Ativan order. *She did not have an anxiety diagnosis. Interview on 1/30/25 at 11:26 a.m. with DON B regarding the Ativan (lorazepam) orders revealed: *She agreed there was no end date on the Ativan order for resident 2. *It was her expectation that the nurse that received the order would enter and date at 14 days unless there was another date specified by the provider. *She verified there was not a diagnosis associated with the Ativan orders for resident 2	F 758		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 758	Continued From page 38 and 28, only an indication for use. *Neither resident had a diagnosis of anxiety in their EMR. Review of the provider's 12/30/24 Psychotropic Medications policy revealed: *"Residents do not receive psychotropic drugs pursuant to a PRN [as needed] order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record." *The order must contain "an appropriate medication, in an appropriate dose and corresponding diagnosis, as well as medical symptoms from the physician." *"PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the prn order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the prn order."	F 758	Unable to correct prior deficient practice. All residents are at potential risk due to deficient practice Education will be provided by the Director of Nursing to all nursing staff regarding safety, and standard nursing professionalism, request self-locking medication carts. Director of Nursing, or designee will audit medication/treatment cart to ensure locking mechanism. Director of nursing or designee, will audit for compliance weekly x 3, every other week x 3, monthly x 3. Director or Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Director of Nursing, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 761	Continued From page 39 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: *Medications for three of three residents (30, 32, and 35) were properly labeled. *An insulin pen for one of one resident (89) was dated when opened. *Two of two medication carts were locked when left unattended. *An outdated medication for one of one resident (22) was properly disposed of. Findings include: 1. Observation on 1/30/25 at 7:36 a.m. of the medication cart in the 200-hallway revealed: *The medication cart was unlocked. *No staff were present at the medication cart. *Registered nurse (RN) J exited a resident room, returned to the medication cart, and charted medication administration. Observation on 1/30/25 at 11:16 a.m. revealed the medication cart in the 100-hallway was not locked and there was no staff at or within eyesight of the medication cart.	F 761		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 761	Continued From page 40 2. Observation on 1/29/25 at 10:58 a.m. of the medication cart in the 100-hallway revealed a Lantus (long-acting) insulin pen that belonged to resident 89 without a date on the pen that would have indicated when the pen was removed from the refrigerator and was opened. Interview on 1/29/25 at 11:08 a.m. with licensed practical nurse (LPN) F regarding resident 89's insulin pen revealed she: *Verified the insulin pen was not dated. *Indicated it should have been dated when it was opened. *Disposed of the insulin pen. *Stated the pen needed to be disposed of because the date it was opened could not be verified. 3. Observation and interview on 1/29/25 at 11:28 a.m. of the medication cart in the 200-hallway revealed: *Two open packages of "4 x 4 Hydrogel Impregnated [for wound healing] Gauze Dressing". -There was a portion removed from each of the gauze dressings. -The dressings did not include an opened date or a resident identification. *A medication card that of hydrocodone-acetaminophen (pain medication) 5/325 milligrams (mg) indicated it had been dispensed on 11/1/23 for resident 22. -The back of that medication card indicated the medication expired on 10/24. *Certified Nursing Assistant (CNA)/unlicensed medication aide (UMA) L indicated that licensed nursing staff completed all dressing changes. *He verified the expiration date of that medication and stated he would alert the charge nurse.	F 761		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 761	Continued From page 41 4. Observation and interview on 1/30/25 at 8:25 a.m. with RN J during medication pass on the 200-hallway revealed: *There was no dose indicated on resident 35's Calcium Citrate with vitamin D medication card. *Resident 35's Preservision (eye health supplement) order read 1 unit and the label on the bottle reflected tablets. *Resident 32's had an order for Senna S 8.6/50 mg one tablet daily. *That medication card did not indicate a dose and the name of the medication on the medication card was Stimulant Laxative Plus, which did not match the medication name on the order. *Resident 30's ordered dose of Calcium + Vit D liquid did not match the dose on the label of the medication bottle. *RN J verified all of the above, collected those medications, and brought them to the charge nurse. *The charge nurse then gave the collected medications to the director of nursing (DON). Interview on 1/30/25 at 11:05 a.m. with DON B revealed: *She was notified of and verified the above medication and label issues with the medications and had notified the pharmacy. *It was her expectation that insulin pens be dated when opened. *She would expect that a new dressing be opened with each dressing change and any dressing that was left over was to be disposed. *She witnessed the unlocked medication cart in the 100-hallway and locked it. Review of the provider's 9/5/24 Medication: Insulin Administration policy revealed during the	F 761		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 761	Continued From page 42 procedure indicated, "Verify provider order, the expiration date and the number of days the pen has been open." Review of the provider's 3/29/24 Medications: Acquisition Receiving Dispensing and Storage policy revealed: *"Licensed nursing employees are responsible for ordering from the pharmacy and checking all new orders of medications from the physician's orders." *"The order will include the date of change, the location name, resident's name, medication name, dosage, route, quantity, or duration and strength, diagnosis or indication for use and the physician's name." *"Medications will be stored in a locked medication cart, drawer or cupboard." *"The location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations."	F 761	Unable to correct prior deficient practice All residents are at potential risk due to deficient practice Education will be provided by the Dietary Manager to all dietary staff on requirements of the Dining service Standards Food and Nutrition Services policy and Safe Handling of Personal Food, Outside Food, Food and Nutrition Policy. Dietary Manager, or designee will audit procured food for appropriate food-handling practices. Dietary manager or designee, will audit for compliance weekly x 3, every other week x 3, monthly x 3. Dietary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Dietary Manager, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 812	Continued From page 43 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Kitchenware was stored in a clean and sanitary manner. *Food items in one of one refrigerator designated for resident use and one of one side-by-side refrigerator in the dining room were properly labeled and dated. *One of one refrigerator designated for resident use and one of one side-by-side refrigerator were maintained in a clean manner. *Kitchenware was handled in a manner to mitigate the risk of cross-contamination by one of one lead cook (G) during two of two observed meal services. Findings include: 1. Observation on 1/28/25 at 10:40 a.m. during the initial kitchen tour revealed: *Multiple plastic water pitchers and pitcher lids were stored inside one of the slide-out drawers of the six-drawer kitchenware storage unit. -The pitchers sat upside down inside of that drawer. Two pitchers and one of the lids sat on top of an area that was damp with water. *A four-drawer "Tool Shop" cabinet held kitchen utensils. -A piece of black foam sat on the bottom of the inside of those drawers. Food crumbs were scattered on top of that foam where the kitchen utensils sat on top of. -Some of the drawers had plastic organizers	F 812		

