

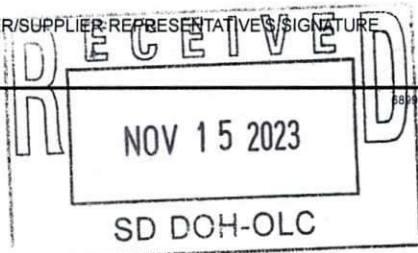
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH:	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 10/24/23 through 10/25/23. Good Samaritan Society-Sioux Falls Hearthstone AL was found not in compliance with the following requirement: S685.	S 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
S 685	44:70:07:09 Self-administration of drugs A resident with the cognitive ability to understand may self-administer medications. At least every three months, the licensed nurse, the physician, physician assistant, or nurse practitioner shall evaluate and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or the nursing staff is responsible for storage of the drug and include documentation of its administration in accordance with the provisions of chapter 44:70:07. A resident may self-administer drugs if the registered nurse, if applicable, and physician, physician assistant, or nurse practitioner have determined the practice is safe. No resident may keep medications on the resident's person or in the resident's room without a medication order allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, care record review, and policy review, the provider failed to ensure three of three sampled residents (1, 2, and 3) who self-administered medications had quarterly	S 685	S 685 1. Assessments for residents 1, 2 and 3 were completed and schedules have been set for assessments to trigger in three months. Resident 1 self-administration evaluation was completed on 10/25/2023 and evaluation schedule corrected on 11/6/2023. Resident 2 self-administration evaluation schedule was verified as correct on 11/6/2023. Resident 3 self-administration evaluation schedule was verified as correct on 11/6/2023. 2. Senior Living Nurse Consultant reviewed all residents with self-administration on service plan and identified those with evaluations needing to be completed and schedules needing to be corrected. Evaluations and schedules needing corrected were fixed by 11/6/2023. EDUCATION PROVIDED TO NURSE ON 10/25/2023 BY SENIOR LIVING NURSE CONSULTANT ON EVALUATION SCHEDULES. 3. Assisted Living residents who will be self-administering their medications will be assessed by a nurse prior to self-administering medications and re-assessed for continued appropriateness of self-administration per state regulations. 4. MANAGER or designee will audit self-administration evaluations monthly x3 and report to QAPI committee to determine need for continued auditing.	11/10/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Hannah Peters	TITLE Manager, Assisted Living	(X6) DATE 11/15/23
---	--	----------------------------------



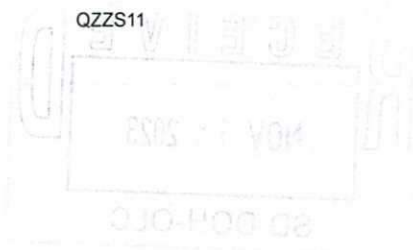
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH:	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 685	<p>Continued From page 1</p> <p>evaluations completed to determine their continued abilities to safely self-administer medications. Findings include:</p> <p>1. Interview on 10/24/23 at 1:30 p.m. with resident 1 revealed she:</p> <ul style="list-style-type: none"> *Self-administered her nebulizer treatments, inhaler, and one diabetic medication. *Checked her own oxygen levels and would put on her oxygen when she needed. *Received medications from the staff four times a day. *Did not understand why certain medications were okay for her to keep in her apartment and others were kept on the medication carts, but thought it might have been because one staff person had recently "messed up" when she administered medications to her. <p>Review of the 5/20/21 Move-In Level of Care Evaluation in the electronic care record (ECR) for resident 1 revealed:</p> <ul style="list-style-type: none"> *She had mild short-term memory loss *She chose to "manage mail order meds [medications]" *The service plan was for staff to support resident 1 with independent self-administration. *She was independent with the use of oxygen. <p>Review of the quarterly Self-Administration of Medication Evaluation (S-AME) history for resident 1 in the ECR revealed:</p> <ul style="list-style-type: none"> *There was no evaluation completed on 5/20/21 at the time she moved in. *The first evaluation was completed on 11/10/21. *The February 2022 evaluation was not done. *The next evaluations were completed on 4/14/22 and 6/6/22. *The September 2022 evaluation was not done. *The next evaluation was completed on 10/19/22. 	S 685		
-------	---	-------	--	--



