STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 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) COMPLETION DATE
F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/14/25 through 4/17/25 and from 4/22/25 through 4/24/25. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: F554, F561, F609, F679, F684, F689, F695, F725, F730, F758, F880, F919, F947, with an Immediate Jeopardy violation at F700. An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/14/25 through 4/17/25 and from 4/22/25 through 4/24/25. Areas surveyed included resident safety related to a resident who had an elopement from the facility and the quality of care provided to a resident prior to their death. Good Samaritan Society Sioux Falls Village was found in compliance.	F 000		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review failed to ensure: *Three of three sampled residents (55,103, and 116), observed with medications stored in their rooms, were assessed for the ability to safely self-administer and store medications, and had physician's orders to self-administer medications	F 554	**F554, SS= E** By 5/16/25 residents 55, 103 and 116 were assessed for the ability to safely self-administer and store medications. Physician orders were updated as appropriate per assessment. This was completed by clinical care leader. By 5/20/25 Director of Nursing or designee will review all residents to ensure all residents who self-administer medications have appropriate assessment and orders for self-administration of medications.	5/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ballou | TITLE: Administrator | (X6) DATE: 5/20/25

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 554	Continued From page 1 according to the provider's policy. *On of One sampled resident's (116) care plan included the resident's self-administration of medications. 1. Observation on 4/14/25 at 3:17 p.m. of resident 103's room revealed: *There was a tube of Triad wound dressing paste (for wound healing) on her bedside table. -The instructions on the pharmacy label read, "apply bid [twice daily] as directed." Review of resident 103's electronic medical record (EMR) revealed: *She was admitted on 12/14/22. *Her 2/25/25 Brief Interview for Mental Status assessment score was 0, which indicated she was severely cognitively impaired. *She had a diagnosis of dementia with other behavioral disturbance. *She had an order for "Triad Hydrophilic Wound Dress External Paste (Wound Dressings) Apply to both buttocks topically two times a day for rash apply on both buttocks twice a day". *There was no physician's order for self-administration of medications. *There was no completed assessment of her ability to safely self-administer medications. 2. Observation on 4/14/25 at 3:18 p.m. of resident 116's room revealed: *There were three partial bottles on her over-the-bed table, one was calcium with vitamin D3 medication, one bottle was a supplement labeled "veggie", and another bottle was a supplement labeled "fruit". *On the cabinet beside her nebulizer machine (device that converts liquid medication into an inhaled mist), there was an unopened individual	F 554	To ensure the deficient practice does not recur, Director of Nursing or Designee will educate all nursing staff on the appropriate storage of medications, as well as, appropriate orders and assessments for residents to self-administer medications by 5/15/25 or prior to next shift worked. To monitor performance and ensure ongoing compliance the Director of nursing or designee will audit self-administration orders and assessments weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Director of Nursing or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 554	Continued From page 2 vial of ipratropium-albuterol (DuoNeb) nebulizer solution (medication for breathing problems). Observation and interview on 4/15/25 at 9:27 a.m. with resident 116 in her room revealed: *A tube of Neosporin medicated cream was on her over-the-bed table in addition to the calcium with vitamin D3, veggie, and fruit bottles. *The unopened DuoNeb vial remained on her cabinet beside her nebulizer machine. *Resident 116 indicated she did not take the calcium with vitamin D3 anymore, but she did self-administer the fruit and vegetable supplements. *She self-administered the Neosporin on an area on her arm to help it heal faster, but she did not always use it. Review of resident 116's EMR revealed: *She was admitted on 12/24/24. *Her 4/1/25 BIMS assessment score was 15 which indicated she was cognitively intact. *A physician's order for "DuoNeb Solution 0.5-2.5 (3) MG [milligrams]/3ML [milliliters] (Ipratropium-Albuterol) 1 inhalation inhale orally via nebulizer two times a day for SOB [shortness of breath]/wheezing" and "every 4 hours as needed for SOB/Wheezing". *A physician's order for "Okay for patient to self-administer nebulizer treatments upon completion of setup by nursing". *A physician's order for "Calcium 600+D Plus Minerals Oral Tablet 600-400 MG-UNIT (Calcium Carbonate-Vitamin D w/ [with] Minerals) Give 1 tablet by mouth one time a day for Chronic low back pain". *There was no physician's order for self-administration for her calcium with vitamin D. *There was no physician's order for the	F 554		

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F 554	Continued From page 3 Neosporin, Veggie supplement, or the Fruit supplement. *There was no physician's order for the self-administration of the Neosporin, Veggie supplement, or the Fruit supplement. *Her 3/31/25 Resident Self-Administration of Medications assessment revealed: -It was a quarterly assessment. -The DuoNeb solution was to be "kept on locked med cart, setup/cleanup [was to be done by] nursing." *Resident 116's care plan did not include her self-administration of medications or if those medications were to be stored in her room. 3. Observation on interview on 4/15/25 at 3:09 p.m. with resident 55 in her room revealed: *There were two containers of Vicks Vapor Rub medicated ointment in her cube storage unit beside her bed. *She indicated she applied the Vicks Vapor Rub to her black toenails. *She had a plastic container filled with medicated cough drops on the arm of her recliner. Review of resident 55's EMR revealed: *She was admitted on 2/26/20. *Her 1/13/25 BIMS assessment score was 14, which indicated she was cognitively intact. *There was no Resident Self-Administration of Medications assessment found in her record. *There was no physician's order for self-administration of the Vicks Vapor Rub or cough drops. *There was no physician's order for Vicks Vapor Rub or the medicated cough drops. 4. Interview on 4/17/25 at 10:48 a.m. with registered nurse (RN)/clinical care leader (CCL)	F 554		

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F 554	Continued From page 4 M revealed: *She was not aware of any residents, in the facility, who were supposed to have medications stored in their rooms. *Only nebulizers were self-administered by residents after a nurse of certified medication aide (CMA) set up the nebulizer medication treatment for administration. *All medications were to be stored in the medication cart until the time of administration. *Triad wound cream was to be stored in the medication cart. *Vicks Vapor Rub required a physician's order and was to be stored in the medication cart. 5. Interview on 4/24/25 at 8:13 a.m. with director of nursing (DON) R regarding residents' self-administration of medications revealed: *She expected the Resident Self-Administration of Medications assessment be completed on admission, quarterly, and if there was a new order for the self-administration of medications for any resident who self-administered medications. *Medications should not be stored in resident rooms without an order. *She expected staff to follow the process for medication self-administration assessment and physician's orders related to the self-administration of medications. *The medications for self-administration were to be stored on the medication cart until the time of administration. *She expected residents' care plans to reflect the current cares the resident was to receive. 6. Review of the provider's 10/29/24 Resident Self-Administration of Medications policy revealed:	F 554		

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F 554	Continued From page 5 *"Complete the Resident Self-Administration of Medications UDA [assessment] to determine if the resident can safely administer medications and create a plan to assist the resident to be successful in this process." *"The interdisciplinary team will determine if the resident has any specific educational needs". *"The interdisciplinary team will also determine where the medications will be stored. This can be at the nurses' station, in a locked medication cart, a locked compartment or locked drawer in the resident's room." *"Medication cannot be left within reach of another resident and must be under the control of the resident who is self-administering." *"A physician's order must be obtained prior to the resident self-administering medications." -"The order must be specific to the medication being self-administered". *"The care plan must indicate which medications the resident is self-administering, where they are kept, who will document the medication and the location of administration, if applicable." *"The resident's ability to continue to safely self-administer medication must be reviewed during the care planning process. It is recommended that this be done at least quarterly and with any significant change." *"All medications that the resident stores in his or her room must be reconciled (counted or observed for the amount used, e.g., ointments and inhalers) and documented by a licensed nurse at least weekly on the MAR [medication administration record]."	F 554		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		

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F 561	Continued From page 6 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to support residents' choices for five of five sampled residents (85, 139, 356, 361, and 363) on the rehab unit regarding menu options and food preferences at meals. Findings include: 1. Observation and interview on 4/15/25 at 8:22 a.m. with resident 363 in her room revealed:	F 561	**F561, SS= E** Resident 85, 139, 356, 361 and 363 no longer reside in facility. By 5/15/25 all residents on the rehab unit were educated on menu options and food preferences at meals by Assistant Director of Nursing and had menus placed in their rooms by Administrative Assistant. By 5/15/25 the Always Available Menu was also placed in all rehab resident rooms by Administrative Assistant. By 5/16/25 all rehab residents were audited by Assistant Director of Nursing to ensure dietary preferences were documented. To ensure the deficient practice does not recur, by 5/15/25 or prior to next worked shift all staff were educated on dietary menus and always available menu by Dietary Supervisor or designee.	5/20/25

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F 561	Continued From page 7 *She was waiting for her breakfast and wanted to know what was being served and when her meal would arrive. *She ate most of her meals in her room and never knew when or what she would be served. *She had not received a planned menu and had not chosen what she was served at her meals. *The breakfast meal was typically good, but she would have liked to have a choice about what she ate for lunch and dinner. Observation and interview on 4/16/25 at 9:37 a.m. with resident 363 in her room revealed she: *Was upset because she had gone to the dining room for breakfast that day and had not enjoyed that experience. She stated that she planned to eat the rest of her meals in her room. *Stated they had not provided her with a planned menu and was frustrated that she did not know what would be served to her. *Was unaware if there was a way to make an alternate meal selection because she did not even know what the meal would be. *Did not have a copy of the planned menu in her room. Interview on 4/22/25 at 2:58 p.m. with resident 363 in her room revealed she stated: *"I just want to go home. Don't even ask. We didn't even have ham for Easter." *"There are no [food] choices." Review of resident 363's electronic medical record (EMR) revealed: *She was admitted on 4/6/25. *Her diagnoses included nausea, major depressive disorder, and anxiety. *Her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated she	F 561	By 5/15/25 dietary department leadership was educated by Administrator on expectations of obtaining resident dietary preferences per policy. To monitor performance and ensure ongoing compliance, Dietary Manager or designee will audit that menus are placed in rehab residents rooms and rehab dietary preferences are being documented weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Dietary Manager or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 561	Continued From page 8 was cognitively intact. *A 4/7/25 social services progress note (PN) indicated resident 363's Patient Health Questionnaire-9 (PHQ-9), an assessment of the degree of depression, interview indicated resident 363 had little interest in doing things, had expressed feeling down/depressed, feeling tired/little energy, poor appetite, feeling bad about herself, having trouble concentrating, and feeling fidgety. *There was no documentation that indicated that the dietary department had discussed food preferences with resident 363. 2. Observation and interview on 4/14/25 at 3:34 p.m. with resident 356 in her room revealed she: *Stated the food is "crappy and cold." *Had eaten some meals in her room and others in the dining room. *Had not had a choice about the meals she received. *Had complained to administrator B about the meals, and there had been no improvements. *Did not have a copy of the menu in her room or available to her. Resident 356 was unavailable for further observation and interview during the survey. Review of resident 356's EMR revealed: *She was admitted on 4/5/25. *Her diagnoses included myocardial infarction (heart attack), reflux disease, and Type 2 Diabetes Mellitus *Her BIMS assessment score was 15, which indicated she was cognitively intact. *A 4/13/25 nursing PN indicated the writer discussed resident 356's food preferences with her, and she would request that the dietitian visit	F 561		

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F 561	Continued From page 9 with resident 356 about her nutrition needs. *There was no documentation that indicated that the dietary department or the dietitian had discussed food preferences with resident 356. 3. Interview on 4/15/25 at 2:38 p.m. with resident 361 revealed she: *Stated lunch was good today, but "it's always a surprise." *Had not received a copy of the menu since she was admitted. *Stated she would have liked a copy of the menu. Review of resident 361's EMR revealed: *She was admitted on 3/24/25. *Her diagnoses included cerebral vascular accident (a stroke), cognitive communication deficit, and Aphasia (impaired ability to understand or express language). *Her BIMS assessment score was 7, which indicated she was severely cognitively impaired. *A 3/24/25 social services PN indicated resident 361's PHQ-9 interview indicated resident 361 had little interest in doing things, had expressed feeling down/depressed, and had a poor appetite. *There was no documentation that indicated that the dietary department or the dietitian had discussed food preferences with resident 361. 4. Observation and interview on 4/15/25 8:42 a.m. with resident 85 and her son in her room revealed: *She ate all her meals in her room. *She had not received a copy of the menus and had been unaware of what food would be served each day. *She and her son had been unaware that printed menus were available. *She had several food preferences and stated,	F 561		

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F 561	Continued From page 10	F 561		

"Here, you get what you get."
*She had not had a choice of food she was served at mealtimes. She recalled that they had provided her with something else when she had not eaten anything at one meal, but it had taken "A while."
*Her call light was on because staff had brought her coffee with no cream or sugar.
-She would have preferred a hot chocolate, but she was not given a choice.
-She was unaware that there was an additional menu of items that were always available.

Observation and interview on 4/15/25 at 2:32 p.m. with resident 85 revealed:
*Her son had asked for a menu, and someone had brought her a copy.
*She was still unaware of how to choose something different if she did not like what was on the planned menu to be served that day.

Review of resident 85's EMR revealed:
*She was admitted on 2/25/25.
*Her diagnoses included nausea, major depressive disorder, and anxiety.
*Her BIMS assessment score was 15, which indicated she was cognitively intact.
*A 3/24/25 nutritional status PN indicated resident 85 had inadequate protein energy intake related to limited personal food preferences, a history of weight loss and poor intake at times, was particular about the foods that she was willing to accept, and preferred most food "be prepared a certain way." Staff were to "Encourage resident to continue to request [an] always available [menu] substitution if [she] does not like something."
-There were no further notes regarding her food preferences.

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F 561	Continued From page 11 5. Observation and interview on 4/15/25 at 10:01 a.m. with resident 139 in her room revealed: *She ate her meals in her room. *The meals came from a central kitchen; she had not had a choice of what she ate at each meal, and she did not know what time the meals were served. -She stated, "It is a surprise." *If she did not like the meal that was served, she did not eat it. *She did not have a copy of the menu in her room or available to her. Interview on 4/22/25 at 3:08 p.m. with resident 139 revealed: *She had not been provided with a copy of the menu. *The Easter meal had been "fair." There had not been a choice of foods, but she would have liked ham. *She was unsure if she could have selected something different than what she had been served. Review of resident 139's EMR revealed: *She was admitted on 3/17/25. *Her diagnoses included irritable bowel syndrome, major depressive disorder, anxiety disorder, and moderate protein-calorie malnutrition. *Her BIMS assessment score was 15, which indicated she was cognitively intact. *A 3/17/25 social services PN indicated resident 139's PHQ-9 interview included she had little interest in doing things, had expressed feeling down/depressed, had trouble sleeping, felt tired/little energy, had a poor appetite, and had trouble concentrating. *A 4/1/25 nutritional status PN indicated that she	F 561		

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GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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F 561	Continued From page 12 was at risk for malnutrition, and her appetite was fair. *There was no documentation that indicated that the dietary department had discussed food preferences with her. 6. Observation on 4/15/25 at 11:53 a.m. on the rehab unit revealed: *There was a "Spring/Summer Dinner Menu posted, in the hallway on the wall across from the dining room. -That menu listed Week 1, Week 2, Week 3, and Week 4 across the top and the days of the week along the left side. *The meal posted was for Wednesday, April 16th, but it was 4/15/25. *A sign indicated that always available food order forms should have been turned into the kitchen at least one hour before meal service, if possible. 7. Interview on 4/23/25 at 7:57 a.m. with certified medication assistant (CMA) HH revealed: *The menu was posted on the wall in the hall across from the dining room on the rehab unit. *Residents used to get a copy of the monthly menu, but now they used a weekly rotating menu. *If a resident asked her for a copy of the weekly menu, she would provide them with a copy. *Residents could have filled out an "always available" meal slip and provided that slip to the staff if they did not want what was being served on the regular menu. -Those slips needed to be turned into the kitchen at least one hour before the meal. 8. Interview on 4/23/25 at 9:16 a.m. with assistant director of nursing/infection preventionist G revealed: *She was the nurse manager on the rehab unit.	F 561		

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F 561	Continued From page 13 *Residents were educated about their meal choices and provided always available menu slips on admission. *Social worker (SW) II provided residents with a copy of the menu on admission. *If a resident wanted something other than what was on the planned menu, they were to fill out a request slip one hour before the meal. *The staff would assist residents in filling out a request slip and provide it to the kitchen if the resident asked. *Menus were not posted in the residents' rooms to decrease potential infection control risk. 9. Interview on 4/23/25 at 9:45 a.m. with SW II revealed: *She would have provided residents with the menu and an always available menu if nursing had not already provided them a copy. *She made a photocopy of the menu that was posted on the wall outside of the dining room if a resident requested a copy. *Sometimes, there were printed menus in the dining room for the residents to take. 10. Interview on 4/24/25 at 8:46 a.m. with administrator B revealed: *He expected that dietary department staff would educate the residents about the meal choices and how to complete the always available meal slips when they completed their admission assessment. *He expected that dietary department staff would provide residents with the planned weekly menu and always available meal slips at admission. *He thought the nursing staff would assist residents in filling out the always available meal slips if needed.	F 561		

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F 561	Continued From page 14 11. Interview on 4/24/25 at 9:19 a.m. with dietitian CC and dining service director EE revealed: *Dietitian CC completed the dietitian assessment, which included a review of the resident's physician orders and any resident allergies, and a conversation with the resident regarding their food preferences when she completed their admission assessment. *She expected that dining services manager DD would have educated the residents on the menu rotation, the always available menu slips, and to have documented resident food preferences in the resident meal tray ticket system. *The tray ticket system allowed the provider to print the meal ticket to be referenced by dietary and nursing staff to serve the resident their meal. *Menus were posted near each dining room. -Two seasonal planned menus were used, Spring/Summer and Fall/Winter. -Menus were provided to residents at their request. *Recently, there was an increase in residents requesting daily menus, so they changed the menu format on 4/1/25 to a weekly seasonal rotation to reduce the amount of printing. -Residents could now request a copy of the full planned seasonal menu. *The always available meal slips were in the dining room at the front counter in the rehab area. -The residents could take a slip themselves, or a staff member could have provided them with one. *The planned menu and always available menu slips had not been provided to the resident on admission by the dietary department. *They felt that the nurses were "pretty good" at providing menus to the residents on admission. 12. Interview on 4/24/25 at 9:31 a.m. with dining	F 561		

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F 561	Continued From page 15 services manager DD revealed he: *Met with residents within 72 hours of their admission. *Discussed their diets, allergies, and completed a list of their food likes and dislikes. -Those were documented on the residents' meal ticket. *Educated them on their choices and the location of the planned daily and weekly menus. Review of the provider's Resident's Rights booklet stated: *"The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice." *"The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident." Review of the provider's revised 4/21/25 Person-Centered Care policy revealed: *"To improve resident quality of life and quality of care by honoring preferences that support individuality, independence and choice." *"Person-centered care is a central theme in nursing home regulations. Many sections in the regulations (i.e., resident rights, comprehensive person-centered care planning and quality of life) stress the importance of person-centered care. Specifically, the residents' rights section contains many provisions which directly support residents having [a] choice and maintaining control over their lives while residing in a nursing home." *"Employees will support residents in achieving the level of well-being that is individually practicable by providing person-centered care. This is done by incorporating personal preferences (food, activities and routines) into	F 561		

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F 561	Continued From page 16 daily care and life." Review of the provider's revised 11/14/24 Menu Requirements policy revealed: *"Employees will communicate menu options to residents based on the system that the facility has in place." *"Residents should have input into menus (e.g., resident council, food committee, individual expression of menu preferences).	F 561		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609	**F609, SS= D** Resident 127 was redirected back to locked memory care unit by facility staff and state was made aware of incident during annual survey. By 5/20/25 other resident elopement incidents for the past six months will be reviewed by the Administrator to ensure reporting standards were met. By 5/15/25 employee A and C were educated by Director of Nursing on reporting standards per state regulation.	5/20/25