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GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 812	Continued From page 44 inside of them that held kitchen utensils. Food crumbs were scattered on the bottom of those organizers that the kitchen utensils sat on top of. *The wall-mounted plastic knife holder had scattered food crumbs on the bottom of it. *There was a Cook Cleaning List taped onto a wall. One of the weekly tasks included "Clean utensil drawers inside and out." and was initialed as having been completed on 1/24/25. 2. Observation on 1/28/25 at 11:25 a.m. of the refrigerator designated for resident use revealed: *A white carton of peach and vanilla ice cream. It had no open or expiration date on it. *A jar of Buffalo Berry jam without an open date. *About 75% of the refrigerator's back wall was covered in a layer of thin, lumpy white ice build-up. 3. Continued observation of the side-by-side refrigerator next to the resident refrigerator revealed the bottom of the inside of that refrigerator had a dried red-colored substance on it. That same substance had run down one side of the inside of that refrigerator. Interview on 1/29/25 at 1:30 p.m. with food service assistant (FSA) H regarding the above refrigerators revealed: *All staff were responsible for cleaning both refrigerators on a regular and an as needed basis. *Residents' families or kitchen staff were expected to have labeled and dated all food placed inside the resident designated refrigerator. -All staff were responsible for ensuring the refrigerator's contents were regularly checked for outdated or unlabeled food and to have removed those food items.	F 812		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 812	Continued From page 45 4. Observations on 1/28/25 from 11:35 a.m. through 12:10 p.m. and on 1/29/25 at 5:00 p.m. of lead cook G preparing food in the kitchen and serving food at the steam table revealed he: *Removed a metal container of pureed vegetable from the steam oven using his bare thumb to hold the inside rim of that container as he removed it. -Shook then wiped off his thumb after it had touched the contents of the pureed food mixture when it was removed. *Used the countertop blender to puree a mixture of boneless pork chop, gravy, and vegetable stock. -Took the blender lid off then placed his bare thumb on the inside rim of the blender cup, removed it from its base, and poured the contents into a metal container for serving. *Removed mashed potatoes from the steam oven and inserted a digital food thermometer far enough into the potatoes to cover both the temperature probe and the bottom surface of the plastic base attached to the probe. *Used his bare thumb to hold the inner lip of each plated dish that was served to a resident. -Handled paper menus, touched the metal top of the steam table and other items in and around that food service area in between touching each plate and without having performed any hand hygiene. *Placed two re-usable squeeze bottles of salad dressing inside the same container of lettuce salad mix causing those bottles to touch the salad mix. -Removed and returned the squeeze bottles from that container throughout the meal service to dispense salad dressing. At the end of the meal service the bottles were placed back into a refrigerator.	F 812		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 812	Continued From page 46 Interview on 1/30/25 at 11:30 a.m. with dietary manager D regarding the above observations revealed: *Since November 2024 he had been splitting his time as dietary manager between this facility and a "sister" facility until a full-time dietary manager was hired for this facility. *He had educated kitchen staff about safe kitchenware storage practices. He knew kitchenware that was stored on moist surfaces had the potential to attract bacteria. *He had assigned a FSA to examine the contents of both the above refrigerators to ensure all food items had been properly labeled/dated or discarded if that was appropriate. Examining the refrigerators would have also included ensuring they had been clean. He had not checked to ensure the assigned FSA had completed the task as he requested. *He expected hot food vessels to be handled using hot pads preventing the need for contact with the inside of that vessel. Bare fingers should not have been used to handle the inside of a blender cup or to hold the inner rim of serving plates. Only the probe of the digital food thermometer was expected to have touched food including the potatoes. Re-usable plastic squeeze bottles should not have been placed in the same container with a consumable food item. -Failure to perform the practices above in an appropriate manner had increased the risk of cross-contamination. Review of the provider's revised 5/12/23 Safe Handling of Personal Food, Outside Food-Food and Nutrition policy revealed: *Procedure: "6.b. Food and beverages without manufacturer expiration date should be dated	F 812		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 812	Continued From page 47 upon arrival in the facility and discarded 7 days after date marked." *Personal Food Stored in Common Areas: -"3. The resident/family: a. Labels, dates and covers all opened foods that are brought in for the resident. All food must have the resident name and room number clearly visible on the container/package." l"b. Removes personal food when no longer considered safe for consumption. 4. Employees monitor common food storage areas, clean the equipment and remove unsafe foods without replacing the items." Review of the provider's revised 6/13/24 Dining Service Standards-Food and Nutrition Services policy revealed employees will "follow procedures for prevention of foodborne illness when serving meals."	F 812		
F 880 SS=F	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	F 880		