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH:	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 685	<p>Continued From page 2</p> <p>*The January 2023 evaluation was not done. *The next evaluations were completed on 3/6/23 and 6/1/23. *The September 2023 evaluation was not done.</p> <p>Review of the 1/27/22 Significant Change of Condition Level of Care Evaluation for resident 1 in the ECR revealed she: *"May have occasional mild short-term memory loss (no assistance needed)." *Had an "exacerbation" [increased severity] of chronic obstructive pulmonary disease, a progressive lung disease with respiratory symptoms and airflow limitations. *Chose not to independently manage her own medications *Received nine or more medications per day that required medication assistance one to three times a day. *Was independent with oxygen management and nebulizer treatments.</p> <p>Review of the service plan last reviewed on 5/25/23 for resident 1 revealed the following self-administration interventions: *"Resident will independently work with provider to manage and implement all changes to prescriptions." *"Resident will independently self-administer the following medications: inhalers, nebs [nebulizer], oxygen, insulin, rx [prescription] mouthwash, and creams." *"Medication-trained staff to administer medications per provider order."</p> <p>Interview on 10/24/23 at 5:40 p.m. with administrator (ADM) A and registered nurse (RN) B regarding resident 1's missing S-AMEs revealed: *ADM A stated:</p>	S 685		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH!	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 685	<p>Continued From page 3</p> <p>-There had been turnover of the RN position the past few years. -Some evaluations "potentially got missed." -RN B had started her position in March 2023. *RN B stated: -Her nurse consultant had helped her to "reset the evaluation schedules" in the ECR. -She had also started adding the due dates to her personal calendar. *Both agreed that the S-AMEs should have occurred every three months for any residents who were self-administering medications.</p> <p>2. Interview on 10/24/23 at 1:10 p.m. with resident 2 in her apartment revealed she had: *Moved into assisted living two years ago. *Taken her own medications since she moved in. *Fallen in her apartment three or four months ago injuring her right arm. *Been hospitalized late August 2023 after her toe was amputated. *Required staff assistance with certain tasks since her return from the hospital in September 2023. *Required assistance with administering her eye drops. *Maintained her ability to take her own oral medications which she kept locked in her kitchen cupboard.</p> <p>Review of resident 2's ECR revealed: *She was admitted on 6/16/21. *She scored 15 on her 9/25/23 Brief Interview for Mental Status (BIMS) indicating she was cognitively intact. *Her current physician orders included the following medications for "unsupervised self-administration:" -Ten daily oral medications.</p>	S 685		
-------	---	-------	--	--