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F 609	Continued From page 17 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure their policy related to elopement reporting had been followed regarding an incident of elopement (left the area without staff knowledge) from a secure unit for one of one sampled resident (127). Findings include: 1. Review of resident 127's electronic medical record (EMR) revealed: *She was admitted on 1/11/24. *Her 1/13/25 Minimum Data Set (MDS) indicated that she was rarely understood or able to understand others and was severely cognitively impaired. *A 12/27/24 revised care plan focus area included: "The resident has potential for elopement R/T [related to] dementia, wandering. Resides on the locked memory care unit." *A 2/19/25 progress note indicated "Activity staff report to writer that resident was seen in front office area without staff with her." *The resident was then redirected back to the secured unit. *The incident was reported to the charge nurse. 2. Interview on 4/23/25 at 4:10 p.m. with administrator A about their investigation revealed: *They had reviewed camera footage of resident 127's 2/19/25 elopement. -Camera footage was not available for the surveyor to review as it was automatically deleted after 30 days. *The provider had determined that resident 127	F 609	To ensure the deficient practice does not recur, Director of Nursing or designee will educate all staff on reporting standards per policy on 5/15/25 or prior to next shift worked. To monitor performance and ensure ongoing compliance Social Worker Supervisor or Designee will audit resident incidents to ensure appropriate incidents are being reported to the South Dakota Department of Health per state regulations weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Social Work Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 609	Continued From page 18 had followed a family member who was taking a resident out of the secured unit. That family member did not notice her behind them. *They had implemented an intervention of providing education to the family member who was followed out of the unit. -Investigation documentation indicated that administrator A spoke with the family member "on 2/20/25 at 11:30 about safety of residents on the secure unit" as another resident had followed her out of the unit on 2/19/25. -Administrator A reminded the family member that she should "be cautious and aware of other residents following her out of the unit when exiting and alert staff if she needs assistance." *The chaplain was the staff member who identified that resident 127 was a resident from the secured unit who was not accompanied by staff and was near the front office, by the main entrance/exit of the facility. "Administrator A stated she had not reported the elopement incident because resident 127 had not made it out of the building, staff had spotted her, "and honestly, it just happened so fast." -She confirmed resident 127 resided in the secure unit, had made it out of the secure area, down the hallway, around the corner, down the next hallway that led to the front door area, where she was then located by the chaplain. *Investigation documentation did not indicate how long resident 127 had been out of the secure unit before she was found by the chaplain. 3. Interview on 4/24/25 at 9:53 a.m. with CMA C revealed: *She was aware of resident 127's 2/19/25 elopement incident and asked, "Was that the time she was found in the 400 hall?" *She stated the resident had "gotten out of the	F 609		

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F 609	Continued From page 19 [secure] unit a couple of times." 4. Interview on 4/24/25 at 10:03 a.m. with CMA O revealed: *She was aware of resident 127's 2/19/25 elopement incident. *Staff and family members had received education after the elopement. *She said that the resident had gotten out of the unit on more than one occasion. 5. Review of the provider's 4/7/25 "Elopement-Rehab/Skilled & Adult Day Services" policy revealed: *Definition -"Elopement- When a resident/client who needs supervision leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so." *Policy -"When an elopement occurs, immediate efforts to locate the resident/client will be taken. All occurrences will be documented and follow-up will be completed as required by state and federal regulations." *Elopement Search -"Notify other agencies as required by state and/or federal regulation." 6. Review of the provider's 4/7/25 "Abuse and Neglect- Rehab/Skilled, Adult Day Services, Therapy & Rehab" policy revealed: *Policy -"The location will have evidence that all alleged or suspected violations are thoroughly investigated ..." -"Results of all investigations will be reported to the administrator or designated representative	F 609		

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F 609	Continued From page 20 and to other officials in accordance with state law, including to the state survey and certification agency within five working days of the event, or sooner as designated by state law." *Procedure -Notification procedures: –"Designated agencies will be notified in accordance with state law, including the State Survey and Certification Agency."	F 609		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure three of three sampled residents (139, 361, and 363) who resided in the Rehab unit were provided activities that were meaningful and of interest to maintain their psychosocial well-being. Findings include: 1. Observation and interview on 4/15/25 at 8:22 a.m. with resident 363 in her room revealed: *She ate her meals in her room and participated in therapy. *There had not been any activities or programs	F 679	**F679, SS= E** Resident 139, 361 and 363 no longer reside in facility. Other residents on the Rehab unit had the potential to be affected. Upon interview, no other resident expressed concerns with the activity programming. By 5/20/25 Activity Supervisor or designee will review all residents residing on rehab unit to ensure activities are posted in resident room and activities are being offered to rehab residents.	5/20/25

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F 679	Continued From page 21 for her to attend. *She felt alone and like there was no one to talk to. *She did not have an activities calendar of events happening in the facility. Observation and interview on 4/16/25 at 9:37 a.m. with resident 363 in her room revealed she: *Had been encouraged to go to the dining room for her meals for socialization. *Was upset because she had gone to the dining room for breakfast, hoping to talk to other residents, and had not enjoyed that experience. *Stated that she planned to eat the rest of her meals in her room. Interview on 4/22/25 at 2:58 p.m. with resident 363 in her room revealed: *She stated there had been no activities in the past four days. *She had stayed in her room. *She stated, "I just want to go home. Don't even ask. We didn't even have ham for Easter." *She felt that there was "nothing to do," and "There are no choices." -She was unaware if there had been a church service for Easter and would have wanted to attend that if there was one. *She was unaware that a music program had been held that afternoon and would have wanted to attend that. Review of resident 363's electronic medical record (EMR) revealed: *She was admitted on 4/6/25. *Her diagnoses included nausea, major depressive disorder, and anxiety. *Her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated she	F 679	To ensure the deficient practice does not recur, Administrator or designee will educate Activity staff on providing activities that are meaningful and of interest to all residents in order to maintain psychosocial well-being per policy by 5/16/25 or prior to next shift. To monitor performance and ensure ongoing compliance Activity Supervisor or designee will audit 5 residents on the rehab unit weekly for satisfaction with activity programming weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Activity Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 679	Continued From page 22 was cognitively intact. *A 4/7/25 social services progress note (PN) indicated resident 363's Patient Health Questionnaire-9 (PHQ-9) (an assessment of the degree of depression) interview indicated resident 363 had little interest in doing things, had expressed feeling down/depressed, feeling tired/little energy, poor appetite, feeling bad about herself, having trouble concentrating, and feeling fidgety. *"Section F - Preferences for Routines & Activities" of her 4/8/25 Minimum Data Set (MDS) assessment indicated: -Doing things with groups of people and doing her favorite things was marked as "somewhat important" to her. -Participation in religious activities or practices was marked as "very important" to her. *Her current care plan indicated: -"The resident has potential for activity deficit R/T [related to] acute pain and depression." -She "will participate in activities of her choice by next review date." *Care plan interventions for her activities included: -"Introduce resident to residents with similar background, interests and encourage/facilitate interaction." -"Invite and remind resident of scheduled activities, assisting to and from locations as needed." -"Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s [signs/symptoms] or c/o [complaint of] pain or discomfort. *There was no documentation that indicated resident 363 had participated in or was offered and refused any group or one-to-one activities since her admission.	F 679		

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F 679	Continued From page 23 2. Observation and interview on 4/14/25 at 4:45 p.m. with resident 361 revealed she: *Participated in therapy and went to the dining room for most meals. *Slept a lot because "It can get boring." *Did not have an activities calendar of events happening in the facility. *Was unaware if there were activities to attend in the facility. Interview on 4/22/25 at 3:03 p.m. with resident 361 revealed *She stated there had been no activities in the past four days, so she just slept in her chair. *She had not gone to any church services and was unsure if there were any offered. *She requested an activities calendar after her discussion with the surveyor the day before about her participation in activities at the facility, and someone brought her the April activities calendar yesterday (4/21/25). Review of resident 361's EMR revealed: *She was admitted on 3/24/25. *Her diagnoses included cerebral vascular accident (CVA) (a stroke), cognitive communication deficit, and Aphasia (impaired ability to understand or express language). *Her BIMS assessment score was 7, which indicated she was severely cognitively impaired. *A 3/24/25 social services PN indicated resident 361's PHQ-9 interview indicated she had little interest in doing things, had expressed feeling down/depressed, and had a poor appetite. *"Section F - Preferences for Routines & Activities" of her 3/29/25 MDS assessment indicated: -Keeping up with the news and doing her favorite	F 679		

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F 679	Continued From page 24 things was marked as "somewhat important" to her. *Her care plan indicated: -A focus area, "The resident has potential for activity deficit R/T CVA, E/B [evidenced by] some cognitive impairment, some memory loss" was marked resolved on 3/31/25. -A goal "Resident will maintain involvement in cognitive stimulation, social activities as desired through review date" was marked resolved on 3/23/25. -An intervention "Introduce resident to residents with similar background, interests and encourage/facilitate interaction" was marked resolved on 3/23/25. *There was no documentation that indicated she had participated in any group or one-to-one activities since her admission. 3. Interview on 4/15/25 at 10:01 a.m. with resident 139 in her room revealed she: *Ate her meals in her room, went to therapy, and watched television. *She stated there were books available in the dining room, but she was "bored a good part of the day." *She had not received an activities calendar and was not aware of any activities that she could do. Observation and interview on 4/22/25 at 3:08 p.m. with resident 139 revealed she: *Stated the past Easter weekend was "quiet" and that she had "sat here all by myself." *Did not have an activities calendar. *Was unaware whether there had been any activities or church services offered at the facility. Review of resident 139's EMR revealed: *She was admitted on 3/17/25.	F 679		

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F 679	Continued From page 25 *Her diagnoses included major depressive disorder and anxiety disorder. *Her BIMS assessment score was 15, which indicated she was cognitively intact. *A 3/17/25 social services PN indicated resident 139's PHQ-9 interview indicated she had little interest in doing things, had expressed feeling down/depressed, had trouble sleeping, felt tired/little energy, had a poor appetite, and had trouble concentrating. *"Section F - Preferences for Routines & Activities" of her 3/21/25 MDS assessment indicated: -Participation in religious activities or practices was marked as "very important" to her. -Listening to music and doing her favorite things was marked as "somewhat important" to her. *Her care plan indicated staff were to: -"Be conscious of my location when in groups, activities, dining room to promote proper communication with others." -"Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: PT/OT [physical therapy/occupational therapy] to evaluate and treat for skilled stay." -"Invite resident to food-related activities and offer food, beverages of choice to encourage intake." -"Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s [signs/symptoms] or c/o [complaints of] pain or discomfort." *There was no documentation that indicated she had participated in any group or one-to-one activities in the last 30 days. 4. Observation on 4/15/25 at 11:53 a.m. on the rehab unit revealed the facility activities calendar was posted outside the dining room, by day, for	F 679		

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F 679	Continued From page 26 the entire week, and included the location of the activity. -None of those posted daytime activities were listed to or were observed to have occurred in the rehab unit during the survey. 5. Interview on 4/16/25 at 10:17 a.m. with certified nursing assistant (CNA) S revealed: *Residents can participate in the activities listed on the calendar posted near the dining room. *She confirmed that none of the activities occurred in the rehab unit. *If the resident asked, the staff would have taken them to the activity. *Not many residents in the rehab unit asked to go to the activities. 6. Interview on 4/17/25 at 11:44 a.m. with director of nursing (DON) R revealed: *She expected the activities department staff to post the monthly activities calendar in each resident's room on the first of the month. *All residents were to be invited to all activities and could attend activities of their choice. 7. Interview on 4/17/25 at 11:49 a.m. with activities supervisor JJ revealed: *There were no activities staff assigned to the rehab area. -She was working on getting someone hired for that area. --She stated a position had been posted. *No scheduled activities occurred in the rehab area. *Residents who resided in the rehab area could attend facility activities that occurred in other areas of the facility. *She expected the rehab unit staff to bring those residents to activities if they wanted to attend.	F 679		

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F 679	Continued From page 27 *Activities were announced at breakfast in each dining room and on the overhead paging system. *A weekly activities calendar was posted in the rehab unit outside the dining room. *She completed an activities assessment when rehab residents were admitted, but was not responsible for their care plans for activities. *There were currently no residents in the rehab unit who wanted to attend group activities. *Independent activities like magazines, books, and puzzles were available in the dining room. *The chaplain visited and provided communion to residents in the rehab unit. *She was unsure if the residents in the rehab unit had activity calendars because she could not recall if she had provided them to social worker (SW) II. *She expected SW II to provide those activity calendars to the residents on the rehab unit upon admission. *One activity that was available for the rehab unit residents was socializing in the dining room at meals. 8. Interview on 4/23/25 at 7:59 a.m. with certified medication aide (CMA) HH revealed: *Most of the residents in the rehab unit do not go to any scheduled activities. -Occasionally, residents would go to church services. *The activities department did not hold activities in the rehab unit for those residents. *Residents had a monthly activities calendar, could let staff know when they wanted to attend, and the staff would bring them. 9. Interview on 4/23/25 at 9:12 a.m. with assistant DON/infection preventionist G revealed: *She was the nurse manager on the rehab unit.	F 679		

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F 679	Continued From page 28 *Activities supervisor JJ completed the residents' activities assessments. *She expected activities calendars would be provided to residents by SW II or activities supervisor JJ on admission. *She felt that therapy kept the residents in the rehab unit very busy. *No group or individualized activities were provided in the rehab unit by the activities department. *Residents on the rehab unit were often younger than long-term residents and often had not wanted to participate in facility activities. *Some rehab unit residents had gone to receive hair care at the facility salon. *Some residents had gotten together on their own to play cards. *She encouraged residents to eat in the dining room for social interaction. *The residents were made aware of the facility's activities on admission and that they could join them if they wanted to. *A paper copy of the monthly activity calendar was not hung in the rehab unit resident rooms due to potential infection control issues with the short-term rehab stays. 10. Interview on 4/23/25 at 9:45 a.m. with SW II revealed: *Activities offered at the facility were posted in the hall outside the dining room each week. *"Sometimes," she had activities calendars, and would provide those calendars to the residents of the rehab unit when they were admitted. *She confirmed that she did not have the April activities calendars. -Those calendars should have been provided to her by the activities department. *If a resident indicated during their social history	F 679		

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F 679	Continued From page 29	F 679		

that a particular activity was important to them, she would email activities supervisor JJ, to let her know.

11. Interview on 4/23/25 at 11:09 a.m. with administrator A revealed:
*She expected activities calendars to have been posted in each resident's room.
*She was not aware that the rehab unit residents did not have a copy of the activities calendar.
*She stated the activities calendar was posted outside of each dining room.
*She expected education about the facility activities would be provided to the residents on admission.
*The rehab unit residents were invited to attend all facility activities.
*She was unsure if the rehab unit residents were offered individualized or one-to-one activities.
*She confirmed there was no documented activity participation or documented offerings and refusals for residents 139, 361, or 363.

12. Interview on 4/24/25 at 8:46 a.m. with administrator B revealed:
*He expected that activities supervisor JJ would have provided a copy of the activities calendar to rehab unit residents when she completed their admission assessment.
*Rehab unit residents could have attended facility activities, and if they asked, staff were to bring them to the activity.

Review of the provider's revised 12/23/24 Group Programming-ACT policy revealed:
*"The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of

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F 679	Continued From page 30 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of the resident, encouraging both independents and interaction in the community." Review of the provider's revised 4/21/25 Person-Centered Care policy revealed: *"To improve resident quality of life and quality of care by honoring preferences that support individuality, independence and choice." *"Person-centered care is a central theme in nursing home regulations." *"Person-centered care includes making an effort to understand ... what is important to each resident with regards to daily routines and preferred activities ..."	F 679		
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, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (139) was provided daily warm showers according to her preferences and according to her physician's orders during her short-term rehab stay.	F 684	**F684, SS= D** Resident 139 no longer resides in facility. By 5/15/25 all rehab resident bathing preferences were updated and schedule was created based on resident preference and physician orders by Assistant Director of Nursing. By 5/15/25 all rehab resident EMRs were updated by Assistant Director of Nursing to ensure accurate bathing schedule and accurate staff charting is completed. By 5/16/25 water temperature was audited on rehab unit to ensure water for	5/20/25

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F 684	Continued From page 31 Findings include: 1. Observation and interview on 4/15/25 at 10:19 a.m. with resident 139 in her room revealed: *She stated she had not showered recently because there was "only cold water" in her shower. *The bathroom had a walk-in shower with a bench and a hand-held shower head. -After the surveyor ran the water for three minutes in that shower, the water never felt warm to the touch. *Staff had attempted, when she first admitted, about a month ago, to shower her in that shower, and the water was cold. -That day, the staff shower her in the room "next door," and she recalled having felt very cold. *Staff had since told her no other shower was available because all the rooms were now occupied by other residents. *She was upset and had complained to the staff and her physician that there was no hot water for her to shower. -It had taken "weeks" for anyone to look at the shower water temperature. *A "plumber" had come last Thursday or Friday and told her the shower needed a new "cartridge." -He had not returned to make that repair that she was aware of. *She had refused to shower if there was no hot water. 2. Interview on 4/16/25 at 9:48 a.m. with certified nursing assistant (CNA) S revealed: *A master shower schedule for the residents was posted in the nurse's station. *She knew when a resident in her assigned area was scheduled for showering because it would be	F 684	bathing is at appropriate temperature per facility policy by maintenance technician. To ensure the deficient practice does not recur, Director of Nursing or designee will educate all rehab staff of bathing residents per their preference and charting bathing per EMR by 5/19/25 or prior to next shift. To monitor performance and ensure ongoing compliance Director of Nursing or designee will audit five rehab resident baths weekly x4, bi-weekly x2, monthly x1 and quarterly x1. Hot water in five rehab unit rooms will be audited by Ancillary Services Supervisor or designee weekly x4, bi-weekly x1 and then monthly per TELs report thereafter.	