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	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 880	Continued From page 48 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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.	F 880	Proper Personal Protective Equipment has been provided for resident 10 and 23. Unable to correct prior deficient practice All residents requiring PPE have a potential risk to be affected. All residents with positive Quantiferon Gold test are at potential risk Education will be provided by the Director of Nursing to all nursing staff regarding PPE usage, storage, and signage Education will be provided by the Director of Nursing to all nursing staff regarding pending outcomes of diagnostics, notification to appropriate management, and isolation guidelines for infectious diseases. Director of Nursing, or designee will audit Isolation/EBP to ensure available and utilized. Director of nursing or designee, will audit for compliance weekly x 3, every other week x 3, monthly x 3.	2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 §483.80(e) Linens. 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: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Contact precautions were appropriately implemented and utilized for one of one sampled resident (10) with a feeding tube and a history of MRSA Bacteria [Methicillin-resistant Staphylococcus aureus], VRE [Vancomycin-resistant Enterococci], and MDR [multidrug-resistant organism] infections. *Enhanced barrier precautions (EBP) were appropriately implemented and utilized for one of one sampled resident (23) with an indwelling urinary catheter and daily dressing changes. *One of one resident (27) was separated from other residents while awaiting further tests following a positive QuantiFERON (blood test for tuberculosis) result. Findings include: 1. Observation on 1/28/25 at 5:47 p.m. of resident 10's room and tube feeding placement revealed: *There was a sign on her door that stated to use contact precautions. -Directions on the sign included to put on gloves and a gown before entering the room and to remove the gown and gloves before leaving the room. -There was no available gloves and gown	F 880	Director of Nursing, or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Director of Nursing, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435104	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 SOUTH MADISON NEW UNDERWOOD, SD 57761