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH:	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 685	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Three daily oral medications as needed. -One daily nasal spray. -One daily topical powder. <p>*Her self-administration of medication evaluation (S-AME) schedule in 2021 and 2022 included:</p> <ul style="list-style-type: none"> -An initial evaluation completed on 6/28/21, twelve days after her admission. -An 11/10/21 evaluation completed five months later. -A 2/10/22 evaluation that was not signed as completed until 4/14/22. -An 11/1/22 evaluation completed nine months after her 2/10/22 assessment. <p>*In 2023, her S-AMEs occurred quarterly, completed on 2/10/23, 5/15/23, and 8/17/23.</p> <p>*The most recent S-AME was completed on 9/25/23 after her return to the assisted living due to her significant change of condition.</p> <p>Interview on 10/24/23 at 5:40 p.m. with ADM A and RN B regarding resident 2's self-administration of medication evaluations revealed:</p> <ul style="list-style-type: none"> *Both agreed resident 2's: <ul style="list-style-type: none"> -Initial 6/28/21 evaluation should have been completed on admission. -The 11/20/21 S-AME had not been completed within 3 months of the initial evaluation. --There was a missed opportunity for an evaluation. -In 2022 there should have been four evaluation and not the two evaluations that occurred nine months apart. --There were two missed opportunities for an evaluation. *Both agreed that the evaluations should have occurred every three months. <p>3. Interview on 10/24/23 at 2:10 p.m. with resident 3 in her apartment revealed she:</p>	S 685		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH:	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 685	<p>Continued From page 5</p> <p>*Had moved into the assisted living five and a half years ago. *Stated she took "a lot of medications" at seven different times throughout the day. *Relied on staff to give her oral medications.</p> <p>Review of resident 3's ECR revealed: *She was admitted on 3/1/18. *She scored 8 on her 8/3/23 BIMS indicating she had moderately impaired cognition. *A 7/7/23 physician order "Resident ok to self administer [sic] eye drops, nasal wash/meds, and topicals. Rest of meds managed by staff." *Her current physician orders included the following for "unsupervised self-administration:" -Two different types of eye drops. -One eye ointment. -Two topical creams. -One topical gel. -One topical powder. -"Misc [miscellaneous] Natural Products External Lotion..." -One nasal wash solution. -One nasal spray. *Her current care plan stated her "Need" for "Medications" that included: -A desired "Outcome" that resident 3 "Will be supported to take all medications safely and as ordered" with the following "Interventions": --"Resident is independent with self-administration of Nasal Spray, Netti Pot, eye drops, and topicals." --"Medication-trained staff to administer medications per provider order." --"Nurse to communicate and coordinate with the provider." *Her S-AME schedule included: -A 7/10/19 evaluation. -An 11/5/19 evaluation was completed four months later.</p>	S 685		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH:	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 685	<p>Continued From page 6</p> <p>-A 2/20/20 evaluation.</p> <p>-A 10/19/20 evaluation was completed seven months later.</p> <p>-A 4/7/21 evaluation was completed six months later.</p> <p>-A 7/20/21 evaluation.</p> <p>-An 1/19/22 evaluation was completed six months later.</p> <p>-A 6/6/22 evaluation was completed five months later.</p> <p>-A 12/13/22 evaluation was completed six months later.</p> <p>-In 2023 her S-AMEs occurred quarterly on 3/16/23, 6/14/23, and 8/3/23.</p> <p>Interview on 10/24/23 at 6:30 p.m. with ADM A and RN B regarding resident 3's self-administration of medication evaluations revealed:</p> <p>*Both agreed resident 3's:</p> <p>-11/5/19 had not been within 3 months of the 7/10/19 evaluation.</p> <p>-In 2020 and 2021 there should have been four evaluations each year, not the two assessments that occurred each year.</p> <p>--There were four missed opportunities for evaluation.</p> <p>In 2022, there should have been four evaluations, not the three evaluations completed five or six months apart.</p> <p>*Both agreed that the evaluations should have occurred every three months.</p> <p>Review of the provider's 9/5/23 Self-Administration of Medications-Assisted Living policy revealed:</p> <p>*Policy:</p> <p>-"A. An ALC (assisted living center) resident who chooses to self-administer medications will be assessed by a registered nurse (or as allowed</p>	S 685		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/25/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HEARTH:	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
---	--

(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 685	<p>Continued From page 7</p> <p>per state regulations and state board of nursing Nurse Practice Act) for their ability to safely administer their own medication.</p> <p>-B. Provider's orders will be obtained and documented in the medical record for the ALC resident who chooses to self-administer medications."</p> <p>*Procedure:</p> <p>"B. ALC residents who will be self-administering their medications will be assessed by a nurse prior to self-administering medications and re-assessed for continued appropriateness of self-administration per state regulations."</p>	S 685		
-------	--	-------	--	--

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 58558	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/30/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY-SIOUX FALLS HI	STREET ADDRESS, CITY, STATE, ZIP CODE 4001 S MARION RD SIOUX FALLS, SD 57106
--	--

(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}	<p>Compliance Statement</p> <p>A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 11/30/23 for deficiencies cited on 10/25/23. All deficiencies have been corrected, and no new noncompliance was found. Good Samaritan Society-Sioux Falls Hearthstone AI is in compliance with all regulations surveyed.</p>	{S 000}		
---------	---	---------	--	--

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