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F 684	Continued From page 32 listed on her daily assignment sheets. *Two showers a week were scheduled based on the resident's room number. *She confirmed resident 139 was scheduled for showering on Tuesday mornings and Saturday evenings. 3. Interview on 4/16/25 at 9:50 a.m. with registered nurse (RN) N regarding resident showering revealed: *She confirmed the residents' shower schedule was posted at the nurse's station. *Resident showers were scheduled by room number because of the rapid change in residents on the rehab unit. *Each resident was to receive two showers a week. *If changes were made to that schedule, it would be indicated in the resident's care plan. *Sometimes, staff had time to provide residents with an "extra" shower if the resident requested one and the staff had time. 4. Interview on 4/16/25 at 2:06 p.m. with CNA S revealed: *Resident 139 required the assistance of one staff member for showering and dressing. *She had not provided resident 139 a shower and was unaware that resident 139 had stated that the water in her shower was cold. *She would tell the charge nurse if a resident told her they had no hot water. *Sometimes the water needed to run for a few minutes to get warm. *Resident 139 was scheduled to receive a shower last night (4/15/25). 5. Interview on 4/16/25 at 2:11 p.m. with resident 139 revealed she:	F 684	The results of those audits will be brought to the QAPI committee by the Director of Nursing or Designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 684	Continued From page 33 *Had received a shower last night (4/15/25) and the water was hot. *Appeared happy and stated it was the "first real shower" she had had since she was admitted here. *Stated, "Of course they waited til I was going home to give me a shower." 6. Interview on 4/22/25 at 3:08 p.m. with resident 139 revealed: *Staff had attempted to shower her that morning. -The water started hot and got progressively colder. *She was upset and stated she could not "tolerate it" and made them stop the shower. *She was going home tomorrow and was looking forward to taking a hot shower in her own home. 7. Review of the provider's current shower schedule revealed: *Each resident was scheduled to shower on one morning and one evening weekly on the days of the week based on their room number. *Resident 139 was assigned showers on Tuesday day shifts and Saturday evening shifts. 8. Review of resident 139's electronic medical record (EMR) revealed: *She was admitted on 3/17/25 for a short-term rehab stay following a surgical procedure. *Her diagnosis included fracture of right humerus (upper arm bone), fracture of right femur (upper thigh bone), irritable bowel syndrome, major depressive disorder, and anxiety disorder. *Her Brief Interview of Mental Status assessment score was 15, which indicated she was cognitively intact. *A 3/27/25 physician's order indicated "May leave incision right hip open to air. May shower	F 684		

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F 684	Continued From page 34 and let water run over, No baths or whirlpools with this incision for 4 more weeks." *A 4/11/25 orthopedic physician's note indicated, "Betadine paint on incision after shower daily for 7 days. Patient [resident] needs to be able to shower with warm water may let this run over her incision - please check into getting water heater for shower fixed." *A 4/12/25 physician's order, "Betadine paint on incision after shower X7 days one time a day ..." was documented as completed daily from 4/12/25 through 4/18/25. *Review of residents 139's "Task BATHING:" documentation revealed: -On 3/18/25 "Sponge [bath]" was documented. -On 3/22/25 "ADL [activity of daily living] activity itself did not occur..." "Resident refused" was documented. -On 3/25/25 "One person physical assist [assistance]." "Shower" was documented. -On 4/1/25 "One person physical assist." "Bed bath" was documented. -On 4/8/25 "No set up or physical help from staff." "Shower" was documented. -On 4/15/25 "One person physical assist." "Shower" was documented. -On 4/19/25 "Not applicable" "ADL activity itself did not occur..." was documented. *No documentation in the nurse's progress notes indicated why resident 139 was not provided with showers as scheduled and as ordered by her physician. *Her care plan indicated, "I require staff assistance of one with the use of a shower chair." -There was no documentation in the care plan regarding the frequency of her showering. 9. Interview on 4/23/25 at 8:15 a.m. with ancillary services manager QQ revealed he:	F 684		

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F 684	Continued From page 35 *Had not been made aware of hot water not being available in resident 139's shower. *Expected maintenance concerns and issues to be entered in the "TELS" electronic maintenance management system. 10. Interview on 4/23/25 at 8:18 a.m. and again at 10:58 a.m. with maintenance mechanic associate (MMA) OO revealed: *Initially, he had not recalled any issues with resident 139's shower, but after he discussed the situation with administrator B, he recalled that he had "replaced and tightened the set screw so the water would be hot." -He had not documented that repair or when it had occurred. *Today (4/23/24) he "replaced the cartridge" and "placed a new screw" in resident 139's shower. *He stated the water temperature was "now reaching 105 to 110 degrees" Fahrenheit. *There was no place for him to document that the repair was completed because there had not been a maintenance request on the TELS system. *He stated that staff would inform him of maintenance issues by writing them in a binder at the nurse's station, entering it in the TELS system, or by telling him in person. *If the staff used the TELS system, it allowed them to see who opened and closed a work order. 11. Interview on 4/23/25 at 8:49 a.m. with assistant director of nursing/infection preventionist (ADON/IP) G revealed: *She was the nurse manager on the rehab unit where resident 139 resided. *Staff could report issues, such as no hot water, to maintenance staff by writing it in a binder at the	F 684		

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F 684	Continued From page 36 nurse's station, entering it into the "TELS" system, or telling maintenance staff verbally. *Staff in the rehab unit typically told her of maintenance issues, and she would tell maintenance staff. *She became aware of resident 139's shower not having hot water when she reviewed the physician's orders and recommendations shortly after the resident's 4/11/24 orthopedic appointment. *She thought the physician's note for the resident to have daily showers was only a recommendation, and they did not provide daily showers. -The most showers a resident could have received weekly was two, unless the resident was independent and could take showers without staff assistance. *She expected that the residents' showers would be completed as posted and scheduled. *Regarding the physician's recommendation that resident 139's shower needed to be fixed, she had notified administrator B, and he had worked with maintenance to get the shower fixed. *She was unaware that resident 139 had continued to have problems with her shower after that time. *She confirmed that there were four documented showers for resident 139 from 4/19/24 through 4/23/24. *There had been a problem within the EMR documentation system related to charting evening showers, and resident 139 may have received more showers than had been documented. -That information was not documented anywhere else. *She thought that the resident refused showers frequently.	F 684		

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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 684	Continued From page 37 12. Interview on 4/23/25 at 8:57 a.m. and again at 9:11 a.m. with administrator B revealed: *After resident 139's 4/11/25 orthopedic appointment, ADON/IP G had informed him that the resident's shower needed to be looked at because it may have had a problem with hot water. *At that time, he and MMA OO looked at resident 139's shower and adjusted the handle to make the water warmer. *There was no documentation of that repair. *No shower water temperature checks or audits had been completed to confirm the shower was fixed. *He had not put that maintenance request in the TELS system. -If a repair was completed immediately, it would not always get put in the TELS system. *He had requested that MMA OO change the shower "cartridge" today (4/23/25) to ensure resident 139 would have hot water for her shower. *He confirmed that resident 139 was discharged to home today. 13. Interview and review of resident 139's 4/12/25 physician's order on 4/23/25 at 2:15 p.m. with director of nursing (DON) R revealed: *Resident 139 had seen her orthopedic physician on 4/11/25. *The order for "Betadine paint on incision after shower daily for 7 days" had been documented as completed daily from 4/12/25 through 4/18/25. *She confirmed that resident 139 was documented as having received only four showers in the last 30 days. *She expected there to have been clarification with the physician that the shower would not have been provided every day because, "Realistically,	F 684		

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F 684	Continued From page 38	F 684		

there would be no way to do that."
*She stated the resident would likely not have agreed to shower every day, and there is no way the staff could give a shower every day to every resident.
*She stated the physician "doesn't consult with us on those orders."
*She declined to answer if that task having been documented as completed would indicate the shower was completed in addition to the Betadine application.
*She again stated the order should have been clarified because it was not a realistic expectation and the resident had received the Betadine to her incision.
*There had been an issue within the EMR system with documenting evening showers but that issue had been identified and corrected.
*There was no additional shower documentation to review for resident 139.

14. Interview on 4/24/25 at 8:46 a.m. with administrator B regarding the physician's order and documentation of showers received by resident 139 revealed:
*He thought that resident 139's shower had been fixed.
*He was unaware that resident 139 had not received showers as scheduled or ordered.
*He expected that the nursing staff would have reached out to the physician and requested that the order be changed or to provide clarification on why the showers would not have been provided as ordered.

15. Review of the provider's revised 4/21/25 Person-Centered Care policy revealed:
*"Person-centered care is a central theme to federal nursing home regulations."

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F 684	Continued From page 39 *"Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care." *"Employees will support residents in achieving the level of well-being that is individually practicable by providing person-centered care." Review of the provider's revised 4/6/25 Physician/Practitioner Orders policy revealed: *"To provide Individualized care to each resident by obtaining appropriate, accurate and timely physician/ practitioner orders." *Clarification orders are needed when reviewing any type of physician/practitioner order that are incomplete or raise questions." Review of the provider's revised 9/3/2024 Bathing policy revealed: *"Purpose: To promote cleanliness and general hygiene." *"To promote comfort, relaxation, and well-being." *"To observe resident's condition." Review of the provider's undated Work Orders policy revealed: *"Encourage residents to request maintenance work orders using the Work Order Request (this is an optional form). *"If the request is made verbally ...the information should be transferred to ...approved maintenance software system." *"Respond to all resident requests within 24 hours with either a fix or a plan of action."	F 684		

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F 689 F 689 SS=E	Continued From page 40 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one sampled resident (112) who used a recliner was evaluated for potential safety risks. *Assess for entrapment of mattresses that were on nine of 159 residents (5, 17, 22, 73, 83, 103, 106, 123, 137) beds. *Foot board railing was assessed for risk of entrapment for one of one sampled resident (453). *Safe, secure storage of chemical in two of two sampled residents rooms (55 and 103). Findings include: 1. Observation on 4/14/25 at 3:42 p.m. of resident 112 in her room revealed she was sitting in her recliner with her feet elevated. Observation and interview on 4/15/25 at 10: 43 p.m. with resident 112 in her room revealed: *She was sitting in her electric recliner with her feet elevated and her eyes closed. *She had a pillow under her feet in addition to having the footrest elevated that the chair completely reclined. *She began speaking but kept her eyes closed.	F 689 F 689	**F689, SS= E** Resident 112's recliner was removed by maintenance from her room and family was notified by Director of Nursing on 4/23/25. Resident 5, 17, 22, 73, 83, 103, 106, 123 and 137 mattresses/bed frames were corrected to prevent mattress from sliding and creating gap greater than four inches on 4/16/25 by maintenance technicians. Resident 453's brass foot rail was removed from bed and family notified on 4/16/25 by maintenance technician. By 5/14/25 fingernail polish in resident 55's room was removed. By 5/14/25 Febreze air freshener and Lysol air freshener were removed from resident 103's room by Clinical Care Leader.	5/20/25

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F 689	Continued From page 41 *When she was asked if she was able to lower the footrest of the recliner, she stated she thought she could but when she attempted to demonstrate this, she indicated she did not know how. Interview on 4/16/25 at 3:03 p.m. with registered nurses (RN)/Minimum Data Set (MDS) nurses D and E revealed: *The Physical Device and/or Restraint Evaluation and Review assessment was competed quarterly, annually, and with a significant change. *If a resident was not able to use an electric recliner the resident's family or staff would use the controls to adjust the chair position. *If the staff placed the resident in the recliner and the resident was unable to use the recliner controls, they would expect staff to check on the resident frequently. *They indicated that if a resident was placed in a recliner, the resident's feet were elevated, and the resident was unable to operate the recliner this could be considered a restraint. Interview on 4/17/25 at 10:34 a.m. with certified nursing assistant (CNA) LL regarding resident 112 revealed: *Staff did not assist resident 112 into her recliner often because she would try to slide herself out of the recliner. *Resident 112 was unable to operate the controls of her electric recliner. Review of resident 112 electronic medical record (EMR) revealed: *She was admitted on 6/28/24. *Her Brief Interview for Mental Status (BIMS) assessment score was 0, which indicated she rarely understands or is understood.	F 689	By 5/19/25 Director of Nursing or designee reviewed all resident recliners to ensure recliner was appropriate for resident per physical device assessment. By 4/16/25 Ancillary Service Supervisor or designee reviewed all mattresses and bedframes in facility to ensure there was no gap greater than 4 inches. By 5/16/25 Administrator or designee reviewed all resident rooms to ensure no chemicals were in resident rooms per policy.	

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F 689	Continued From page 42 *Her diagnoses included history of falling, generalized muscle weakness, cognitive communication deficit, and Alzheimer's disease. *She had nine falls from her recliner documented between 7/13/24 and 11/24/24. *Her care plan had a focus areas of: -"The resident has impaired cognitive function R/T [related to] Alzheimer's/dementia E/B [evidence by]] significant memory loss, family assists with decision making, disorganized thoughts at times, poor safety awareness, impulsive." -"The resident has had an actual fall with No Injury, R/T self-transfer E/B slid out of chair" that was initiated on 7/15/24. *She required assistance from staff for all her activities of daily living. *Resident 112's care plan did not address the use of the recliner/lift chair. *She had a 2/11/25 Physical Device and/or Restraint Evaluation and Review assessment that addressed her recliner/lift chair. -The assessment indicated "Staff and resident use recliner as an alternative seating option. Staff uses [the] controls to assist in repositioning. Staff anticipate resident's needs while in [the] recliner." -The assessment did not include: --"Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcomes, etc.)." --"Alternatives that have been attempted". --"General restraint and/or device education provided". Interview on 4/23/25 at 10:16 a.m. with director of	F 689	To ensure deficient practice does not recur, Director of Nursing or designee educated MDS coordinators on assessing resident recliners upon admission or when a new recliner comes into a resident's room and quarterly thereafter or with any significant change per facility policy by 5/15/25 or prior to next shift worked. Director of Nursing or designee will educate all staff on reporting resident recliner concerns to leadership by 5/15/25 or prior to next shift worked. Education will be provided by a Clinical Learning and Development Specialist or Designee to all staff by April 16, 2025 or prior to their next shift. All staff members not currently on the schedule will receive education prior to their next shift.	

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F 689	Continued From page 43 nursing (DON) R revealed: *The fall team had not reviewed resident 112's falls from her recliner to determine if her feet were elevated in the recliner at the time of the fall. *DON R stated she had not seen resident 112 in her recliner for months. *She felt resident 112 could operate the controls of the recliner if she wanted to. *It was her expectation if resident 112's feet were elevated in the recliner and she was unable to operate the recliner controls, staff would round on her frequently and if she was anxious staff would take her out of her chair. *She stated there was a potential that the recliner could be viewed as a restraint but resident 112 needed the recliner for pressure off loading to prevent pressure ulcers because resident 112 did not like lying in bed. Observation and interview on 4/23/25 at 4:44 p.m. with licensed practical nurse (LPN) H revealed: *Resident 112 was in her recliner with her legs elevated and a soft touch call light beside her left hip. *LPN H was not aware of any falls from the recliner but did state staff had found her sitting on the footrest of her recliner. *Resident 112 was unable to operate her electric recliner so staff and family would operate the controls for her. *She indicated she was not concerned that the recliner was a restraint because resident 112 was able to scoot herself on to the footrest of the recliner and if she scooted far enough the recliner would tip forward and she could get herself to the floor. Observation and interview on 4/23/25 at 5:21	F 689	This training will cover entrapment risks, immediate interventions to address entrapment, and the appropriate personnel to notify if a resident is identified as being at risk. Director of Nursing or designee will educate all staff on chemicals in resident rooms per facility policy by 5/15/25 or prior to next shift worked. To monitor performance and ensure ongoing compliance, Director of Nursing or designee will audit ten resident recliners and physical device assessments weekly x4, bi-weekly x2, monthly x1 and quarterly x1.	

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F 689	Continued From page 44 p.m. in resident 112's room with administrator A and DON R revealed: *Administrator A and DON R were notified of the report by staff that resident 112 has been found sitting on the footrest of the chair and the staff were aware that if resident 112 scooted far enough forward on the footrest the chair would tip forward. *It was demonstrated with resident 112's empty recliner that with pressure applied on the footrest the recliner would tip forward and the footrest would come to rest on the floor. *Administrator A and DON R acknowledged the information but did not offer any further information at this time. Interview on 4/24/25 at 10:29 a.m. with administrator A revealed: *It was her expectation for staff to notify their manager if an area of concern was identified such as a recliner that would tip forward when a resident sat on the footrest. *She did not feel every box of an assessment, such as the Physical Device and/or Restraint Evaluation and Review, needed to be addressed for every single resident. Interview on 4/24/25 at 12:25 p.m. with resident 112's daughter revealed she: *Expressed concern regarding resident 112's recliner having been removed from her room. *Indicated resident 112 had only fallen out of her recliner one time since her admit, nine months ago. *Felt resident 112's dementia had affected her ability to understand that she could no longer stand up and walk. *Stated "we don't want her to get out of the chair" after the concern for resident 112's safety and the	F 689	To monitor performance and ensure ongoing compliance, Ancillary Services Supervisor or designee will audit ten resident mattresses and bedframes to ensure any gaps meet policy weekly x4, bi-weekly x2, monthly x1 and quarterly x1. Audit of mattresses and bedframes will also be completed by Ancillary Services Supervisor or designee in TELS monthly.	

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F 689	Continued From page 45 possibility of the recliner being a restraint was described to her. *Felt the recliner was the safest place for resident 112 because there was an alarm to alert staff when resident she moves. 2. Observation on 4/16/25 at 9:57 a.m. of resident 103's bed revealed: *The mattress slid up and down in the bed. *When the mattress was slid to the foot of the bed there was a gap of nine inches between the headboard and the mattress. Observation on 4/16/25 at 10:36 a.m. of resident 123's bed revealed a five-inch gap between the headboard and mattress. Observation on 4/16/25 at 10:56 a.m. of resident 5's bed revealed a six-inch gap between the headboard and the mattress. Observation on 4/16/25 at 11:00 a.m. of resident 22's bed revealed a six-inch gap between the headboard and the mattress. Observation on 4/16/25 at 11:02 a.m. of resident 17's bed revealed a four- and three-quarter inch gap between the headboard and the mattress. Observation on 4/16/25 at 11:10 a.m. of resident 137's bed revealed a seven-and-a-half-inch gap between the headboard and the mattress. Observation on 4/16/25 at 11:17 a.m. of resident 83's bed revealed a seven-and-a-half-inch gap between the headboard and the mattress. Observation on 4/16/25 at 11:22 a.m. of resident	F 689	To monitor performance and ensure ongoing compliance, Ancillary Services Supervisor or designee will audit five resident rooms for any chemicals in resident rooms per facility policy weekly x4, bi-weekly x2, monthly x1 and quarterly x1. To monitor performance and ensure ongoing compliance Director of Nursing, Ancillary Services Supervisor or their designees will bring audit findings to QAPI committee for review until the facility demonstrates sustained compliance as determined by the committee.	