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F 880	Continued From page 50 available outside of resident 10's room. *Registered nurse (RN) J entered resident 10's room and washed her hands. -She then placed clean one-time-use gloves on her clean hands. -She did not have on a gown. *RN J then completed the tube feeding. Observation 1/29/25 at 9:55 a.m. of resident 10's room and hallway. *The door to her room was closed. *The contact precaution sign remained posted on her door. *There was a personal protective equipment (PPE) cart located in hallway, next to her room, with gowns and gloves in it. *There was a trashcan with lid located next to PPE cart. Review of resident 10's electronic medical record (EMR) revealed: *Her admission date was 12/5/23. *Her 12/9/24 Brief Interview of Mental Status assessment score was a 14, indicating her cognition was intact. *Her diagnoses included: multiple sclerosis, adult failure to thrive, unspecified severe protein calorie malnutrition, adjustment disorder w/depressed mood, chronic kidney disease, major depressive disorder. *There was a 12/6/23 physician order that indicated to use contact precautions when performing cares or in close contact as per facility policy. -This order included "No swab for VRE Clearance at this time." *Her 1/27/25 care plan included a 12/6/23 focus of a history of "MRSA Bacteria, VRE and MDR infections requiring Contact Precautions during	F 880		

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F 880	Continued From page 51 cares." -The goal for this focus included, " The resident's infection will resolve with minimal complications as evidenced by negative culture, vital signs WNL [within normal limits] and no s/s [signs and symptoms] of acute infection through the review date." -The interventions for this focus and goal included, "CONTACT PRECAUTIONS: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry." Interview on 1/29/25 at 1:25 p.m. with licensed practical nurse (LPN) S regarding resident 10's care revealed: *She had been placed on contact precautions since "enhanced barrier precautions [EBP] were initiated for the facility." -She was not certain of that date. *When she provided care to resident 10, she wore a gown, gloves, and a mask "just because". Interview on 1/29/25 at 2:40 p.m. with infection preventionist (IP)/registered nurse (RN) E regarding contact precautions for resident 10 revealed: *Contact precautions included a staff member wearing a gown and gloves when providing care. *Resident 10 was admitted on 12/6/23 with a physician's order to use contact precautions. -When staff members went into resident 10's room they were to complete hand hygiene before entering the room and when exiting the room. -They were to wear a gown and glove when providing her "close contact cares". *Her expectation was for a nurse to wear a gown and gloves when assisting resident 10 with her	F 880		

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F 880	Continued From page 52 tube feeding. *She was not aware PPE was not outside of resident 10's room on 1/28/25. -She stated the trashcan should be in the resident's room and not in the hallway. *Regarding contact precautions due to "no swab for VRE clearance", she thought resident 10 had a "couple of drug-resistant organisms in her urine." *Review of resident 10's care plan confirmed contact precautions were to be used. -Those contact precautions listed did not include gloves. -She stated "gloves should be a big part of that [contact precautions]." *Her expectations for contact precautions included the use of a gown and gloves and a trashcan should be placed in the resident's room for disposal of PPE before leaving the room. Review of the provider's 4/2/24 Standard and Transmission Based Precautions revealed: *"Standard precautions are meant to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. They are the basic level of infection control precautions which are to be used in the care of all residents. These precautions are designed to reduce the risk of microorganisms regardless of diagnosis. They are designed to protect employees and residents from both recognized and unrecognized sources of infection." *"Contact precautions will be used in addition to standard precautions for residents/patients with known or suspected infections or evidence of syndromes that represent an increased risk for contact precautions." *"Post clear signage on the door or wall outside of	F 880		