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F 689	Continued From page 46 73's bed revealed a five-and-a-half-inch gap between the headboard and the mattress. Observation on 4/16/25 at 11:28 a.m. of resident 106's bed revealed a five-inch gap between the headboard and the mattress. Observation on 4/17/25 at 8:30 a.m. of resident 73's bed revealed: *There was no metal mattress retainer bar on the foot of the bed. *There was a gap measuring five-and-one-quarter inches between the footboard and the mattress. Interview on 4/16/25 at 11:55 p.m. with administrator B revealed: *Monitoring of the beds was completed monthly with a check mark task. *Not all the monitoring was documented in the computerized system. *He was trying o locate more documentation of the beds monitored. Interview on 4/16/25 at 12:06 p.m. with administrator A revealed: *A facility wide assessment of the beds was completed on 2/6/25 and all repairs were completed by maintenance on 2/10/25. *The checklists in the computerized system were not specific to each bed. Interview on 4/16/25 at 3:03 p.m. with registered nurses (RN)/Minimum Data Set (MDS) nurses D and E revealed: *An entrapment evaluation is completed on admission. *Maintenance was responsible to be sure the mattresses fit the beds appropriately.	F 689		

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F 689	Continued From page 47 *The Physical Device and/or Restraint Evaluation and Review was completed quarterly, annually, and with a significant change. *Verified there was a location on the Physical Device and/or Restraint Evaluation and Review that addressed "Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcomes, etc.)." Interview on 4/16/25 at 3:41 p.m. with DON R revealed: *The entrapment assessment was completed on the Physical Device and/or Restraint Evaluation and Review. *There was no formal process or form for assessing entrapment risks. Interview on 4/16/25 at 3:41 p.m. with administrator B revealed: *There was no form or process to assess entrapment risk. *The facility has different sizes of mattresses and beds. *He would expect nurses to complete and assessment to identify if the mattress was the appropriate size for the bed. *He expected staff to notify maintenance if a mattress was identified as being incorrect for the bed or there was an identified gap between the foot or headboard and the mattress staff. -Maintenance was then responsible to resolve the identified issue. Interview on 4/23/25 at 10:45 a.m. with LPN H revealed: *She was not aware if there were any large gaps between the head or foot of the bed and the	F 689		

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F 689	Continued From page 48 mattress. *She indicated a large gap between the head or foot of the bed and the mattress could be an entrapment risk. *If she noticed a mattress slid on the bed frame causing a large gap, she would tip up the metal piece at the foot of the bed to hold the mattress in place. *If she was unable to resolve the issue with the mattress, she would notify maintenance. 3. Observation on 4/14/25 at 3:50 p.m. of resident 453's room revealed: *Her room was located in a secured unit for residents diagnosed with memory problems, who had elopement risks or attempts, and exhibited wandering behaviors. *There was a brass footrail on her bed. *The footrail was made up of two horizontal rails and several vertical rails. *The distance between each of the vertical rails was seven and one-fourth inches. Review of resident 453's EMR revealed: *She was admitted on 4/2/25. *She had a 4/8/25 BIMS assessment score of 4, which indicated she had severe cognitive impairment. *A progress note indicated the resident's bed had been brought in by her family on 4/10/25. Interview on 4/16/25 at 4:03 p.m. with administrator B and DON R regarding resident 453's bed revealed: *The resident's family had brought her personal bed into the facility. *They were aware the bed had a metal footboard. *They had not assessed the footboard for safety or entrapment risk.	F 689		

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F 689	Continued From page 49 *They were unaware that the vertical metal bars of the footboard were a potential entrapment risk due to the large space between each of them. Interview on 4/23/25 at 10:45 a.m. with LPN H revealed: *She was not aware if there were any large gaps between the head or foot of the bed and the mattress. *She indicated a large gap between the head or foot of the bed and the mattress could be an entrapment risk. *If she noticed a mattress slid on the bed frame causing a large gap, she would tip up the metal piece at the foot of the bed to hold the mattress in place. *If she was unable to resolve the issue with the mattress, she would notify maintenance. 4. Observation on 4/14/25 at 3:09 p.m. of resident 55's room revealed a bottle of fingernail polish remover was on a shelf at the foot of her bed and the room was shared with resident 40. Observation and interview on 4/15/25 at 8:19 a.m. with resident 55 in her room revealed she used the fingernail polish remover independently and painted her fingernails with clear polish. Review of resident 55's EMR revealed she had a 1/13/25 BIMS assessment score of 14, which indicated she was cognitively intact. Review of resident 40's EMR revealed: *She had a 2/4/25 BIMS assessment score of 8, which indicated moderate cognitive impairment. *She used oxygen. *She was able to transfer and ambulate.	F 689		

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	435045	A. BUILDING _____ B. WING _____	C 04/24/2025

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F 689	Continued From page 50 Observation on 4/14/25 at 3:18 p.m. of resident 103's room revealed: *There was a bottle of Febreze air freshener and a bottle of Lysol air freshener on her roommate's over-the-bed table. *The bottle of Lysol had the cap removed. Observation on 4/15/25 at 9:27 a.m. of resident 103's room revealed the bottles of Febreze and Lysol remained on the over-the-bed table. Review of resident 103's EMR revealed: *She had a 2/25/25 BIMS assessment score of 0, which indicated she was severely cognitively impaired. *Her care plan indicated she had a history of "wandering/pacing in [her] wheelchair within the facility". Interview on 4/23/25 at 10:33 a.m. with CNA P revealed: *Chemicals were not allowed to be stored in resident rooms for safety of all residents. *Fingernail polish remover and air fresheners were considered chemicals and should not have been stored unsecured in resident rooms. Interview on 4/23/25 at 10:45 a.m. with LPN H revealed: *She was not aware of any resident who had chemicals stored in their room. *If she found a chemical in a resident's room she would have removed it from the room for the resident's safety. Interview on 4/24/25 at 8:13 a.m. with DON R revealed: *The facility has asked residents' families not to bring in chemicals.	F 689		

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F 689	Continued From page 51 *If a family did bring in a chemical it needed to be in a locked area to secure it for resident safety. *There was an increased risk to the residents if a flammable chemical was stored in a room with a resident on oxygen. *There was an increased risk for improper use of the unsecured chemical in a room with a resident who had cognitive impairments. Interview on 4/24/25 at 10:29 a.m. with administrator A revealed: *Cleaning supplies were to be locked in a designated area for resident safety. *Fingernail polish remover was to be locked in the beauty salon or locked in activities storage for resident safety. 5. Review of the provider's 2/2/24 Bed Safety and Side Rail Entrapment Resource Packet revealed: *"Physical restraint: Any manual method, physical, or mechanical device, equipment or material that meets the following criteria: -Is attached or adjacent to the resident's body; Cannot be removed easily by the resident and; -Restricts the resident's freedom of movement or normal access to his/her body. -'Removes easily' means that the manual method, physical or mechanical device equipment, or material can be removed intentionally by the resident in the same manner as it was applied by the staff". *"A resident's bed should be a place of comfort and relaxation, a safe place. When the bed system does not fit correctly and the resident becomes trapped or injured, the resident's bed is no longer a safe place." *"Conditions such as agitation, delirium, pain, confusion, incontinence, or uncontrolled body movements can cause the resident to be more	F 689		

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F 689	Continued From page 52 active in bed or attempt to get out of bed. The proper sizing of the mattress, the fit and integrity of the bed rail or other design elements such as wide spaces between the bars in the rail can also increase the risk for resident entrapment, injury and in some instances death." *"It is important to remember that not all rails and mattresses fit all bed frames". *"Inspect the bed system for: Proper fit of mattress in the bed frame, no gaps or spaces". Review of the provider's 10/2/24 Housekeeping, Resource Packet revealed "No cleaning supplies or cleaning equipment should be stored in the resident rooms." Review of the provider's 7/8/24 Oxygen Administration, Safety, Mask Types policy revealed "Avoid use of flammable materials (oil, greases, alcohol or alcohol-based products etc.) near residents using oxygen." Review of the provider's 7/30/21 Safety Data Sheet for Professional LYSOL Disinfectant Spray revealed it has a hazard statement of "Flammable aerosol" and "Causes eye irritation". Review of the provider's 8/24/16 Safety Data Sheet for Nail Polish Remover-Regular revealed: *"Precautionary Statements-Storage -Store in a well-ventilated place. Keep container tightly closed -Store locked up". *It has hazardous statements of "Causes serious eye irritation", and "Flammable liquid and vapor".	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		

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F 695	Continued From page 53 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Proper cleaning and storage of a nebulizer device that converts liquid medication into an inhalable mist) as directed in the provider's policy for one of one sampled resident (116). *Proper storage of nasal cannulas (flexible tubing that delivers oxygen through the nose) while no in use and replacement of soiled nasal cannulas as directed in the provider's policy for one of one sampled resident (116). Findings include: 1. Observation on 4/14/25 at 3:18 p.m. of resident 116's room revealed: *She had an oxygen concentrator and nebulizer machine in her room. *An assembled nebulizer delivery device was lying beside the nebulizer machine on a cabinet. *There was no barrier between the nebulizer delivery device and the cabinet. *A coiled nasal cannula was lying directly on the over-the-bed table. *A nasal cannula that was not contained in a plastic bag was lying on an unmade bed, draped over a chux (protectant pad). 2. Observation of 4/15/25 at 8:41 a.m. of resident 116's room revealed:	F 695	**F695, SS= D** By 5/15/25 resident 116 was given proper oxygen and nebulizer storage container by Clinical Care Leader. By 5/20/25 Director of Nursing or designee reviewed all residents in the facility who use oxygen and/or nebulizer for proper cleaning and storage of oxygen and nebulizer equipment. To ensure the deficient practice does not recur, Director of nursing or designee will educate all staff on proper storage and cleaning of oxygen and nebulizer equipment by 5/15/25 or prior to next shift worked. Changing oxygen bags weekly will be added to the TAR and signed when completed by nursing staff.	5/20/25

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F 695	Continued From page 54 *The nebulizer tubing was draped over the cushion in the recliner. *The oxygen concentrator was running and resident 116 was not in the room. *A nasal cannula was draped over an unmade bed. 3. Observation on 4/15/25 at 9:07 a.m. of resident 116's room from the hallway revealed: *Resident 116 was wheeled into her room by registered nurse (RN) AA. *RN AA picked up the nasal cannula that was draped over the unmade bed and placed it on resident 116's face for administration of the oxygen. 4. Interview on 4/15/25 at 9:27 a.m. with resident 116 in her room revealed she: *Wore oxygen all the time because her oxygen was "too low". *Received nebulizer treatments every day. 5. Observation on 4/22/25 at 2:59 p.m. of resident 116's room revealed: *There were no plastic bags on the oxygen concentrator or the oxygen cylinder device. *A nasal cannula was draped over the back of resident 116's wheelchair. 6. Interview on 4/23/25 at 10:33 a.m. with certified nursing assistant (CNA) P revealed: *Nasal cannulas were to be stored in a plastic bag when not in use to keep them free from contamination. *If a nasal cannula became soiled, such as if it fell on the floor, it would need to be changed. 7. Interview on 4/23/25 at 10:45 a.m. with licensed practical nurse (LPN) H revealed:	F 695	To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit oxygen and nebulizer equipment of five residents weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to QAPI committee meeting by Director of Nursing or Designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 695	Continued From page 55	F 695		

*Oxygen cannulas were to be stored in a plastic bag when not in use to keep them free from contamination.
*Plastic bags were to be changed every Monday when the oxygen tubing and nebulizer delivery devices were changed, and that was documented on the resident's treatment administration record (TAR).
*If the nasal cannula fell on the floor, it would need to be changed as it would have been considered soiled.
*If a nasal cannula was found on a chux, the nasal cannula would need to be changed because it could not be determined if the chux was clean.

8. Interview on 4/24/25 at 8:13 a.m. with director of nursing (DON) R revealed:
*When nasal cannulas were not in use, they were to be stored in a plastic bag attached to the oxygen concentrator, hanging on the wall, or attached to the oxygen cylinder.
*She expected the nasal cannula to be changed if it fell on the floor or became soiled.
*She would consider a nasal cannula lying on a chux on the bed to be soiled.
*The nebulizer delivery device was to be taken apart, rinsed, and laid out to dry after each use.

9. Review of resident 116's EMR revealed:
*She was admitted on 12/24/24.
*Her 4/1/25 BIMS assessment score was 15 which indicated she was cognitively intact.
*She had a diagnosis of emphysema (a chronic progressive lung disease).
*A physician's order for "DuoNeb Solution 0.5-2.5 (3) MG [milligrams]/3ML [milliliters] (Ipratropium-Albuterol) 1 inhalation inhale orally via nebulizer two times a day for SOB [shortness

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F 695	Continued From page 56	F 695		

of breath]/wheezing" and "every 4 hours as needed for SOB/Wheezing".
*A physician's order for "Oxygen via nasal cannula 1-4 liters per minute as needed for dyspnea, hypoxia, (O2 saturation less than 88%) or acute angina [chest pain]."
*There was no order to change the resident's oxygen tubing or the nebulizer administration set.
*Her care plan had not addressed her respiratory symptoms, diagnosis, the use of oxygen, or the use of nebulizers.

10. Interview on 4/24/25 at 11:08 a.m. with RN/clinical care leader (CCL) M revealed:
*When staff changed the nasal cannulas and nebulizer delivery devices it was to be charted on the resident's TAR.
*She verified resident 116 did not have a place to document the changes of the oxygen cannula or nebulizer delivery devices on her TAR.

11. Review of the provider's 7/8/24 Oxygen Administration, Safety, Mask Types policy revealed:
*"Turn oxygen off when not in use, if appropriate."
*"All oxygen therapy equipment will be clean, safe, and functional at all times."
*"When oxygen is not in use, store cannula, face mask or face tent and tubing in zip-lock bag/plastic bag secured to the oxygen cylinder or concentrator."

Review of the provider's 12/23/24 Nebulizer policy revealed:
*"Following medication administration clean nebulizer after each use:"
-"Disconnect the tubing from the nebulizer."
-"Separate the nebulizer parts (mask/mouthpiece, cup) and wash in warm soapy water and rinse

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F 695	Continued From page 57 thoroughly." -"Place mask or mouthpiece and cup on paper towel and air-dry until the next use. Cover with clean cloth or towel."	F 695		5/20/25
F 700 SS=J	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the safety and prevention for potential entrapment or injury for 16 residents (5, 18, 19, 47, 67, 72, 83, 97, 99, 103, 108, 112, 126, 137, and 356) who had side rails on their bed and 10 other residents (5, 17, 22, 73, 83, 103, 106, 123, 137, and 453)	F 700	**F700, SS= J** Corrective Action: A comprehensive assist bar audit has been completed for the 26 of 159 residents. The 26 residents have been corrected on 4/16/2025 as follows: 1. 104A- assist bars removed 2. 105- assist bars removed 3. 112A- assist bars removed 4. 112B- bed footboard removed from bed, family notified 5. 113- assist bars removed 6. 114A- assist bars removed 7. 115- assist bars removed 8. 203- assist bars removed 9. 207- assist bars removed 10. 208A- assist bars removed 11. 208B- assist bars removed	

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F 700	Continued From page 58 who had a risk for entrapment related to their mattresses and headboards or footboards. Concerns were identified with: *The safety of the side rails related to their installation, ongoing maintenance, and risk for entrapment. *Documentation for consents for side rail use, alternatives that had been attempted, and education regarding the risk and benefits of side rails. *The safety of mattresses and the potential for entrapment between the headboard and footboard or the gaps within the footboard. Findings include: 1. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy of F700 was given verbally and in writing on 4/16/25 at 4:21 p.m. to administrator A regarding: *The provider failed to ensure bedrails were securely attached, mattresses were able to be elevated when the side rail(s)/grab bar(s) were moved, and there were gaps greater than five inches between the end of the mattress and the headboard. These identified concerns were related to the bedrail installation, maintenance, and bed zone safety and entrapment assessments. -Observations made throughout the survey and throughout the entire building on 4/16/25 revealed the following: *In residents 18, 47, 67, 97, 108, and 126s' rooms the side rails/grab bars were not securely attached to the bedframe, that created a risk for entrapment and the potential for injury. *In residents 5, 18, 47, 72, 83, 89, 97, 99, and 112s' rooms the side rails/grab bars were not securely attached to the bed frame, and the mattress on those beds were able to be elevated	F 700	12. 209A- assist bars removed 13. 210A- assist bars removed 14. 210B- Bed replaced as resident wished to keep assist bars 15. 213A- assist bars removed 16. 213B- footplate put in place to prevent gap greater than 4 inches 17. 218B- assist bars removed 18. 304- assist bars removed 19. 305B- assist bars removed and footplate put in place to prevent gap greater than 4 inches 20. 308- footplate put in place to prevent gap greater than 4 inches 21. 309A- footplate put in place to prevent gap greater than 4 inches 22. 310A- footplate put in place to prevent gap greater than 4 inches 23. 311A- assist bars removed and footplate put in place to prevent gap greater than 4 inches	

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F 700	Continued From page 59 when the side rails/grab bars were moved, that created a risk for entrapment zone and the potential for injury *In residents 5, 22, 73, 83, 89, 106, and 137s' rooms there were gaps greater than five inches between the end of the mattress and the headboard, that created a risk for potential entrapment and injury. *In residents 86, 100, 122, 133, and 148s' rooms there were a bed rail particle board frames in place under the mattresses. There were no bed rails attached. There were two exposed metal installation holes, where the bed rails would attach, that created a risk for potential injury. *Resident 356 was using side rails and did not have a Physical Device and/or Restraint Evaluation and Review assessment completed. *Other residents who had side rails had not been accurately or fully assessed for the use of side rails.. *The style of bed rail used with the Hill-Rom spring bed frames was not compatible according to the manufacturer's instructions. *Resident 103's bed rail was broken and not secured to the spring bed frame. When weight was applied to the bed rail as if a resident were to use it for mobility and stability, the bed rail buckled backwards potentially creating a fall hazard. The particleboard grab bar frame was broken in one corner creating potential for injury. *The above concerns had the potential to cause serious harm, injury, impairment or death for residents. *A plan for the removal of the immediacy was requested at that time. IMMEDIATE JEOPARDY REMOVAL PLAN On 4/16/25 at 8:39 p.m. the provider submitted the following immediate jeopardy removal plan for	F 700	24. 311B- assist bars removed 25. 312- footplate put in place to prevent gap greater than 4 inches 26. 804- Physical device evaluation was completed on 4/7/2025 and updated 4/16/25 The residents who had their assist bars removed, resident was educated- family was called and educated for residents with a BIMs score of under 13 or those who could not comprehend education.	

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F 700	Continued From page 60 review: *"A comprehensive assist bar audit has been completed for the 26 of 159 residents. The 26 residents have been corrected on 4/16/2025 as follows:" -Assist bars were removed from the beds of residents 5,18, 47, 67,72, 83, 86, 89, 97, 99, 100, 103, 112, 122, 126, 133, and 148. -The bed footboard was removed from resident 453's bed and the family was notified. -Resident 108's bed was replaced as the resident wished to keep the assist bars. -The footplate to hold the mattress in place to prevent gaps of greater than four inches in resident 5, 22, 73, 83, 99, 106, and 137s' rooms were put into place. -A physical device evaluation was completed on 4/7/2025 and updated on 4/16/25 for resident 356. --"The residents who had their assist bars removed, resident was educated-family was called and educated for residents with a BIMs score of under 13 or those who could not comprehend education. *"Identification of others: -An audit of all grab bars and mattresses in the facility was completed as of 4/16/2025 in order to identify residents at risk for similar deficient practice. Resident was educated if assist bar needed to be removed from their bed-family was called and educated for residents with BIMs score of under 13 or those who could not comprehend education. During the audit, bed rails that were identified as noncompliant were replaced or removed. Care plan and physical device assessment updated as appropriate." *"Process/Systemic Changes to Prevent Recurrence: -1. The facility is currently in compliance with the	F 700	Identification of Others: An audit of all grab bars and mattresses in the facility was completed as of 4/16/2025 in order to identify residents at risk for similar deficient practice. Resident was educated if assist bar needed to be removed from their bed- family was called and educated for residents with a BIMs score of under 13 or those who could not comprehend education. During the audit, bed rails that were identified as noncompliant were replaced or removed. Care plan and physical device assessment updated as appropriate.	

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	435045	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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F 700	Continued From page 61 'Bed Safety and Side Rail Entrapment Resource Packet' which is an internal [corporate] policy. -2. Physical Device Assessments listed in the policy titles 'Restraints Policy' will be completed on April 16th, 2025. -3. During the daily nurse clinical meeting, the team will review and evaluate all new residents to ensure that a comprehensive physical device assessment has been completed in accordance with the Restraint Policy. -4. The Maintenance Supervisor or designee will complete a preventative maintenance task 'Bed Inspection, Testing and Maintenance' [corporate] audit monthly. Maintenance staff were educated task audit on 4/16/25." *"Education and Training: -An On-Shift message was sent to all employees' personal phones educating on entrapment and potential entrapment hazards on April 16 at 5:28 p.m. -Education will be provided by a Clinical Learning and Development Specialist or Designee to all staff by April 16, 2025 or prior to their next shift. All staff members not currently on the schedule will receive education prior to their next shift. This training will cover entrapment risk, immediate interventions to address entrapment, and the appropriate personnel to notify if a resident is identified as being at risk." *"Monitoring: -Comprehensive audits will be conducted by Quality RN or Designee on resident assist bars weekly x4 [times four] weeks, then biweekly x2 [times two] for two months. Findings will be presented to the Quality Assurance Performance Improvement Committee for review. -Audits will be conducted by Maintenance Supervisor or designee on mattress gaps to ensure compliance weekly. The schedule	F 700	Process/Systemic Changes to Prevent Recurrence: 1. The facility is currently in compliance with the "Bed Safety and Side Rail Entrapment Resource Packet" which is an internal Good Samaritan policy. 2. Physical Device Assessments listed in the policy titled "Restraints Policy" will be completed on April 16th, 2025. 3. During the daily nurse clinical meeting, the team will review and evaluate all new residents to ensure that a comprehensive physical device assessment has been completed in accordance with the Restraints Policy.	

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F 700	Continued From page 62 includes x4 for Four weeks, then bi-weekly x2 for two months. Findings will be presented at the QAPI for review." *"Completion Date: -Please consider this IJ removal plan as the facility action to address the immediate concerns of noncompliance. This plan will be implemented and completed on April 16, 2025." The IJ removal plan was accepted on 4/16/25 at 10:18 p.m. The immediate jeopardy was removed on 4/16/25 at 11:15 p.m. after the survey team verified on site on 4/17/25 at 8:45 a.m. that the provider had implemented their removal plan through observation, document review, and staff interviews. After the removal of the immediate jeopardy, the scope and severity of the non-compliance remained an E. Current census was 159 residents. 2. Observation on 4/14/25 at 3:17 p.m. of resident 103's room revealed she had a white metal grab bar on the left side of her bed. Observation on 4/16/25 at 9:57 a.m. of resident 103's grab bars on her bed: *When the left grab bar was pulled away from the bed, it lifted the mattress and separated from the mattress approximately 45 degrees. *Under the mattress the grab bar was attached to a piece of particleboard with a corner broken off. *There were four securement locations, two near the frame of the bed and two over the bed springs. *Neither the grab bars nor the particleboard was secured to the bed frame or the bed springs. Interview on 4/16/25 at 10:11 a.m. with registered nurse (RN) T regarding resident 103 revealed:	F 700	4. The Maintenance Supervisor or designee will complete a preventative maintenance task "Bed Inspection, Testing and Maintenance" GSS audit monthly. Maintenance staff were educated on task audit on 4/16/25. Education and Training: An On-Shift message was sent to all employees' personal phones educating on entrapment and potential entrapment hazards on April 16 at 5:28pm. Education will be provided by a Clinical Learning and Development Specialist or Designee to all staff by April 16, 2025 or prior to their next shift. All staff members not currently on the schedule will receive education prior to their next shift.	

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F 700	Continued From page 63 *She did not use her grab bar. *She was "super stiff" and difficult to roll in bed and required staff assistance with bed mobility. Review of resident 103's 2/23/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The assessment had a comment that indicated "Resident is able to use grab bar appropriately". *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 3. Observation on 4/14/25 at 3:33 p.m. of resident 99's room revealed there were white metal grab bars on both sides of her bed. Observation and interview on 4/16/25 at 10:26 a.m. with resident 99 in her room revealed: *The grab bars on both sides of the bed lifted the mattress when pulled on. *Resident 99 stated she used the grab bars for repositioning herself when in bed. Review of resident 99's 3/3/25 Physical Device and/or Restraint Evaluation and Review revealed: *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 4. Observation on 4/14/25 at 3:37 p.m. of resident 89's room revealed she had white metal grab bars on both sides of her bed. Observation on 4/16/25 at 10:20 a.m. of resident 89's bed revealed:	F 700	This training will cover entrapment risks, immediate interventions to address entrapment, and the appropriate personnel to notify if a resident is identified as being at risk. Monitoring: Comprehensive audits will be conducted by Quality RN or Designee on resident with assist bars x4 for four weeks, then bi-weekly x2 for two months. Findings will be presented to the Quality Assurance Performance Improvement Committee for review. Audits will be conducted by Maintenance Supervisor or designee on mattress gaps to ensure compliance weekly. The schedule includes x4 for four weeks, then bi-weekly x2 for two months. Findings will be presented to the QAPI committee for review.	

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F 700	Continued From page 64 *The right grab bar moved freely when pulled on. -It was not secured to the springs of the bed. *The left grab bar was loose when it was pulled on. Review of resident 89's 2/27/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 5. Observation on 4/14/25 at 3:42 p.m. of resident 112's room revealed she had a white metal grab bars on the right side of her bed. Observation on 4/16/25 at 11:00 a.m. of resident 112's grab bar revealed it was loose and lifted the mattress when it was pulled on. Review of resident 112's 2/11/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.)" had not been addressed. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 6. Observation and interview on 4/16/25 at 9:58 a.m. with resident 19 in her room revealed:	F 700	Completion Date: Please consider this IJ removal plan as the facility action to address the immediate concerns of non-compliance. This plan will be implemented and completed on April 16th, 2025.	

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F 700	Continued From page 65 *She had a white metal grab bar on the left side of her bed. *The grab bar was loose and pulled the mattress up from the bed when pulled on. *Resident 19 stated that the mattress pulls up even when she is sitting on the edge of the bed and pulls on the grab bar. Review of resident 19's 1/21/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Alternatives that have been attempted" did not have any documented alternatives. 7. Observation and interview on 4/16/25 at 10:06 a.m. with resident 47 in her room revealed: *She had a white metal grab bar on the left side of her bed. *There was movement of the grab bar from side to side and up and down when testing it. *Resident 47 was unsure if she used her grab bar in bed or for transfers. Review of resident 47's 3/20/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 8. Observation and interview on 4/16/25 at 10:09 a.m. with resident 97 in her room revealed: *She had bilateral white metal grab bars on her bed. *When the grab bars were pulled in the mattress was lifted from the bed frame.	F 700		

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F 700	Continued From page 66 *Resident 97 stated she used her grab bars while she was in bed, and she felt they were loose when she pulled on them. Review of resident 97's 3/4/25 Physical Device and/or Restraint Evaluation and Review revealed: *The "Alternatives that have been attempted" did not have any documented alternatives. *Documented education related to the grab bars was given to staff. 9. Observation on 4/16/25 at 10:15 a.m. of resident 126's bed revealed: *She had a white metal grab bar on the left side of her bed. *The grab bar was not secured to the bed frame. Review of resident 126's 1/28/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 10. Observation and interview on 4/16/25 at 10:18 a.m. with resident 18 in his room revealed: *He had a white metal grab bar on the left side of his bed. *The grab bar lifted the mattress when it was pulled on. *Resident 18 stated he used the grab bar for repositioning while he was in bed. Review of resident 18's 3/12/25 Physical Device and/or Restraint Evaluation and Review revealed: *The "Alternatives that have been attempted" did not have any documented alternatives.	F 700		

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F 700	Continued From page 67 *There was no documentation of education provided related to the grab bars. 11. Observation and interview on 4/16/25 at 10:22 a.m. with resident 108 in his room revealed: *He is lying in bed, leaning with most of his body weight on his left grab bar. *He stated he used the grab bar for repositioning in bed and he had noticed that it did get loose at times. Review of resident 108's 4/10/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 12. Observation on 4/16/25 at 10:53 a.m. of resident 67's bed revealed: *He had a white metal grab bar on the right side of his bed. *The grab bar moved slightly when shaken. *The grab bar lifted the mattress when it was pulled on. Review of resident 67's 3/3/25 Physical Device and/or Restraint Evaluation and Review revealed: *The "Alternatives that have been attempted" did not have any documented alternatives. *The education documented was given to "staff". 13. Observation on 4/16/25 at 10:56 a.m. of resident 5's bed revealed: *He had white metal side rails on both sides of his bed. *The right grab bar was loose when it was pulled	F 700		

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F 700	Continued From page 68 on. Review of resident 5's 3/17/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.)" had not been addressed. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 14. Observation and interview on 4/16/25 at 11:10 a.m. with resident 137 in her room revealed: *She had a white metal grab bar on the left side of her bed. *The grab bar was able to be moved in all directions when pulled on. *Resident 137 stated she used her grab bar to get out of bed. *She was aware her grab bar was loose and indicated she would have tightened it if she had a screwdriver. Review of resident 137's 4/7/25 Physical Device and/or Restraint Evaluation and Review revealed: *The "Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.)" had not been addressed. *The "Alternatives that have been attempted" did not have any documented alternatives.	F 700		

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F 700	Continued From page 69 *There was no documentation of education provided related to the grab bars. 15. Observation on 4/16/25 at 11:17 a.m. of resident 83's bed revealed: *She had a white metal grab bar on the left side of her bed. *The grab bar was loose when it was pulled on. Review of resident 83's 3/17/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.)" had not been addressed. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 16. Observation and interview on 4/16/25 at 11:20 a.m. with resident 72 in her room revealed: *She had a white metal grab bar on the right side of her bed. *The grab bar lifted the mattress when it was pulled on. *Resident 72 stated she knew the grab bar was loose but had not thought to ask for someone to tighten it. Review of resident 72's 3/22/25 Physical Device and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Potential resident safety risks have been	F 700		

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F 700	Continued From page 70 evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.)" had not been addressed. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. 17. Observation and interview on 4/16/25 at 11:28 a.m. with resident 356 in her room revealed: *Her bed had bilateral tall, white, metal bed rails. *She was currently in bed and was not feeling well. *She used the bed rails to reposition herself when she wanted to sit on the edge of the bed. *She used the right side more than the left. *A wooden platform was visible under the mattress and it appeared to be how the bed rail was attached to the bed. -We were unable to view the attachment as the resident was in bed. Observation and interview on 4/17/25 at 8:22 a.m. with resident 356 in her room revealed: *She indicated she used the right bed rail more than the left. *The right bed rail was loose and moved a couple of inches towards the top of the bed and a couple of inches towards the bottom of the bed. -It was attached to a wooden platform that was attached to the bed. *The left bed rail was significantly loose and could be lifted several inches off the bed. -It appeared to be anchored in only one of three available places. Review of resident 356's 4/7/25 Physical Device	F 700		

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F 700	Continued From page 71 and/or Restraint Evaluation and Review revealed: *The consent for the grab bar was indicated as being given by the resident's physician. *The "Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazard, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.)" had not been addressed. *The "Alternatives that have been attempted" did not have any documented alternatives. *There was no documentation of education provided related to the grab bars. Observation on 4/17/25 at 8:33 a.m. with administrator A of resident 356's bed rails revealed. *Administrator A confirmed that the right bed rail was loose and that the left bed rail could be lifted off the bed. *Administrator A stated that the bed rails would be repaired immediately and confirmed that resident 356 would not be allowed to use the bed until it was fixed to ensure her safety. 18. Observations, interviews, and record reviews during the survey identified residents (5, 17, 22, 73, 83, 103, 106, 123, 137, and 453) had concerns with potential entrapment areas on their beds related to the mattresses and the headboard or footboards. Refer to F689, finding 2. 19. Interview on 4/16/25 at 10:43 a.m. with certified nursing assistant (CNA) PP regarding grab bars and side rails on residents' beds revealed: *She had not seen or heard about any issues related to grab bars.	F 700		

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F 700	Continued From page 72 *She did not feel resident 103's significant movement of her grab bar was an issue because a resident could have used it to pull themselves up in bed. 20. Interview on 4/16/25 at 11:55 p.m. with administrator B revealed: *Monitoring of the beds was completed monthly with a check mark task by the maintenance staff. *Not all the monitoring was documented in the TELS computerized system. *He was trying to locate more documentation of the beds having been monitored. 21. Interview on 4/16/25 at 12:06 p.m. with administrator A revealed: *A facility-wide assessment of the beds was completed on 2/6/25 and all repairs were completed by maintenance on 2/10/25. *The checklists in the computerized system were not specific to each bed. 22. Interview on 4/16/25 at 12:38 p.m. with administrator B revealed: *Most resident beds that were not in the rehab wing of the building were Hill-Rom beds. *Some of the Hill-Rom beds had pre-installed side rails while others had not. *The Hill-Rom beds that did not have pre-installed grab bars had to have the side rails/grab bars ordered separately by the facility. *Some of the grab bars ordered came from a contracted vendor. *Administrator B did not know if the grab bars ordered from the contracted vendor were manufacturer approved and safe for use for those beds. 23. Interview on 4/16/25 at 3:03 p.m. with	F 700		

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F 700	Continued From page 73 registered nurse (RN)/Minimum Data Set (MDS) nurses D and E revealed: *The process for the application of a side rail and grab bars for resident's beds included: -On admission the entrapment evaluation was to be completed, the family would sign a consent and a physician's order for the grab bars would be obtained. -If staff or the resident felt the resident would benefit from a grab bar, the nurse manager would be notified. -If the resident was receiving therapy services, the therapists would be consulted regarding the benefit of the resident getting a grab bar on their bed. -If it was determined the grab bar would be beneficial for the resident, a maintenance work request was to be entered into the electronic maintenance management system (TELS), and the maintenance staff would install the grab bars on the resident's bed. *An entrapment evaluation was to be completed on admission. *The Physical Device and/or Restraint Evaluation and Review was to be completed quarterly, annually, and with a significant change by the MDS nurse. *When the MDS nurse completed the resident's Physical Device and/or Restraint Evaluation and Review assessment they would interview a staff nurse to determine if the resident was using the grab bars. *When asked about education provided as indicated on the Physical Device and/or Restraint Evaluation Review they stated staff were provided education regarding the use of the grab bars or the resident was educated, if the resident was able to understand the education. *If a staff member noticed a loose grab bar a	F 700		

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F 700	Continued From page 74 maintenance work order should have been entered for that to be repaired. *Maintenance was responsible for the installation, maintenance, and removal of the grab bars/side rails to ensure resident's safety. 24. Interview on 4/16/25 at 3:41 p.m. with DON R revealed: *The entrapment assessment was completed on the resident's Physical Device and/or Restraint Evaluation and Review. *The MDS nurse would have indicated in the comment box of the Physical Device and/or Restraint Evaluation and Review if they felt the grab bar was an entrapment risk. *There was no formal process for assessing entrapment risks. 25. Interview on 4/16/25 at 4:05 p.m. with administrator B and DON R revealed: *There was no formal process to assess entrapment risk. *Measurements of bed zones was not a portion of the assessment process when grab bars were installed. *Therapy had not assessed all residents' beds or the residents' ability for use related to grab bars to ensure their safety. 26. Review of the provider's resident admission packet revealed: *There was a prefilled consent form for "Grab bars on bed". *The consent indicated that prior to the instillation of grab bars the facility must have "attempted to use alternatives". *If the alternative interventions attempted were not effective the resident would be assessed for the use of grab bars.	F 700		

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F 700	Continued From page 75 -"The determination includes a review of risk, including entrapment. The location must ensure the bed is appropriate for the resident and that bed rails [grab bars] are properly installed and maintained." 27. Interview on 4/23/25 at 3:19 p.m. with Social Service Supervisor J regarding resident admissions revealed: *The social services staff completed the admission paperwork with the family or the resident upon the resident's admission. *The consent for the grab bar was in the admission paperwork and was to be presented to all families as an option available to help residents reposition themselves in bed. *The social service staff were to explain to the families the risk of entrapment as well as the other risks identified on the consent form. *The consent form would be readdressed if there was a change in the resident's bed or if there was a request from staff, family, or the resident for a grab bar and there was no consent already on file. *The consent having been completed on admission did not allow for alternative interventions to be attempted prior to determine if there was a need for the grab bar. 28. Interview on 4/23/25 at 4:17 p.m. with DON R revealed: *She agreed with the grab bar consent being completed on admission, there was a potential that no alternatives would have been attempted prior to the application of the grab bar on the resident's bed. *She indicated that often the alternatives would be initiated simultaneously with the application of the grab bar.	F 700		

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F 700	Continued From page 76 29. Review of the January 2010 USER MANUAL for the Resident LTC [long term care] Bed from Hill-Rom revealed: *"Use only Hill-Rom parts and accessories." *"Do not make modifications to the bed without authorization from Hill-Rom." *"Evaluate patients for entrapment risk according to facility protocol, and monitor patients appropriately. Make sure all siderails are fully latched when in the raised position. Failure to do either of these could cause serious injury or death." Review of the July 2018 The Transfer Handle For Spring Style Hospital Beds manufacturer's information revealed: *"The Transfer Handle [grab bar] is designed to accommodate a range of different manufacturers. If the device does not easily attach to the bed per the instructions or interferes with the sub-frame, or the mattress does not firmly make contact with the Transfer Handle-DO NOT USE." *"These guidelines were developed by the FDA [Food and Drug Administration] for Bed Rails to help prevent entrapment. It is important information to be aware of." 30. Review of the provider's 2/2/24 Bed Safety and Side Rail Entrapment Resource Packet revealed: *"A resident's bed should be a place of comfort and relaxation, a safe place. When the bed system does not fit correctly and the resident becomes trapped or injured, the resident's bed is no longer a safe place." *"Grab bars or assist bars provide a sturdy and secure handhold to assist residents in repositioning and getting in and out of bed."	F 700		

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F 700	Continued From page 77 *"Conditions such as agitation, delirium, pain, confusion, incontinence, or uncontrolled body movements can cause the resident to be more active in bed or attempt to get out of bed. The proper sizing of the mattress, the fit and integrity of the bed rail or other design elements such as wide spaces between the bars in the rail can also increase the risk for resident entrapment, injury and in some instances death." *"The purpose of the Bed Safety-Including Bed Rails/Side Rails/Assist Bars P&P [policy and procedure] is to: promote bed safety with the appropriate use of bed rails when used for medical necessity to reduce the risk of entrapment as well as the least restrictive alternative to side rails." *"It is important to remember that not all rails and mattresses fit all bed frames". *"Inspect the bed system for: -Proper installation of side rails or assistive devices such as grab bars. -Rails or assistive devices designed for the bed frame manufacturer. -Rails or assistive devices that meet the design elements of bed safety standards to avoid entrapment injuries or death."	F 700		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725	**F725, SS= E** As of 5/16/25 the locked memory care unit will be staffed with two C.N.A.s and one C.M.A. from 6am-2pm to ensure sufficient staffing is met for 17 residents residing on the memory care unit.	5/20/25

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F 725	Continued From page 78 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure sufficient nursing staff for one of one secured unit to safely meet residents' needs, well-being, and the security of 17 of 17 residents (39, 86, 95, 96, 100, 102, 110, 114, 115, 122, 127, 131, 133, 135, 140, 148, and 453). Staff reported concerns with medication errors related to interruptions, difficulty keeping wandering residents within the unit, and difficulty completing all care tasks for residents due to the staffing of the unit. These failures placed those residents at risk for unmet care needs and potentially negative outcomes. Findings include: 1. During the entrance conference on 4/14/25 at 2:45 p.m. with administrator A, she stated the evening meal was served at 5:30.	F 725	This staffing schedule is subject to change by QAPI committee based on staff feedback and acuity review. No other units in the facility were identified as being insufficient for staffing outside of the locked memory care unit. To ensure the deficient practice does not recur, Director of Nursing or designee will educate all staff on memory care unit staffing changes by 5/15/25 or prior to next shift. To monitor performance and ensure compliance the Director of Nursing or designee will audit acuity and staffing on memory care unit which will include random medication passes, medication errors, completion and documentation of resident cares weekly x4, bi-weekly x2, monthly x1 and quarterly x1.	

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F 725	Continued From page 79 2. Initial observation on 4/14/25, beginning at 5:34 p.m., of the dining room of the 100 hall, which is the secured unit, revealed: *Many of the residents had already finished eating and were walking around the adjacent day room and hallway. *Some residents had finished eating and were still seated at tables in the dining room. *Some residents required assistance to eat their meals. *Two unidentified staff members were working in the unit and were: -Assisting residents with their meals. -Transferring residents from their dining room chairs to wheelchairs and to recliners in an adjacent room. -Clearing the tables after the residents had finished their meals. -There were 17 residents in the unit. 3. Interview on 4/14/25 at 5:57 p.m. with certified medication aide (CMA) O revealed: *The dinner meal was served at 5:00 p.m. in the secured unit, not at 5:30 p.m. like the rest of the facility. *The unit was staffed with one CMA and one certified nursing assistant (CNA) from 6:00 a.m. until 10:00 p.m., and one CNA from 10:00 p.m. until 6:00 a.m. *At mealtimes, the CMA and CNA were responsible for getting residents into the dining room and seated for meals, serving the meal, assisting residents to eat their meals, clearing the tables, and helping residents who required assistance with transferring and cares after the meal. *In addition to passing medications, the CMA was responsible for getting residents up in the morning and to bed at night, getting weights	F 725	The results of these audits will be brought to QAPI committee meeting by Director of Nursing or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 725	Continued From page 80	F 725		

before breakfast, giving residents showers and filling out a "Bath Skin Form," providing personal care as needed, and intervening and redirecting with resident behaviors.
*If staff on the secured unit needed assistance, they would use their radio to call the nurse on the 300 hall or a nurse manager.
-The nurse on the 300 hall was also responsible for the residents on the secured unit.

4. Observation on 4/15/25 at 11:24 a.m. in the day room of the secured unit revealed:
*A group of residents was participating in an activity with an activity assistant.
*Many of the doors to residents' rooms were closed.