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F 880	Continued From page 53	F 880		

the resident room indicating the type of Precautions and required PPE.
-Gloves and Gowns".
2. Review of resident 27's electronic medical record (EMR) revealed:
*A progress note from 1/10/25 at 10:19 a.m. written by RN I stated "lab returns showing + quantiferon, order received per physician assistant (PA) X to send resident to urgent care for CXR [chest x-ray] today."
*Progress note on 1/10/25 at 12:43 p.m. noted that resident's sister was informed of the positive TB blood test.
*Progress note on 1/10/25 at 1:26 p.m. stated "resident returned with note to call Radiology for report, per PA X, she will watch for report."
*Progress note on 1/11/25 at 5:43 a.m. stated "24 hr [24 hour] check-still awaiting dictation."

Interview on 1/29/25 at 2:40 p.m. with resident 27 revealed he was not able to recall if he had ever been exposed to tuberculosis or the events that occurred on 1/10/25.

Interview on 1/29/25 at 3:05 p.m. with licensed practical nurse (LPN) F revealed:
*She had never cared for a resident who was positive for tuberculosis.
*Her expectation was if there were a resident positive for tuberculosis, she would notify the director of nursing (DON) immediately and the resident would be separated from other residents to prevent spreading it.

Interview with DON B on 1/30/25 at 10:30 a.m. revealed:
*She was not immediately made aware of resident 27's positive tuberculosis test on 1/10/25.
*She was surprised RN I did not notify her of the

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F 880	Continued From page 54 positive tuberculosis result. *RN I did immediately call the physician, but did not separate resident 27 from other residents and staff. *She reported resident 27's roommate was not moved to a different room after the RN I knew of the positive tuberculosis blood test. *It was the DON's expectation to be notified immediately of a positive tuberculosis test and to separate that resident from any other residents or staff. Interview on 1/30/25 at 1:05 p.m. with administrator A regarding tuberculosis revealed: *It was his expectation that RN I would have notified the DON and administrator immediately. *It was his expectation resident 27 would have been isolated from other residents and staff until the results of his chest x-ray were available. *It was his opinion that a positive tuberculosis blood test should have been considered active tuberculosis until determined otherwise by the chest x-ray. Review of the provider's 5/2023 Tuberculosis Control Plan for Residents, R/S, LTC, Home Health policy revealed: *"PURPOSE: To provide early identification of residents infected with Mycobacterium tuberculosis (TB) to prevent the spread of TB through appropriate screening, placement, and treatment of residents with exposure to TB". *"Residents with Suspected or Confirmed Tuberculosis (SNF and Home Health)" -"Isolate the resident on Airborne Precautions. The resident may be isolated in their own room if roommates are removed." -"Place a warning sign outside the isolation room. The wording must say STOP, HALT, or NO	F 880		

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F 880	Continued From page 55 ADMITTANCE and refer persons to the nurses' station or to other staff members for instructions. -"Restrict contact with the resident until transfer to an appropriate center." -"Notify the transportation company that the resident being transported has suspected or confirmed TB. Respiratory protection is required for the transporting team when the resident is in a closed vehicle. 3. Observation on 1/28/25 at 9:19 a.m. revealed EBP signage was posted outside resident 23's room. Interview and observation on 1/28/25 at 9:20 a.m. with resident 23 revealed she had an indwelling urinary catheter and received daily dressing changes for a pressure ulcer on her buttocks. -She agreed to the observation of her wound care and stated that dressing changes are usually done in the morning. Observation of wound care on 1/29/25 at 10:03 a.m. revealed: *Certified nursing aide (CNA) M had already performed personal hygiene for resident 23 and was holding her on her left side. -CNA M was wearing gloves but no gown. *Licensed practical nurse (LPN) F provided wound care to resident 23's pressure ulcer. -LPN F was wearing gloves but no gown. Interview on 1/29/25 at 2:40 p.m. with infection preventionist/wound care registered nurse (RN) E regarding EBP revealed she expected staff to wear a gown and gloves during close contact care and to perform hand hygiene before and after resident contact.	F 880		