5. Observation on 4/15/25 at 11:42 a.m. of the dining room in the secured unit revealed:
*All the residents' doors were closed except for two.
*The activity assistant and an additional staff member assisted CMA O and the CNA with getting residents to the dining room for lunch and with serving the meal.
*During the meal, dietitian CC and licensed practical nurse (LPN) H also came to the dining room and stayed on the unit for approximately eight minutes.
-They talked to the staff that was already in the dining room, but did not assist with any resident care.

6. Interview on 4/15/25 at 3:49 p.m. with CMA O about the number of staff that were present during the lunch meal earlier that day revealed there were more staff present, and that it was not the normal staffing ratio for the secured unit.

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F 725	Continued From page 81 7. Observation on 4/22/25 at 3:49 p.m. in the day room revealed: *Two residents were outside in the courtyard. *They were knocking and pulling on the door, attempting to reenter the day room, and were not able to get in by themselves. *Another resident who was in the day room was able to open the door and let them into the building. *There was no staff member outside in the courtyard, in the day room, or within sight while the surveyor was observing. 8. Interview on 4/23/25 at 3:14 p.m. with CMA O revealed: *She felt she was interrupted multiple times per shift during medication passes because of resident behaviors that required intervention. *She thought the frequent interruptions to staff responsible for medication administration contributed to some of the medication errors that had been happening in that unit because it was challenging for them to maintain their focus on administering medication. *She did not think the staffing was adequate in that unit because she was unable to meet all the residents' needs, and that other areas of the facility had different staffing ratios of staff per residents. -She had been asked by management to increase the amount of charting and documentation regarding the residents in the unit, but did not feel she had enough time to complete more charting because she was too busy doing tasks and providing resident care. -She stated on one occasion, she had been in the shower room assisting a resident with a shower, and the CNA went into a resident's room to help another resident. When she walked out of the	F 725		

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F 725	Continued From page 82 shower room, she found a resident lying on the floor who had fallen and needed assistance. *A staff member from the 300 hall was supposed to come to the secured unit to cover the CMA and CNA for breaks, but that did not usually happen. *When the CMA or CNA in the secured unit took a break, there was only one nursing staff member in the unit to care for those residents. 9. A staffing policy had been requested, and the surveyor was given the provider's 6/5/24 "Staffing and Scheduling Resource Packet." -This packet contained scheduling guidelines and principles, as well as a formula to calculate the labor per diem (the daily cost of caring for a resident). 10. Interview and record review on 4/24/25 at 8:26 a.m. with staffing coordinator Q revealed: *She had been completing the staff scheduling for approximately four years. *She scheduled the staff for all of the long-term care and rehab units. *She had not seen and was not aware of the provider's 6/5/24 Staffing and Scheduling Resource Packet, and did not use that to guide staffing. *She scheduled staff as she had been trained to by a previous director of nursing (DON). *The 400 wing was staffed with one nurse and two CNAs for the 400 North hall, and one nurse and two CNAs for the 400 South hall. *The 300 hall was staffed with one nurse, one CMA, and two CNAs. *The 100 hall (the secured unit) was staffed with one CMA and one CNA. The nurse for the 300 hall would also cover nursing needs for the 100 hall. *She agreed that there were fewer staff for the	F 725		

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F 725	Continued From page 83 100 hall. 11. Interview on 4/24/25 at 8:43 a.m. with registered nurse (RN)/clinical care leader (CCL) I for the secured unit revealed: *Regarding the staffing ratio in the secured unit, she felt the staffing ratio was common throughout the building. *She felt staffing on the secured unit was adequate. *She felt that the frequent interruptions during the medication pass were not as impactful once the staff got into a routine. *She stated leadership was looking at a time study for the secured unit because they had heard it was "getting a little busier." -She did not offer further details of what was busier. *Regarding a medication error where a medication had been documented as unavailable for four days by a CMA in the secured unit, she agreed that their policy had not been followed, and the CMA should have notified the nurse that the medication was not in the med cart. 12. Interview on 4/24/25 at 9:53 a.m. with CMA C about working on the secured unit revealed: *She had been a CMA for over ten years. *Her first medication error happened in that unit. *She described it as "overwhelming" because of interruptions with medication passes and said the staff were expected to do a lot in the secured unit. *She said she was sometimes asked to do nursing functions like neurological assessments after a resident's fall, and skin assessments. *They would sometimes see a nurse on the unit for only five minutes a day; sometimes they would not see a nurse all day. *Staff from the secured unit had tried to discuss	F 725		

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their concerns about inadequate staffing with management, but there had been no follow-through on improvement attempts.
*She stated that they were supposed to start being relieved for breaks by a staff member from the 300 hall, but that had only happened about three times.
*There were two residents the staff were supposed to try and keep separated because they "fight," but stated she felt that was almost "impossible if you're the only one [working] back here."
*She loved working with the residents who resided in the secured unit, but felt they needed more support from staff.

13. Review of medication error reports for the secured unit from 2/13/25 through 4/19/25 revealed:
*There had been six medication error reports from that period.
*Only one medication error report was for a single administration error.
*Resident 135 had only received 25 milligrams (mg) of his ordered dose of 50mg of Seroquel (an antipsychotic medication) for seven days, from 2/5/25 through 2/12/25.
*Resident 86 had received 50 mg of Seroquel instead of his ordered dose of 25 mg for seven days, from 2/5/25 through 2/12/25.
-The medication error report indicated that staff had noticed he had been more lethargic during the day, but "wakes easily."
*Resident 133 had not received her Seroquel at bedtime for four days.
-The medication was charted as "not available" on 3/12/25 through 3/15/25.
*Resident 114 had received 60 mg of furosemide (a diuretic or "water pill") on Saturday, 4/12/25,

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GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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F 725	Continued From page 85 and Sunday, 4/13/25, when the order was for Mondays, Wednesdays, and Fridays only. *Resident 110 received 45 mg of mirtazapine (an antidepressant) instead of her ordered dose of 15 mg from 3/20/25 through 4/15/25. -An order was received on 3/20/25 to decrease the dose of mirtazapine from 30 mg to 15 mg related to weight gain. -An order for the 15 mg dose was entered, but the order for the 30 mg dose was not discontinued. -A 4/3/25 progress note for medication regimen review by the consultant pharmacist noted that "both doses are active on the MAR [medication administration record], sent communication to DC [discontinue] 30MG [30 mg] dose." -The order was corrected on 4/16/25, 27 days after the order was received. *Resident 127 had received 50 mg of her total ordered dose of 75 mg of sertraline (an antidepressant) on 4/18/25. *Those six medication error reports accounted for 48 medication administration errors from 2/13/25 through 4/19/25. 14. Interview on 4/24/25 at 10:22 a.m. with DON R revealed: *She had no concerns about staff being able to safely care for residents on the secured unit. *Regarding the unit staffing ratios and medication errors potentially related to the frequent interruptions with the medication pass, elopements, and resident behaviors in the secured unit, she stated they had those same types of issues everywhere in the facility. *They had added a CMA to the 300 hall so that the nurse for the 300 hall could be more available to the secured unit. *She stated, "And the activity aide is back there."	F 725		

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F 725	Continued From page 86 -She acknowledged that the activity aide could not provide personal care for the residents, but they could assist residents with some redirection. *She expected skin assessments to be completed by a nurse and documented by a nurse. 15. Review of the provider's 4/8/25 "Medication: Administration Including Scheduling and Medication Aides" policy revealed: *Purpose -To administer medications correctly and in a timely manner. *Policy -Medication administration --"Pre-setting medications is not an acceptable practice. Once the medication pass has begun, interruptions should be avoided. Unless emergent, no one should interrupt the nurse/med aid during the medication pass." -Medication Errors --"A SAFE Event Report will be completed for all medication errors. If a medication is not available for 24 hours, the provider must be notified that the medication is not available and must give direction for how to proceed." *Procedure -Review the MAR [medication administration record] for medications due. -Follow the "Six Rights": Right medication, right dose, right resident, right route, right time and right documentation. -"Perform three checks: Read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication ..."	F 725		

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F 725	Continued From page 87 16. Review of the provider's 2/7/25 facility assessment revealed: *Regarding the number of staff utilized for residents who have behavioral health needs: -They did not identify the number of staff utilized to provide care for residents with behavioral health needs. *Regarding appropriate staffing on all shifts: -They "Identify needs daily using census and resident acuity to staff accordingly to help where needed." -They did not indicate the number of staff that would be appropriate.	F 725		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of four sampled certified nursing assistant (CNA)/certified medication aides (CMA) (U and KK) who worked in one of one secured memory care unit had an annual performance review completed. Findings include: 1. Review of CNA/CMA KK's personnel records revealed: *She was hired on 11/16/21. *Her last annual performance review was conducted on 5/31/23.	F 730	**F730, SS= E** On 5/16/25 Administrator completed a performance review for employee U and employee KK. By 5/15/25 Administrator or designee reviewed all staff for employee performance reviews completed per policy. To ensure the deficient practice does not recur, by 5/20/25 Administrator or designee educated all supervisors on the requirement per policy to complete annual employee performance reviews.	5/20/25

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F 730	Continued From page 88 -Her annual performance review was more than 10 months overdue. 2. Review of CNA/CMA U's personnel records revealed: *She was hired on 12/28/22. *Her last annual performance review was conducted on 5/31/23. -Her annual performance review was more than 10 months overdue. 3. Interview on 4/24/25 at 11:11 a.m. with administrator A regarding the completion of the annual performance evaluations for CNAs revealed: *She confirmed that CNA/CMA U and CNA/CMA KK's last performance reviews had been completed on 5/31/23. *The provider's human resources department staff tracked the completion of the annual performance reviews. *She was unaware that CNA/CMA U and CNA/CMA KK had not had the required annual performance reviews completed. 4. Review of the provider's revised 6/11/24 Performance Management policy revealed: *"The performance management process should be dedicated time for employees and their leaders, to connect. These connections are intended to be frequent meetings throughout the calendar year and personalized based on the work and individual." *"Based on the performance expectations of the position, performance management conversations may serve as a reference point when determining career growth, developmental needs ..." *"Leaders should schedule one-on-one meetings	F 730	Supervisors are notified via workday that an employee performance evaluation is due. To monitor performance and ensure ongoing compliance the Administrator or designee will audit employee performance reviews for completion weekly x4 and bi-weekly x2. The results of those audits will be brought to QAPI committee by Administrator or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 730	Continued From page 89 with each of their employees to check-in, provide timely meaningful feedback, discuss performance, share performance ratings, and focus on career growth and development consistently throughout the year." *"Once per year, depending on role requirements, Employees and leaders will have the opportunity to seek feedback from others they work with ..." Refer to F725 Finding 8, 11, 12, 13, 14, and 15.	F 730		
F 758 SS=D	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 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;	F 758	**F758, SS= D** PRN order for Ativan for resident 49 was corrected per policy on 4/24/25 by Clinical Care Leader. By 5/16/25 Director of nursing or designee reviewed all residents with PRN psychotropic medications to ensure there was a 14 day stop date as ordered by the physician. To ensure the deficient practice does not recur, 5/15/25 or prior to next shift, Director of nursing or designee educated nursing staff on the requirement for PRN psychotropic medications to have a 14 day stop date per policy.	5/20/25

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F 758	Continued From page 90 §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 review, the provider failed to ensure one of one sampled resident (49), had her PRN (as needed) psychotropic medication discontinued after 14 days as ordered by the physician. Findings include: 1. Review of resident 49's electronic medical record (EMR) revealed: *A 3/27/25 order for Lorazepam (anti-anxiety/psychotropic medication) 0.5 mg tablet by mouth every six hours PRN for anxiety/agitation/restlessness. -The physician's order note regarding that same medication indicated: "If PRN, order stop date=14 days."	F 758	New orders for prn antipsychotics will be reviewed on the PCC Clinical dashboard during daily clinical meeting for a 14 day stop date. Clinical Care Leaders will reach out to physician immediately if a stop date is identified as not being entered during the daily clinical meeting. To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit PRN psychotropic medications to ensure policy is being followed weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee by the Director of Nursing or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 758	Continued From page 91 Review of resident 49's March 2025 and April 2025 medication administration records revealed: *She had not been administered the PRN Lorazepam in either month. *The PRN lorazepam order had not been discontinued after 14 days as originally ordered on 3/27/25. 2. Interview on 4/24/25 at 8:35 a.m. with registered nurse (RN)/clinical care leader (CCL) I revealed: *She would review medications and resident's PRN orders and then address the PRN order with the primary care provider (PCP) on the PCP's clinical rounds day while they were in the facility. *PRN psychotropic medications were also addressed at the monthly psychotropic meeting for all residents receiving those medications. *She was unable to find resident 49 on the schedule for the lorazepam order to be reviewed by the PCP. *She confirmed there was no stop date on the order. Interview on 4/24/25 at 8:43 a.m. with director of nursing (DON) R revealed she would have expected PRN psychotropic medications to be reviewed within 14 days by the PCP to renew or for the ordered medication to be discontinued as ordered. 3. Review of the provider's 12/9/22 Psychotropic Medications policy revealed: *"7. While the use of PRN psychotropic medications is not encouraged, if a PRN physician's order is received, ensure that the order has clear parameters, i.e., severe agitation that does not respond to other care plan	F 758		

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F 758	Continued From page 92 interventions. It is important to initiate other care plan interventions prior to use of PRN psychotropic medications. 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. PRN orders for anti-psychotropic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of the medication."	F 758		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880	**F880, SS= E** No residents were identified in this tag. All residents have the potential to be at risk when the deficient practices stated in this F880 citation occur. By 5/16/25 Ancillary Services Supervisor or designee reviewed all soiled utility rooms to ensure no supplies were being stored under sinks.	5/20/25

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F 880	Continued From page 93 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	By 5/16/25 Ancillary Services Supervisor or designee removed outdated resident care and cleaning supplies in 400 South hall soiled utility room, 300 hall soiled utility room and 100 hall shower room. By 5/16/25 Ancillary Services Supervisor or designee reviewed that there were no outdated items in any soiled utility rooms or shower rooms in the facility. By 5/16/25 Ancillary Services Supervisor or designee installed or ordered for installation, proper splash guards in all soiled utility rooms. By 5/16/25 Ancillary Services Supervisor or designee reviewed all biohazard containers to ensure they are covered and stored per policy.	

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F 880	Continued From page 94 §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 follow proper infection control practices to ensure *Supplies were not stored under sinks in four of four soiled utility rooms. *Resident care and cleaning supplies were monitored for outdates and disposed of in two of four soiled utility rooms (400 South hall, and 300 hall) and one of four resident shower rooms (100 hall). *Splash guards were properly installed on three of four hoppers (specialized sink for disposing of bodily fluids) in the soiled utility rooms. *One of one biohazard container was covered as directed in the provider's policy to safely contain biohazardous material during storage and transport to prevent leakage, spilling, and potential exposure. *Personal care products (combs, brushes, finger-nail clippers, and personal hygiene supplies) were not shared between residents in four of four shower rooms (100, 200, 300, and 400 hall). *Clean linen was covered while stored and transported as directed in the provider's policy to protect it from potential contamination. *Soiled linen was covered in one of four resident shower rooms (400) to prevent cross-contamination, and the spread of infection as directed in the provider's policy. *Multiple chairs were free of dust, dirt, and food particles in accordance with the provider's policy in the dining room in the 400 hall and in the	F 880	By 5/16/25 Director of Nursing or designee reviewed shower rooms on 100, 200, 300 and 400 hall to ensure no personal care items are being shared between residents. By 5/16/25 Director of nursing or designee reviewed all shower rooms in the facility to ensure no personal care items are being shared between residents. By 5/16/25 Ancillary Services Supervisor or designee will review clean linen carts are provided on all units and accessible for staff to use when transporting clean linens through the halls. By 5/16/25 Director of Nursing or designee ensure the 400 unit shower room had a covered soiled linen cart.	

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F 880	Continued From page 95 common areas in the 100 and 400 halls. Findings include: 1. Observation on 4/14/25 at 3:50 p.m. of the 400 hall lobby area revealed: *A purple dining room chair with a white unknown substance located on the middle front of the seat cushion. *A white and gray chair with an unknown dried yellow stain in the middle of the seat cushion. *A light green colored chair with an unknown yellow stain on the front of the seat cushion. 2. Observation on 4/14/25 at 3:55 p.m. of the 100 hall day room revealed: *A brown suede recliner with a wet area on the seat, a greasy stain on the headrest, and a brownish-red substance on the arm of the chair. *An empty wheelchair with a solid unidentified brownish yellow crusty substance on the seat. 3. Observation on 4/14/25 at 5:39 p.m. of the 400 hall dining room revealed: *There were multiple dining room chairs with dried unidentified discolorations to the fabric on the backs and seats of the chairs. *Residents were seated in those chairs for the meal. 4. Observation and interview on 4/22/25 at 2:51 p.m. in the 200 hall shower room with certified nursing assistant (CNA) W revealed: *On a shelf in the wooden cabinet were two hairbrushes, one black comb, one opened stick deodorant, one opened tube of toothpaste, one partially used tube of skin protectant cream, and a pair of scissors without resident identifiers listed on them. *In the shower was a partial bottle of shampoo.	F 880	By 5/16/25 Director of Nursing or designee reviewed all shower rooms for soiled linen carts. By 5/16/25 all chairs in the 400 hall dining room, 400 common area and 100 common area were reviewed for dust, dirt and food and cleaned if appropriate by Ancillary Services Supervisor or designee. By 5/16/25 all dining room furniture and common area furniture were inspected for dust, dirt and food and cleaned if appropriate by Ancillary Services Supervisor or designee.	

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F 880	Continued From page 96 *CNA W stated she was unsure why the partially used containers and brushes were in the cabinet. She indicated she would have used supplies from each resident's room or gotten new supplies from the supply room if needed. *She indicated she would not be able to identify which resident the above personal care items belonged to because there were no resident identifiers on the items. *On the back of the toilet were two containers of personal hygiene wipes. -One of the wipe containers was opened and partially used. *CNA W indicated the containers of wipes were used for multiple residents. 5. Observation and interview on 4/22/25 at 3:02 p.m. in the 400 hall shower room with CNA K revealed: *There was a bag of soiled linen that was uncovered. *In the wooden cupboard were two razors, partial bottles of body wash, partial bottles of lotion, partial tubes of zinc oxide (medicated) cream, and a nail clipper that did not contain resident identifiers. *CNA K stated if the personal hygiene supplies were for a specific resident, they should have been labeled with resident identifiers. *She indicated she would not have used fingernail clippers or razors on a resident if it did not belong to that resident. *She did use the facility-supplied body washes and shampoos between residents and did not wipe the bottles or have a process in place to prevent potential cross-contamination between residents. *She agreed the nail clipper appeared to have been used and was not clean.	F 880	To ensure deficient practice does not recur, Director of nursing or designee will educate all staff on personal care items not being shared between residents, residents have their own personal care items and it will be brought from their room to the shower room or items will be used 1 time and then disposed of, checking for outdated personal care items, properly covering biohazard containers, clean linens are stored properly when transporting and staff are utilizing soiled linen containers that are covered to prevent cross contamination by 5/15/25 or prior to next shift.	

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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 97 *She stated if a fingernail clipper was used between multiple residents, it would need to be cleaned with an alcohol wipe, but she would have obtained a new fingernail clipper from the storage room for each resident. 6. Observation and interview on 4/22/25 at 3:09 p.m. in the 400 South hall soiled utility room with CNA K revealed: *There was a plastic splash guard on the floor next to the hopper. *CNA K stated the guard used to be mounted on the hopper to protect staff from splashing substances onto themselves or outside of the hopper when they were rinsing soiled linen. *Above the hopper, there was a sign that said, "Please wear gown, gloves, and goggles when using the hopper spray." -No gowns and gloves were available in the room. Goggles were present, but they were soiled with a thick layer of dust. *Paint was peeling from the wall and ceiling, making it an uncleanable surface. *The following items were stored under the sink: -A plastic bag that contained a pair of utility gloves. -A gray basin with dried brown and white sediment on the bottom. -A white bucket that had a dried, white, crusty substance in it. -A clear mason jar with dust and a brown coating on it. -Two "U" shaped metal strips approximately 18 inches long. -A pink bedpan. -A gray basin with a dead spider in it. -A two-compartment black container that contained a toilet brush with holder, a black wireless battery, a skin prep pad that had expired	F 880	The Ancillary Services Supervisor or designee will educate Maintenance and Housekeeping staff on identifying outdated cleaning supplies and disposing of those, not storing supplies under soiled utility room sinks, properly installed splash guards on hoppers and identifying furniture that needs cleaned or replaced by 5/16/25 or prior to next shift.	

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F 880	Continued From page 98 October 2020, two white metal assist bars, a gray commode or toilet lid, and a green folder that contained a Safety Data Sheet (SDS) for Good Sense RTU Odor Counteractant. *On top of a cabinet, there was an Emergency Response kit with no expiration date seen. 7. Observation and interview on 4/22/25 at 3:19 p.m. in the 400 North hall soiled utility room with environmental services (EVS) technician RR revealed: *A trash bin that did not have a cover to prevent the potential spread of infection, debris, and odor. *The plastic splash guard for the hopper was not attached properly. *There was a large red bin that was overfilled with used, locked sharps containers. It was so full that the lid could not be closed and sealed properly to contain the medical waste. *On a shelf above the sink, there was a suction machine with a cover labeled "Return to Central Supply." *The wall had visible clusters of gray dust on it. *The following items were stored under the sink: -A white towel with flecks of unidentified brown, solid material. -A tan colored plastic container that had approximately a half-inch of standing water in it, and the bottom of the container was covered with brown sediment. -A gray circular piece of plastic. 8. Observation on 4/22/25 at 3:31 p.m. in the 300 hall shower room revealed: *A partial bottle of body wash and a gray basin with a white, crusty substance on the bottom of it on the shower chair. *A Roho cushion (a pressure-relieving cushion) and a wet Roho cushion cover were on a shelf,	F 880	To monitor performance and ensure ongoing compliance Director of Nursing or designee will complete the following audits weekly x4, bi-weekly x2, monthly x1 and quarterly x1: • Audit to review resident personal care items are not being shared between residents • Audit to review no outdated personal care items are being used on residents • Audit to review biohazardous containers are being covered per policy	

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F 880	Continued From page 99 which in this environment could increase the risk of contamination and potential spread of infection. *In the cabinet were partial bottles of shaving cream, lotion, baby powder, foam cleanser, shampoo, body wash, a black wrist brace, a nail clipper, and a partially used container of washcloth wipes, which were all unlabeled. *There was dust and debris along the outer edges of the floor of the room. 9. Observation on 4/22/25 at 3:32 p.m. of the 300 hall soiled utility room revealed: *There were flakes of brown residue at the bottom of the basin of the hopper, which could indicate the presence of dirt, organic matter, or other contaminants. *The splash guard on the hopper was covered with a layer of dust. *The following items were stored under the sink: -A bottle of drug destroyer. -A container of peroxide multi-surface cleaner wipes that were dry. -A white plastic bucket. -A white plastic square container with a brown residue covering the bottom that contained a tube of Carmex, a sliver squeegee, a toilet brush holder, and a yellow plunger. -A "Facts on MRSA 2009" information paper. -An opened box of surgical masks and goggles with a white, crusty substance on it. -An opened box of masks with visors. -A white bucket that contained an ice cream bucket with green sediment in the bottom of it, and a nebulizer machine. -A wheelchair foot pedal. -A toilet brush and holder. -Two short white metal siderails. -A basin covered with a white and yellowish-brown substance with clear liquid in the	F 880	Ancillary Services Supervisor will complete the following audits weekly x4, bi-weekly x2, monthly x1 and quarterly x1: • Audit to review no outdated cleaning supplies are being stored in soiled utility rooms • Audit to review no supplies are being stored under sinks in soiled utility rooms • Audit to review splash guards are properly installed • Audit to review furniture in dining rooms and common areas is free of dust, food and dirt Audits findings will be brought to the QAPI committee meeting by Director of Nursing, Ancillary Services Supervisor or their designee and continued until the facility has demonstrated sustained compliance as determined by the committee.	

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F 880	Continued From page 100 bottom of it that contains a bottle of Oxivir disinfectant concentrate that expired October 2017, along with peroxide multi-surface cleaner wipes. 10. Observation on 4/22/25 at 3:44 p.m. of the 100 hall soiled utility room revealed: *A water bottle was on the floor. *A box of bags was on the counter with a coffee cup on top of it. *A wheelchair cushion cover was on the floor. *Six damp floor mop pads were draped over the sink, which could transfer bacteria to the sink surface, potentially contaminating other items used in the soiled utility room and staff clothing. *The following items were stored under the sink: -A bottle of Pine-Sol. -A clear glass vase. -A black bag that had a toilet seat and cover in it. -Two green plastic containers with two compartments that contained a toilet scrub brush, a bag of utility gloves, seven glass vases, three plungers, a container of wet task wipes, a spray can of matte finish acrylic sealer, and a dustpan. -Those items stored under the sink increase the risk of cross-contamination. 11. Observation and interview on 4/22/25 at 4:04 p.m. of the 100 hall shower room with CMA O revealed: Clean, folded linen was stored uncovered on the top shelf of a cart near the shower, exposing it to potential contamination from moisture, splashes, and airborne particles. *There was an unlabeled partial bottle of body lotion on the shower ledge. *The cabinet on the wall contained: -An unlabeled electric razor full of gray hair stubble.	F 880		

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F 880	Continued From page 101 -An unlabeled partially used package of disposable washcloths. -Ketoconazole 2% (antifungal) shampoo with no resident identifier that had been spilled onto the cabinet shelf. -An unlabeled bottle of Selsun Blue shampoo that expired in May 2024. -Partially used and unlabeled containers of deodorant, rinse-free foam cleanser, baby powder, body wash, shampoo, conditioner, lotion, barrier creams, and skin protectants. -A fingernail clipper that had a crusty buildup on it. -A spoon. -Two combs with gray hairs and a white crust on them. -A gray hair tie with gray hair attached to it. -A blue bin containing two gray hair brushes with copious amounts of gray hair in them, a pair of resident socks, 13 black combs with white dried material and long gray hair on them, a tube of Chapstick, a partial roll of clear tape, a foot/callous file with white sediment on it, two hair picks with white sediment and gray hair, and an abundant amount of unsecured elastic hair ties. -A clear tub containing a black brush that was full of gray hair and white sediment, a black comb with white sediment, an almost empty bottle of Aveeno baby lotion that expired in September 2019, three opened stick deodorants, one roll-on deodorant, and a nail clipper. *CMA O agreed that the personal care items were not labeled with resident identifiers and stated that some personal care items were shared between residents. 12. Interview on 4/23/25 at 7:44 a.m. with director of nursing (DON) R and assistant director of nursing (ADON)/infection preventionist (IP) G revealed:	F 880		

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F 880	Continued From page 102 *It was their expectation that resident care equipment, such as nail clippers, electric razors, barrier creams, hairbrushes, personal hygiene wipes, creams, and cleansers, was not to be shared between residents because that could lead to the spread of infection. -They indicated these items should have been disposable or designated for a specific resident to limit the potential spread of infection. *Clean linens should have been covered during transportation and storage in the shower rooms to reduce the potential for contamination. *The red biohazard buckets in the soiled utility rooms should be covered. *Nurse managers were responsible to be sure expiration dates were checked on their respective halls. *Chairs in the common areas and in the dining room were cleaned by housekeeping and maintenance would assist as needed. *Agreed PPE should be accessible to staff who used the hoppers in the soiled utility room to prevent contamination from splash when they washed out soiled linen. 13. Observation and interview on 4/23/25 at 8:30 a.m. in the laundry room with lead laundry technician L revealed: *A linen cart used to transport clean linens had a cover with a rip so large on one side that linens could not be covered. The opposite side of the cover was torn and frayed, making it an uncleanable surface. *Laundry must be covered during transportation. She agreed the cover did not provide adequate protection for clean linens. *Clean laundry should have been covered in public areas, such as a shower room, due to the risk of contamination.	F 880		

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F 880	Continued From page 103 14. Interview on 4/23/25 at 8:41 a.m. with registered nurse (RN)/clinical care leader (CCL) M revealed: *She was not aware there was a suction machine stored in the soiled utility room. *It should not have been stored in the soiled utility room because it was considered a clean item in a soiled environment. *Residents that required a suction machine had one in their room and if additional suctions machines were needed there were ones on the crash cart or "up front". 15. Interview on 4/23/25 at 8:46 a.m. with administrator A revealed the provider did not have a policy for shared personal care equipment cleaning or a policy regarding supply expiration dates. 16. Interview on 4/23/25 at 10:02 a.m. with lead environmental technician V revealed: *The soiled utility rooms were not on the environmental service staff's cleaning schedule and did not get cleaned routinely. *Shower rooms were cleaned three times per week. *Chairs in the common areas and dining rooms used to be cleaned by a man who no longer worked there. 17. Interview on 4/23/25 at 10:33 a.m. with CNA P revealed: *No items were to be stored under sinks. *Each resident was to have their own personal care items such as hygiene supplies, fingernail clippers, and electric razors. *After each use an electric razor was to have the hair emptied, the head of the razor rinsed, and	F 880		

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F 880	Continued From page 104 then wiped down with an alcohol wipe. *Clean and dirty linen was to be covered when it was in the hallway and the shower rooms. 18. Interview on 4/24/25 at 9:58 a.m. with RN/CCL M regarding expiration dates revealed: *The nurses on the floor were responsible for checking for expiration dates on the medication carts. *She would assist the nurses if they did not have time. *There was no schedule in place to check supplies other than medications for their expiration dates. *She expected housekeeping staff to check for outdates on chemicals in the soiled utility rooms. *Any staff could and should have looked for outdated supplies and should have disposed of them appropriately. 19. Interview on 4/24/25 at 10:29 a.m. with administrator A revealed: *She expected staff to follow the manufacturer's expiration dates and dispose of the item when it was outdated. *Cleaning of the dining room chairs and chairs in the common areas were the responsibility of maintenance staff. -There was no schedule to indicate when the chairs were to be cleaned. -If there was soiled chair identified she would have expected maintenance staff to attend to the chair that day. 20. Review of the provider's 12/2/24 Infection Prevention and Control Program policy revealed: *Purpose: -"To establish and maintain an infection prevention and control program designed to	F 880		

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F 880	Continued From page 105 provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. *Definitions: -"Infection Prevention and Control Program- A program that prevents, identifies, reports, investigates, and controls infections and communicable diseases for all residents, staff, and visitors, following nationally accepted standards and guidelines." *Policy: -"The infection Prevention and Control Program is a facility-wide effort involving all disciplines and individuals and is an integral part of the Quality Assurance and Performance Improvement Program." -"The components of an Infection Prevention and Control Program include, but are not limited to: Program Oversight, Policies and Procedures, Surveillance, Data Analysis, Antibiotic Stewardship, Outbreak Management, Prevention of Infection, Immunizations, and Employee Health and Safety." *Program Components -"The skilled nursing facility has designated at least one individual as the Infection Preventionist, who is responsible for the facility's Infection and Control Program." -"The facility has developed and implemented written policies and procedures for the provision of infection prevention and control." -"Process surveillance (ex, hand hygiene compliance program) and outcome surveillance (ex, monthly infection rates) are used as measures of the Infection Prevention and Control Program effectiveness." Review of the provider's 9/30/24 "Surveillance,	F 880		

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F 880	Continued From page 106 AL, Rehab/Skilled, Home Health, Hospice" policy revealed: *"Surveillance is an activity that a healthcare institution employs to find, analyze, control and prevent nosocomial [healthcare-associated] infections." *Process surveillance reviews practices directly related to resident/patient care in order to identify whether practices comply with established prevention and control policies and procedures. Review of the provider's 10/2/24 "Housekeeping, Resource Packet" revealed: *Policy/Procedure: -"Environmental cleaning plays an important role in an infection control program. While most infections result from person-to-person transmission, the spread of infections from contaminated surfaces is significant and supports the need for good procedures and practices related to cleaning and disinfecting of surfaces." -"All staff members play a role and should be aware of the general principles of environmental cleaning and safety." -"Adequate safety levels can be achieved for most non-critical [examples include computers, walls, tabletops, and medical equipment surfaces like blood pressure cuffs and lift equipment] and low touch areas by keeping the surfaces visibly clean using water and a detergent or a low-level disinfectant." *Barber/Beauty Shops -"A clean, closed, and locked container will be provided for all creams, lotions, soaps, solutions, cosmetics, powders, and other products used in direct contact with residents." *Bio-Hazardous-Infectious Material Collection and Disposal -"For these reasons, regardless of the knowledge	F 880		

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F 880	Continued From page 107 of diagnosis, all bio-hazardous material should be considered, collected, and handled as potentially infectious substances and should be properly separated, stored, and disposed." -"All [provider] locations will comply with applicable federal, state, and local regulations pertaining to the collection, handling, storage, and disposal of bio-hazardous material and will, at a minimum, follow procedures to reasonably limit the potential for cross-contamination." *Common Area Cleaning -"Keep all common areas clean, neat and free of litter." -"Clean (disinfect if needed or required by regulations) chairs in dining rooms weekly or as needed." -"Clean surfaces as often as necessary to keep furniture and equipment free of accumulations of dust, dirt, food particles, etc." -"Spot clean walls, door and partitions as needed to remove visible material. Use a soft, clean cloth with disinfectant cleaner solution and wipe dry." -"All mops and rags will be handled wearing the proper PPE [personal protective equipment] for the product being used. All used/soiled mops and rags will be stored in an appropriate storage container in accordance with [provider] or local cleaning procedures ..." *Monitoring and Quality Assurance -"Visual assessments of housekeeping and custodial outcomes should be monitored on a regular basis. This monitoring is the responsibility of all staff members working in the building."	F 880		
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	F 919	**F919, SS= D** By 5/14/25 facility ensured resident 103 had her call light placed according to policy by Clinical Care Leader.	5/20/25

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F 919	Continued From page 108 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 observations, interviews, record reviews, and policy reviews, the provider failed to ensure that one of the sampled residents (103), whose care plan included a fall prevention intervention of a soft touch call light within her reach to notify staff when she needed assistance, was accessible to her while in her room. Findings include: 1. Observation on 4/14/25 at 3:17 p.m. of resident 103's room revealed: *Resident 103 was lying in her bed. *There was a flat soft touch call light attached to the floor to ceiling room divider curtain about halfway up the curtain. *Due to the location of the call light related to resident 103's location she would not be able to access the call light to call for assistance. Observation on 4/15/25 at 9:26 a.m. of resident 103 in her room revealed: *She had been assisted to bed by staff with the use of a sit-to stand mechanical lift (used to assist from a seated to a standing position). *She had not responded to staff when she was spoken to. *Her soft touch call light was clipped to the room divider curtain about halfway up the floor-to-ceiling curtain.	F 919	By 5/16/25 Director of Nursing or designee reviewed all residents at risk with a Brief Interview for Mental Status assessment (BIMs) of zero. Reviewed included ensuring residents had appropriate type of call light and clip placed on call light for appropriate call light placement. To ensure the deficient practice does not recur, Director of nursing or designee will educate all staff on proper placement of call lights per policy by 5/15/25 or prior to next shift. By 5/15/25 or prior to next shift Director of nursing or designee educated nurse leadership on types of call lights and updating care plan with resident call light preferences.	

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F 919	Continued From page 109 Observation on 4/16/25 at 9:32 a.m. of resident 103 in her room revealed: *She is sitting in her wheelchair facing her bed with her eyes closed. *Her soft touch press call light was clipped to the room divider curtain about halfway up the floor to ceiling curtain. 2. Interview on 4/16/25 at 3:03 p.m. with registered nurse (RN)/Minimum Data Set (MDS) nurses D and E revealed: *The flat soft touch call lights were given to a resident that was unable to push the button on a standard call light. *They were not aware of any residents that had been care planned as unable to use their call light. 3. Interview on 4/17/25 at 11:37 a.m. with certified nursing assistant (CNA) X regarding resident 103 revealed: *The resident was unable to use her call light due to her cognition. *Staff placed the call light close to her in case she could access it, but she did not, so staff checked on her frequently to ensure her needs were met. 4. Interview on 4/23/25 at 10:33 a.m. with CNA P regarding call light placement fore residents revealed call lights were to be in reach of a resident while the resident was in their room whether the resident was able to use the call light or not. 5. Interview on 4/23/25 at 10:45 a.m. with licensed practical nurse (LPN) H regarding call lights revealed: *It was her expectation for call lights to be within reach of the residents while they were in their	F 919	To monitor performance and ensure ongoing compliance Director of nursing or designee will audit call light placement weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to QAPI committee by Director of Nursing or designee and continued until facility demonstrates sustained compliance as determined by the committee.	

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	435045	A. BUILDING _____ B. WING _____	C 04/24/2025

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F 919	Continued From page 110 room. *Soft touch call lights were used for the residents that were unable to press a standard call light to call for assistance by placing it beside the resident while in bed, in a recliner, or in a wheelchair, to alert staff the resident was getting up. *The call light clipped to the divider curtain in resident 103's room was not accessible to the resident while she was in her wheelchair or bed and would not alert staff if the resident were to attempt to get out of her bed or wheelchair. 6. Interview on 4/24/25 at 8:13 a.m. with director of nursing (DON) R regarding call lights revealed: *It was her expectation call lights be placed within reach of the residents while they were in their room. *Soft touch call lights were also used as a fall intervention by placing the call light alongside the resident to alert staff when the resident moved. 7. Interview on 4/24/25 at 10:29 a.m. with administrator A revealed it was her expectation that staff follow facility policies and procedures related to call lights. 8. Review of resident 103's electronic medical record (EMR) revealed: *She was admitted on 12/14/22. *Her 2/25/25 Brief Interview for Mental Status assessment score was 0, which indicated she was severely cognitively impaired. *She had a diagnosis of dementia with other behavioral disturbance. *Her 4/15/25 care plan revealed: -She had a focus area of "The resident has had an actual fall with No Injury R/T [related to] self transferring, impulsive" initiated on 2/20/23 with	F 919		

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F 919	Continued From page 111 an intervention of "Soft touch call light" initiated on 3/7/25. -She had a focus area of "The resident is at risk for fall R/T dementia without behavioral disturbances, anxiety" initiated on 12/14/22 with an intervention of "I need my soft touch call light and personal items within reach and my floor clear of clutter" initiated on 12/14/22. Review of the provider's 7/29/24 Call Light policy revealed: *"PURPOSE -To ensure resident always has a method of calling for assistance." *"When leaving the room, place [the] call light within easy reach of [the] resident." *"For residents [who are] unable to use [the] call light, care plan appropriate interventions and provide an adaptive call light if applicable."	F 919		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff.	F 947	**F947, SS= D** No residents were identified in this tag. All residents have the potential to be at risk when nurse aide education is not complete per regulation.	5/30/25

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F 947	Continued From page 112 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure one of four certified nursing assistant (CNA)/certified medication aide (CMA) (KK) reviewed , who worked in the secure memory care unit (MCU), had completed the required annual in-service training. Findings include: 1. Review of CNA/CMA KK's personnel records revealed: *She was hired on 11/16/21. *CNA/CMA KK had documented medication errors from working in the MCU on 3/12/25, 3/13/25, 3/14/25, and 3/15/25. -She received "Coaching/Counseling" on 3/17/25. -She completed a "Plan of Correction" training on 6/1/24. *Her last annual performance review was conducted on 5/31/23. -Her annual performance review was more than 10 months overdue. *She had received 4.89 training hours of in-service education since 1/1/24. - Of those training hours 1.96 training hours were completed between 1/1/24 and 11/16/24 and 2.93 hours were completed between 11/16/24 and 2/27/25. *There was no documentation that indicated that the above training included dementia management training or resident abuse prevention training. *There was no documentation that indicated that the above training addressed areas of weakness	F 947	Employee KK has been removed from the schedule indefinitely by the Administrator until she is back into compliance with required in-service training for nurse aides per policy. By 5/16/25 Director of Nursing or Designee reviewed all nurse aides for required in-service training per regulation. To ensure the deficient practice does not recur starting 5/15/25 the Clinical Learning and Development Specialist RN will begin sending training compliance reports to not only the Director of Nursing but also the Clinical Care Leader RNs.	