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F 880	Continued From page 56 Review of resident 23's medical record revealed: *She was admitted on 11/4/22 *She had a brief interview for mental status (BIMS) assessment score of 13, which indicated she was cognitively intact. *Her diagnoses included hemiplegia (paralysis that affects one side of the body) and hemiparesis (weakness that affects one side of the body) following cerebral infarct (a stroke) affecting the left non-dominant side, neuromuscular dysfunction of the bladder (nerves controlling the bladder are damaged, leading to disrupted communication between the brain and bladder), and polyneuropathy (multiple peripheral nerves are damaged, leading to problems with sensation and coordination). *A care plan focus area initiated on 6/28/24 indicated: -"The resident requires Enhanced Barrier Precautions (EBP) R/T [related to] indwelling medical device- Foley catheter." *Her care plan included a 6/28/24 initiated intervention: - "Don [put on] gown and gloves when performing high contact care activities including: dressing, bathing, transferring, providing hygiene such as shaving or brushing teeth, changing linens, repositioning, checking and changing [related to incontinence needs], device care and/or use, and wound care." Review of the provider's 4/2/24 "Standard and Transmission-Based Precautions, All Service Lines" policy revealed: *Enhanced Barrier Precautions - "Enhanced barrier precautions expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact	F 880		

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F 880	Continued From page 57 resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing." - "Enhanced barrier Precautions are needed for residents with chronic wounds (Pressure Ulcers, Diabetic Foot Ulcers, Unhealed surgical wounds, and venous stasis ulcers) and Residents with Indwelling Medical devices (central line, hemodialysis catheters, indwelling urinary catheters, feeding tubes, and tracheostomies)." - "High-contact Resident Care Activities include: Transfers, dressing, assisting during bathing, providing hygiene, changing briefs or assisting with toileting, working with resident in therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility, changing linens, device care or use (central line, urinary catheter, feeding tube, tracheostomy), Wound care."	F 880	Unable to correct prior deficient practice All residents are at potential risk for deficient practice Education will be provided by the Director of Nursing to all nursing staff regarding call light availability and usage. Angel rounds complete to ensure all resident call lights are in proper function and available. Director of Nursing, or designee will audit all call lights are witin reach and available ensure residents safety. Director of nursing or designee, will audit for compliance weekly x 3, every other week x 3, monthly x 3. Director of Nursing, or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Director of Nursing, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure an in-room call light system was accessible for three of three sampled residents (10, 28, and 32) who needed staff assistance for their care needs.	F 919		

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F 919	Continued From page 58 Findings include: 1. Observation on 1/28/25 at 5:14 p.m. of resident 28 revealed: *She was sitting in her wheelchair beside her bed. *A staff member was present in the room. *The call light was clipped to the call light cord at the receptacle on the wall. *The staff member exited the room and closed the door without moving the call light to be accessible to resident 28. Review of resident 28's electronic medical record (EMR) revealed: *She was admitted on 12/4/23. *Her 1/10/25 Brief Interview of Mental Status (BIMS) assessment score was 2, which indicated she had severe cognitive impairment. *Her diagnoses include Alzheimer's disease, left wrist fracture, and pubic rami (pelvic) and sacral (lower spine) fractures from falls. Review of resident 28's 1/29/25 care plan revealed: *She was at risk for falls. *She required assistance from one staff member for transfers for safety. 2. Observation on 1/29/25 at 2:10 p.m. of resident 32 revealed: *He was sitting in his wheelchair in the middle of the room, looking out the window. *His call light was on the floor beside his bed. Observation on 1/29/25 at 3:12 p.m. of resident 32 revealed: *He was reclined in his wheelchair in the middle of his room, looking out the window. *His call light was in the top drawer of his bedside	F 919		

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F 919	Continued From page 59 stand. *The bedside stand was on his left side and not within reach. Review of resident 32's EMR revealed: *He was admitted on 7/31/24 *His 10/29/24 BIMS assessment score was 6, which indicated he had severe cognitive impairment. *His diagnoses include cerebral infarct (stroke) and hemiplegia (weakness or partial paralysis on one side of the body) affecting left non-dominant side. Review of resident 32's 1/29/25 care plan revealed: *He required the assistance of one to two staff members for activities of daily living. *He was at risk for falls. *His interventions for falls included: -"Ensure call light is within reach at all times". -"Place call light near [resident's] Right Hand due to LUE [left upper extremity] paralysis". 3. Interview and observation on 01/28/25 at 5:47 p.m. with resident 10 revealed: *She spent a large portion of her time in her bed due to her medical condition. *Staff members often forget to place her call light within her reach. -When she was not able to reach her call light, she would use her cell phone to call the facility and ask for someone to come and assist her. -She felt this was a working solution for her. *She was lying in bed. *Her call light was clipped to the divider curtain in her room, that was not within her reach. Review of resident 10's EMR revealed:	F 919		

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F 919	Continued From page 60 *Her admission date was 12/5/23. *Her 12/9/24 BIMS assessment score was a 14, which indicated her cognition was intact. *Her diagnoses included: multiple sclerosis, adult failure to thrive, unspecified severe protein calorie malnutrition, adjustment disorder with depressed mood, chronic kidney disease, and major depressive disorder. Interview on 1/30/25 at 11:17 a.m. with director of nursing (DON) B revealed: *It was her expectation call light would be placed within the reach of residents. *Audits were being completed on call light placement and response times. Review of provider's 7/29/24 Call Light policy revealed: *The purpose of the call light was "To ensure resident always has a method of calling for assistance". *"When leaving the room, place call light within easy reach of resident."	F 919		

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	435104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 1/28/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society New Underwood was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K345 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain one of one fire alarm system as required (alarming throughout the building). Findings include: 1. Observation of the fire drill in room 101 at on 1/28/25 at 4:25 p.m. revealed the fire alarm system was initiated by the maintenance director using a can of smoke (specifically made for this purpose) to activate the smoke detector on the ceiling of the room. Strobes and chimes were	K 345	Unable to correct prior deficient practice All residents are at risk when staff do not respond to fire alarms as required by policy Education will be provided by the Administrator to all staff regarding Education provided to all staff on Fire Alarm policy and indication that staff pull the fire pull when fire indicated. Administrator, or designee will complete two audits per week x 4, then 1 audit every 2 weeks x 4, then monthly as required by policy. Administrator, or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Administrator, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2-27-25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paul Hubbeling	LNHA	2-25-25

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
	435104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	**412 SOUTH MADISON** **NEW UNDERWOOD, SD 57761**

(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 345	Continued From page 1 activated in the 100 wing where the simulated fire was conducted. At the conclusion of the fire drill several staff commented the fire alarm was not heard in the other areas of the building. Based on the staff comments, the maintenance director initiated a second alarm by having the manual pull station at the nurse's station activated. The alarming that commenced was louder and verified being sounded in the entire building. 2. Interview with the maintenance director at the time of the observation confirmed that finding. Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11 The deficiency affected 100% of the occupants.	K 345	Unable to correct prior deficient practice All residents are at risk when staff do not respond to fire alarms as required by policy Education will be provided by the Administrator, or designee to all staff regarding the Fire Alarm Policy that includes the requirement to announce the fire alarm and remove the resident from the area of the fire. Education completed to include the requirement to pull the fire pull station when there is a sign of fire or fire drill, as well as the location of all fire pulls. Administrator, or designee will complete two audits per week x 4, then 1 audit every 2 weeks x 4, then monthly as required by policy. Administrator, or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendation for improvement, monitoring of results will be reported by the Administrator, or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2-27-25
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to ensure staff were familiar with the	K 712		

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	435104	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2025**

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K 712	Continued From page 2 provider's fire drill procedures (alarm announcement and resident removal from the room). Findings include: 1. Observation of the fire drill on 1/28/25 at 4:25 p.m. revealed staff members responded to a simulated fire in resident room 101. The simulated fire was initiated by the maintenance director using a can of smoke (specifically made for this purpose) to activate the smoke detector on the ceiling of the room. The fire incident was not announced over the walkie-talkie system that many staff carry on their person. While other staff closed the corridor doors, staff responding to the room with fire extinguishers announced "all clear" prior to that room's resident having been evacuated to a safe location. 2. Interview with the maintenance director at the time of the observations confirmed those above findings. These are two of numerous items of fire drill training. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11).	K 712		