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F 947	Continued From page 113 as determined in her nurse aide performance reviews. *There was no documentation that indicated that the above training addressed the care of cognitively impaired residents. 2. Interview on 4/24/25 at 11:11 a.m. with administrator A revealed: *She confirmed that CNA/UMA KK's last performance reviews had been completed on 5/31/23. *She confirmed that CNA/CMA KK had not completed all her annual training as required. *Clinical Learning and Development Specialist (CLDS) MM tracked the completion of annual training of employees and sent reports to director of nursing (DON) R when staff had not completed their scheduled training. *She expected staff to complete their annual required training. 3. Interview on 4/24/25 at 11:18 a.m. with CLDS MM revealed: *She tracked the completion of employee annual training and sent reports to administrator A and DON R when staff had not completed their required annual training. *She confirmed CNA/CMA KK had not completed her required annual training and that she had notified administrator A and DON R. *She expected administrator A or DON R to follow up with staff when overdue training needed to be completed. 4. Interview on 4/24/25 at 11:24 a.m. with DON R regarding CNA/CMA KK's annual training revealed: *An email notification had been sent regarding CNA/CMA KK's incomplete annual training while	F 947	By 5/15/25 or prior to next shift Director of Nursing will educate Clinical Care Leaders on reviewing compliance education report and following up with staff if they do not meet education/in-service training for nurse aides and removing staff from the schedule to complete required training if appropriate. To monitor performance and ensure ongoing compliance Director of Nursing or Designee will audit nurse aide in-service hours weekly x4, bi-weekly x2, monthly x1 and quarterly x1. The results of those audits will be brought to QAPI committee by Director of Nursing or designee and continued until facility demonstrates sustained compliance as determined by the committee.	

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F 947	Continued From page 114 she was on leave from work. -There had been an interim DON at that time. *She stated, "It got missed." *CNA/CMA KK worked "PRN [as needed]" and her last shift worked had been on 4/21/25. *She had notified CNA/CMA KK that she had training she needed to complete. *She expected that CNA/CMA KK would complete that training "as soon as she could." 5. Review of CNA/CMA KK's Past Due training report revealed: *There were 17 required trainings with a "Due Date" between 4/30/23 and 10/31/24 that were marked as "Registered/Past Due." *Those trainings included: -"Protecting Resident Rights in Nursing Facilities," -"Behavioral Health," and -"Communicating Effectively." 6. Review of the provider's revised 9/17/24 Competency and Mandatory Education Requirement policy revealed: *The provider " ...is responsible to provide processes for ongoing education and competency achievement." *"Employees are responsible to attain and maintain competency and complete mandatory education required within their specific job description." *The provider " ... requires organizational mandatory education. Additional mandatory education may be required at the department/clinic or the specific job level." *"Every department/clinic is expected to ensure ongoing competencies and mandatory education requirements that apply to their employees are completed within the designated frames and documented."	F 947		

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F 947	Continued From page 115 *"Competency achievements and mandatory education are required to be documented and are reviewed as part of the performance appraisal process." Review of the provider's revised 6/11/24 Performance Management policy revealed: *"The performance management process should be dedicated time for employees and their leaders, to connect. These connections are intended to be frequent meetings throughout the calendar year and personalized based on the work and individual." *"Based on the performance expectations of the position, performance management conversations may serve as a reference point when determining career growth, developmental needs ..." *"Leaders should schedule one-on-one meetings with each of their employees to check-in, provide timely meaningful feedback, discuss performance, share performance ratings, and focus on career growth and development consistently throughout the year."	F 947		

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K 000	INITIAL COMMENTS A recertification survey was conducted on 4/15/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samartian Society Sioux Falls Village was found not in compliance. Please mark an F in the completion date column for K252 for deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K222, K345, K353, K363, and K374 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6	K 222	Unable to correct prior deficient practice. All residents have the potential to be at risk when egress doors are not properly functioning. By 5/15/25 the 600 wing exit door will be replaced or repaired by Ancillary Services Supervisor or designee. To ensure deficient practice does not recur Maintenance employees will be educated on regularly auditing of egress doors by 5/16/25.	5/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel Bullinger — TITLE: Administrator — (X6) DATE: 5/20/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 222	Continued From page 1 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised	K 222	To monitor performance and ensure ongoing compliance Ancillary Services Supervisor or designee will audit completion of egress door TELS task weekly x4 and biweekly x2. The results of this audit will be brought to QAPI committee by the Ancillary Services Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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K 222	Continued From page 2 automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door (north 600 wing exit door). Findings include: 1. Observation on 4/15/25 beginning at 2:18 p.m. revealed the north 600 wing exit door was unable to be easily opened. Testing of the door revealed it would not open regardless of the amount of force applied in the direction of egress. Further observation at that same time revealed that door had a magnetic lock on it. That magnetic lock was intended to operate as a delayed egress lock and had the requisite signage for that operation. However, that magnetic lock did not enter delayed egress operation after being pressed in the direction of travel for three seconds as required. Interview with the environmental services manager at the time of the observations and testing confirmed that condition. He stated he was unaware that door was not able to be opened. He further stated the facility had recently updated their delayed egress locks in the building and that door should have been operating correctly. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants.	K 222		

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K 222	Continued From page 3 Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		
K 252 SS=C	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain two conforming exits from the basement. Findings include: 1. Observation on 4/15/25 at 12:15 p.m. revealed the basement level was not provided with two conforming exits. One exit was through the boiler room (hazardous area), and the other discharged into the main level kitchen area. Review of previous survey data confirmed those conditions. This deficiency would affect a small number of maintenance staff. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K252.	K 252	**K252, SS= C** F	F
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		

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K 345	Continued From page 4 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 ensure the automatic fire alarm functioned as required for one randomly observed location (room 104). Findings include: 1. Observation on 4/15/25 at 4:02 p.m. revealed the smoke detector installed in room 104 had been covered with cellophane cling wrap. That cling wrap would prevent the detector from operating correctly. Products of combustion would be unable to enter that detector and activate it in a fire event Interview with the environmental services manager at the time of the review confirmed that finding. He revealed they had recently been painting in that area, and the cellophane had been applied to protect the device. He further stated that cellophane should have been removed immediately after the painting was completed.	K 345	**K345, SS= D** Unable to correct prior deficient practice. All residents have the potential to be at risk when smoke detectors have cling wrap. By 5/15/25 the cellophane cling wrap was removed from the smoke detector in room 104 by Ancillary Services Supervisor. To ensure deficient practice does not recur Maintenance employees will be educated on regularly auditing of smoke detectors by 5/16/25. To monitor performance and ensure ongoing compliance Ancillary Services Supervisor or designee will complete audit weekly x4 and biweekly x2 of smoke detectors. The results of this audit will be brought to QAPI committee by the Ancillary Services Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	5/20/25
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		

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K 353	Continued From page 5 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, measurement, and interview, the provider failed to maintain at least 18 inches of unobstructed space under one randomly observed sprinkler deflector required for one randomly observed location (600-wing shower briefs storage closet). Findings include: 1. Observation on 4/15/25 at 11:02 a.m. revealed a sprinkler head in the storage closet in the corridor next to the 600-wing shower room was obstructed by briefs on a storage shelf. Those briefs were approximately only 8 inches below the bottom of the sprinkler head deflector. That shelf and those items would interrupt the proper discharge and operation of the sprinkler head. Interview with the environmental services manager at the time of the observation revealed he was not aware of the obstructed sprinkler head.	K 353	**K353, SS= D** Unable to correct prior deficient practice. All residents have the potential to be at risk when at least 18 inches is not maintained under sprinkler deflectors. By 5/15/25 600 wing shower/storage closet was correct to ensure 18 inches under sprinkler deflector by Ancillary Services Supervisor. To ensure the deficient practice does not recur, the Ancillary Services Supervisor or designee will educate all staff by 5/16/25. To monitor performance and ensure ongoing compliance Ancillary Services Supervisor or designee will audit smoke deflectors for 18 inches underneath weekly x4 and biweekly x2. The results of this audit will be brought to QAPI committee by the Ancillary Services Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	5/20/25
K 363 SS=E	Corridor - Doors	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING 01 - SIOUX FALLS GOOD SAMARITAN VILLAGE B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 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) COMPLETION DATE
K 363	Continued From page 6 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,	K 363	**K363, SS= E** Unable to correct prior deficient practice. All residents have the potential to be at risk when corridor doors are not properly functioning. All doors identified will be replaced or repaired by listed date below: a. Quality Office by 7/30/25. b. Social Workers Office by 5/16/25. c. Activity Center by 5/16/25. d. Kitchen by 7/30/25. e. Dishwashing Room by 7/30/25.	5/20/25

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GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

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K 363	Continued From page 7 etc. This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to ensure five randomly observed corridor doors (Quality Office, Social Workers office, Activity Center, Kitchen and Dishwashing room) were equipped with functioning positive latching hardware to resist the passage of smoke. Findings include: 1. Observation and testing on 4/15/25 at 1:52 p.m. revealed the door from the Quality Office that opened into the corridor was equipped with an automatic door closer. When testing it would latch into the door frame. Further observations at that same time revealed the top of the door where it should meet the door frame had a gap of approximately one-half of an inch. That gap would not resist the passage of smoke in the event of a fire. 2. Observation and testing on 4/15/25 at 3:19 p.m. revealed the door to the Social Workers office that opened into the corridor was equipped with a closer but it was not automatically latching into the door frame. Testing of that door at that same time revealed it did not latch into the door frame on three of three attempts. 3. Observation and testing on 4/15/25 at 3:47 p.m. revealed the door to the activities center that opened into the corridor was equipped with a closer, but it was not automatically latching into the door frame. Testing of that door at that same time revealed it did not latch into the door fame on three of three attempts. 4. Observation and testing on 4/15/25 at 4:17	K 363	To ensure deficient practice does not recur Maintenance employees will be educated by Ancillary Services Supervisor or designee by 5/15/25. To monitor performance and ensure ongoing compliance Ancillary Services Supervisor or designee will audit corridor doors for positive latching hardware to resist smoke passage weekly x4 and biweekly x2. The results of this audit will be brought to QAPI committee by the Ancillary Services Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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K 363	Continued From page 8 p.m. revealed the door to the dishwashing room that opened into the service corridor was equipped with a closer but it was not automatically latching into the door frame. Testing of that door at that same time revealed it did not latch into the door frame on three of three attempts. 5. Observation and testing on 4/15/25 at 4:23 p.m. revealed the southeast door to the kitchen that opened into the dining room/corridor was equipped with a closer but it was not automatically latching into the door frame. Testing of that door at that same time revealed it did not latch into the door frame on three of three attempts. Further observation at that same time revealed the door was sprung in the frame keeping it from latching. Doors provided with closers are required to latch into their frames automatically. Interview with the environmental services manager at the time of the above observations confirmed those findings. He stated he was unaware of those conditions but was aware of the requirements for doors with closers. Those deficiencies could affect 100% of the occupants of their smoke compartments.	K 363		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid	K 374	**K374, SS=E** Unable to correct prior deficient practice. All residents have the potential to be at risk when self-closing barrier doors are not properly functioning. All doors identified will be replaced or repaired by date below:	5/20/25

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K 374	Continued From page 9 bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain self-closing smoke barrier doors on two randomly observed sets of cross-corridor doors (600 wing and therapy gym). Findings include: 1. Observation on 4/15/25 at 2:15 p.m. revealed the north leaf of the cross-corridor smoke-barrier doors of the 600 wing (outside of room 603) would not fully close upon release of the magnetic hold opens. Testing of that door revealed the door coordinator was not properly operating and would not allow that leaf of the door to close. 2. Observation on 4/15/25 at 2:34 p.m. revealed the south leaf of the cross-corridor smoke-barrier doors entering the therapy gym would not fully close upon release of the magnetic hold opens. Testing of that door revealed the door coordinator was not properly operating and would not allow that leaf of the door to close. Interview at the same time as the observations with the environmental services manager confirmed those findings.	K 374	a. 600 wing by 5/16/25. b. Therapy gym by 5/16/25. To ensure the deficient practice does not recur, the Ancillary Services Supervisor or designee will educate Maintenance staff by 5/15/25. To monitor performance and ensure ongoing compliance Ancillary Services Supervisor or designee will audit corridor doors are self-closing weekly x4 and biweekly x2. The results of this audit will be brought to QAPI committee by the Ancillary Services Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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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
	10680	A. BUILDING: _____ B. WING _____	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION ROAD SIOUX FALLS, SD 57106

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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 4/14/25 through 4/17/25 and 4/22/25 through 4/24/25. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: S167, S173, and S210.	S 000		
S 167	44:73:02:18(3-4) Occupant Protection The facility shall: (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system must be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors; This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to lock, install or maintain door alarming for one randomly observed exterior door (rehabilitation [rehab] employee entrance). Findings include: 1. Observation and testing on 4/15/25 at 2:43 p.m. revealed the rehab employee entrance doors did not alarm when opened. There was nobody stationed permanently at the nurses' station. There were no other staff seen in the area. That door could not be considered monitored, locked, or alarmed as required. Interview with the maintenance technician that same day at 2:46 p.m. confirmed those	S 167	**S167** No specific resident was identified. All residents have the potential to be at risk when exterior doors are not alarming and/or locking appropriately. By 5/16/25 the rehab employee entrance door was repaired by maintenance technician to ensure alarm is functioning properly. By 5/16/25 all exterior doors were inspected to ensure appropriately locking and/or alarming system working by Ancillary Services Supervisor or designee. To ensure deficient practice does not recur, Ancillary Services Supervisor or designee will educate maintenance technicians on inspecting exterior doors to ensure the door is properly locking and alarming by 5/15/25.	5/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel Ballou — TITLE: Administrator — (X6) DATE: 5/20/2025

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S 167	Continued From page 1 conditions. He stated the provider used a WanderGaurd (a system of devices that lock a door magnetically when a resident approaches a linked door) system for resident safety on that door. The WanderGaurd system did not meet the requirement to identify when a cognitively impaired resident might exit the building. He further stated he was unaware the WanderGaurd system did not meet the requirements for that door to be considered monitored, locked, or alarmed.	S 167		
S 173	44:73:02:18(8-10) Occupant Protection The facility shall: (8) Ensure that any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any clean laundry and linen storage area, or in any medication set-up area is equipped with a lens cover or a shatterproof lamp; (9) Ensure any clothes dryer has a galvanized metal transition duct for exhaust or UL 218-rated flexible transition duct; and (10) Ensure that the storage and transfilling of oxygen cylinders or containers meets the requirements of the NFPA 99 Health Care Facilities Code, 2012 Edition, chapter 11. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to install galvanized metal exhaust ductwork for one randomly observed residential dryer location (transition room). Findings include: 1. Observation on 4/15/25 at 2:37 p.m. revealed the transition room for the therapy wing had a residential style dryer. That dryer had foil paper	S 173	S 173 No specific resident was identified. All residents have the potential to be at risk when ductwork on dryers are not maintained per regulation. By 5/16/25 a galvanized metal exhaust ductwork was installed on the therapy wing residential dryer by maintenance technician. By 5/16/25 all dryers within the facility were inspected by Ancillary Services Supervisor or designee to insure they met standards with galvanized metal exhaust ductwork, if appropriate. To ensure deficient practice does not recur, Ancillary Services Supervisor or designee will educate maintenance technicians on inspecting dryers they meet standards with galvanized metal exhaust ductwork by 5/15/25. To monitor performance and ensure ongoing compliance an audit will be completed by Ancillary Services Supervisor or designee weekly x4 to ensure dryers meet standards per NFPA. The results of those audits will be brought to the QAPI committee by the Ancillary Services Supervisor or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	5/20/25

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S 173	Continued From page 2 exhaust ducting installed. Interview with the environmental services manager at that same time confirmed that condition. He stated he was unaware of the requirements for dryer exhaust ducting as he had recently became the environmental services manager after having a similar role in a different state with different requirements.	S 173		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee records review, interview, and policy review, the provider failed to ensure the completion of a health evaluation by a	S 210	**S 210** No specific resident was identified. All residents have the potential to be at risk when health evaluations are not completed per regulation. Staff BB and FF have health evaluations were completed but were identified as being out of compliance by not being completed within 14 days of their hire during annual survey. By 5/16/25 an audit of all nursing department employee health evaluations will be completed by Administrator or designee. Findings will be brought to QAPI committee and follow-up as warranted by findings.	5/20/25

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S 210	Continued From page 3 licensed healthcare professional for two of five randomly reviewed employees (BB and FF) within 14 days of their hire. Findings include: 1. Review of certified medication aide (CMA) FF's employee record revealed: *She was hired on 12/10/24. *She completed her employee Communicable Disease Screening form on 1/10/25. *That form was signed by a licensed health professional on 1/10/25 and was not within 14 days of her hire date. Review of registered nurse (RN) BB's employee record revealed: *She was hired through a contract agency on 5/8/24. *There was no Communicable Disease Screening form documented within 14 days of her hire. *She renewed her agency contract on 1/22/25. *She completed her employee Communicable Disease Screening form on 1/22/25. 2. Interview on 4/24/25 at 10:49 a.m. with director of nursing (DON) R revealed: *A new process for completing Communicable Disease Screenings forms for staff started January 2025, she expected that on the day of orientation or the next date she or assistant director of nursing (ADON)/infection preventionist (IP) G would complete communicable disease screening forms with staff and new hires. *RN BB's communicable disease screening form was signed after the 14-day start period from her initial hire date of 5/8/24. -Her new contract was started on 1/22/25 and a new communicable disease screening was completed and signed on 1/22/25. *She agreed CMA FF's communicable disease	S 210	To ensure the deficient practice does not recur, Administrative Assistant in charge of general orientation for new hires will be educated by the Administrator that health employee health evaluations are to be completed within 14 days of hire by 5/15/25. To monitor performance and ensure ongoing compliance the Administrative Assistant or designee will audit nursing department employee health evaluations weekly x4, every other week x2, monthly x1 and quarterly x1. The results of those audits will be brought to the QAPI committee meeting by the Administrative Assistant or designee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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S 210	Continued From page 4 screening form had been signed 30 days after her hire date of 12/10/24. Interview on 4/24/25 at 10:56 a.m. with administrator A revealed: *She expected for staff communicable disease screening forms to be completed during general orientation and that DON R or a designee would complete them with new hires within the 14-day period from when they were hired. *She was unable to find a communicable disease form for RN BB when she signed her first contract on 5/8/24 to work. *She agreed CMA FF communicable disease screening form signed 1/10/25 was not signed within 14 days of hire. 3. Review of providers the revised 3/28/25 Hiring and Screening Policy revealed: *Purpose was to ensure fair and standardized practices regarding recruitment, selection, background screening and pre-employment drug testing. *"Screening: -The manager/designee and/or recruiter may screen applicants using a variety of job relevant tools and interviews." *"A pre-employment drug screening and health assessment (if applicable) will be conducted on all external job applicants who have accepted offers of employment. The health assessment is required prior to the first day of employment and employment is contingent upon successful completion of the drug screen and/or health assessment."	S 210		

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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 4/15/25. Good Samaritan Society Sioux Falls Village was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Daniel Ballinger | TITLE: Administrator | (X6) DATE: 5/20/2025

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.