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
	10657	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY NEW UNDERWOOD	412 S MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761

(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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/28/25 through 1/30/25. Good Samaritan Society New Underwood was found in compliance.	S 000	This plan of correction is prepared and submitted as required by law. By Submitting this plan of correction. Good Samaritan New Underwood does not admit to any statement, findings, facts, or conclusions that form that basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory deficiency, statements, facts, and conclusions that for the basis of the deficiency.	
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 1/28/25 through 1/30/25. Good Samaritan Society New Underwood was found not in compliance with the following requirements: S206 and S301.	S 000		2/27/25
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and	S 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Hubbeling | TITLE: LNHA | (X6) DATE: 2/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10657	A. BUILDING: _____ B. WING _____	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 206	Continued From page 1 hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to ensure required annual training (proper restraint use, resident rights, care of residents with unique needs, and dining assistance, nutritional risks, hydration) was completed for one of five sampled employees, certified nursing assistant (CNA) R. Findings include: 1. Review of the provider's employee personnel records revealed: *CNA R was hired on 10/8/24. *CNA R had not received training on proper restraint use, resident rights, care of residents with unique needs, and dining assistance, nutritional risks, and hydration. Interview on 1/30/25 at 9:30 a.m. with registered nurse (RN) P revealed: *She was in charge of the nurse aide training program. *CNA R was hired in an "as needed" position, had not been working shifts, and had not completed her initial training. *It was her expectation CNA R would need to	S 206	Unable to correct prior deficient practices. C.N.A R will have all education completed prior to next shift. All residents are at potential risk for deficient practice due to non-compliance with education requirements Education will be provided by the Director of Nursing or designee to all staff regarding the expectation of education completion. The Director of Nursing or designee will audit all nursing staff to ensure all are current with annual trainings monthly x3. Director of Nursing or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/23/25

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	10657	A. BUILDING: _____ B. WING _____	01/30/2025

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S 206	Continued From page 2 complete her required training before she would work a shift at the facility.	S 206	Unable to correct prior deficient practices. FSA O and FSA Q will have all education completed prior to next shift. All residents are at potential risk for deficient practice due to non-compliance with education requirements Education will be provided by the Dietary Manager or designee to all staff regarding the expectation of education completion. The Dietary Manager or designee will audit all dietary staff to ensure all are current with annual trainings monthly x3. Dietary Manager or designee will report all findings to the QAPI committee on a monthly basis for follow up. The QAPI committee will review the audit results and if necessary make any recommendations for improvement, monitoring of the results will be reported by the Director of Nursing or designee to the QAPI committee and continued for no less than 2 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee	2/27/25
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review, the provider failed to ensure four of nine required dietary trainings (food handling/prep, serving/distribution, leftovers, and nutrition/hydration) for food service assistant (FSA) O and three of nine trainings (food handling/prep, serving/distribution, and leftovers) for FSA Q were completed. Findings include: 1. Review of the provider's employee personnel records revealed: *FSA O was hired on 3/29/24. *FSA Q was hired on 2/9/24.	S 301		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10657	A. BUILDING: _____ B. WING _____	01/30/2025

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S 301	Continued From page 3 Review of the provider's employee training records revealed: *FSAs O and Q had not received training on food handling and preparation, serving and distribution, and leftovers. -FSA O had not completed the Nutrition/Hydration training. Interview and record review on 1/30/25 at 9:55 a.m. with dietary manager D revealed: *He was aware FSAs O and Q had not completed their required training. *He reported several attempts had been made to have FSAs O and Q come in to complete the training. *FSAs O and Q both work "as needed" and are not regularly scheduled. *FSAs O and Q had worked on 1/24/25. *He felt those employees should not work again until the required training was completed.	S 301		

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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 on 1/28/25. Good Samaritan Society New Underwood was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul Hubbeling

TITLE: LNHA

(X6) DATE: 2/25/25

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.