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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435087	A. BUILDING ______ B. WING ______	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	700 WEST MAIN ST CANISTOTA, SD 57012

(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 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/19/24 through 8/20/24. Areas surveyed included elopements, resident rights regarding self determination, and care plan timing and revision. Good Samaritan Society Canistota was found not in compliance with the following requirements: F561, F657, and past noncompliance at F689.	F 000		
F 561 SS=G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. 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,	F 561	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F- 561 Self Determination 1. Corrective action to residents affected: Resident 2's s food preferences, choices and snack times have been updated. 2. Identify other potential Residents affected: All other residents have been reviewed and updated with time for food preferences and choices. 3. Measures put into place or systemic changes made to ensure that will not recur: Directed in-services education: All staff will be educated on resident rights resident regarding self-determination (snack preference and times) per resident choice. Administrator, DON, SSD, dietary manager, and interdisciplinary team reviewed policies and procedures on individual resident choices/preferences.	9/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Evenson (formerly Amy Schroeder)	Administrator	9/6/24

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 561	Continued From page 1 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 review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview, and policy review, the provider failed to accommodate one of one sampled resident's (2) snack time preferences. Findings include: 1. Review of the provider's 6/24/2024 (SD DOH) (FRI) regarding resident 2 revealed: *On 5/22/24 an incident occurred when resident 2 was offered ice cream. She had stated she wanted ice cream, was told she had already had ice cream and was not allowed more. -Resident 2 became upset and was taken to her room to "calm down". *It was later discovered that resident 2 had a "right eye that was swollen as well as a bump/bruise from her lateral aspect [tail] of the right eyebrow." *The "care plan was updated ..." *"Staff was educated to continue giving ice cream to the resident even if she did already have her normal amounts for the day." *"Staff was educated on resident rights and choices." *"Resident does not have any weight issues or diabetic concerns to support limiting ice cream at this time." 2. Review of resident 2's electronic medical record (EMR) revealed: *An admission date of 8/13/21. *Diagnoses that included: Huntington's Disease, Major Depressive Disorder, anxiety, and a history	F 561	Continued from page 1 4.Monitor process for the system change including frequency and person responsible: Administrator or designee will complete audits to ensure residents receive snack/food preference at residents' choice of time for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee. 5.Dates when corrective action will take place: 9-13-2024	

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F 561	Continued From page 2	F 561		

of other mental and behavioral disorders.
*A Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact.
*A 5/21/24 nutritional status progress note (PN) indicated "Wt [weight] down significantly since was 191 on 12/1 [12/1/23]... Recommend: 1. Provide diet as ordered assisting with all intake. Provide smaller portions per Res [resident] request. 2. General snacks/hydration per diet order to be offered b/t [between] meals. 3. Monitor intake/wt [weight]."
*A 5/22/24 nurse PN indicated: "Reported to this nurse, that after [the] resident had her HS [evening] snack, she asked staff for ice cream, which was given to her. Activities staff then asked her later if she wanted ice cream and she stated yes, but was informed that she already had ice cream. Resident began yelling and swearing at staff as well as kicking staff. At this time, resident in room screaming, as she wants ice cream. Informed resident that she already had her ice cream. Resident yelling and stating, "oh what ever," and "pack my shit I'm leaving."
*A 6/8/24 nurse PN indicated: "Reported to this nurse, that resident in living room screaming as she requested candy, but had just finished with HS [evening] snack and also ice cream. Stated she would need to wait, and began screaming."
*A 6/15/24 nurse PN indicated: "This morning at ~ [approximately] 0600 [6:00 a.m.] resident in [her] room screaming because she wanted candy and ice cream. CNA [certified nursing assistant] had informed [the] resident that it was almost breakfast. Resident then yelling "oh, whatever. Get the hell out of here."
*A 7/1/24 nurse PN indicated: "Reported to this nurse, that this past evening, resident requesting ice cream for the second time, plus an HS snack and staff told her she would have to wait, as other

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F 561	Continued From page 3	F 561		

residents wanted and needed snacks as well. Resident then began screaming and leaning forward in her broda chair [a specialized wheelchair], then throwing herself back into [the] chair."

3.Observation on 8/19/24 at 2:59 p.m. with resident 2 in the main dining room revealed:
*She had involuntary movements that included movements of her head, and upper body and she kicked her leg out in front of her repeatedly.
*She reached for and drank juice from a cup with two handles.
*A staff member assisted her with eating the cake with a fork.
*She wiped her own face with her clothing protector.

Interview on 8/19/24 at 3:40 p.m. with resident 2 and her male friend revealed:
*Her friend brought ice cream to the facility regularly.
-It was stored in the shared resident freezer.
*She stated she wanted ice cream for a snack but could not get the ice cream when she wanted it.
*She stated, "I don't have any independence."
*She preferred ice cream because it was easy to swallow.
*This was a long-standing preference as her friend had provided ice cream for her in her previous living environment.

Interview on 8/20/24 at 8:50 a.m. with certified nurse aide (CNA) E regarding resident 2 revealed:
*Resident 2 required assistance with eating meals and snacks.
-She was able to drink from a 2-handle cup or eat a peanut butter cup if it was opened for her and

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F 561	Continued From page 4 the paper was removed. -She required assistance with using utensils. *Resident 2 was able to make her needs known. *Resident 2 had behaviors that included "cussing at staff", hitting, and kicking. *If resident 2 asked for ice cream at 6:00 a.m. she would be reminded that breakfast was served at 8:30 a.m. and "encouraged to wait til breakfast." Interview on 8/20/24 at 9:01 a.m. with registered nurse (RN) F regarding resident 2 revealed: *Resident 2 had a history of getting very angry and required time to calm down in those circumstances for her safety and the safety of the staff. *RN F expected that when resident 2 requested ice cream it would be provided to her. -She stated, "I would not want to start the day on the wrong foot." *She was not aware if resident 2 had a recent weight loss. Interview on 8/20/24 at 9:06 a.m. with director of nursing (DON) B regarding resident 2 revealed she: *Started in her role as DON on 6/24/24, after the incident on 5/22/24 occurred. *Expected that if a resident requested a candy or ice cream at midnight or 6:00 a.m., "they would be allowed it or an alternative." *Stated, "This is their home." *She was not aware that resident 2 had not received snacks when she requested them. Interview on 8/20/24 at 11:13 a.m. with supervisor, nutrition and food service D revealed: *A snack was served daily at 3:00 p.m. in the dining room which included ice cream once a	F 561		

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F 561	Continued From page 5 week. *Snacks were kept in the nurse station for residents. *The nurses were able to access the main kitchen and resident refrigerators at all times. *Personal food items brought from outside the facility were stored in the resident unit refrigerator. Observation on 8/20/24 at 12:51 p.m. of the day room freezer revealed four containers of ice cream and 17 peanut butter cups. Interview on 8/20/24 at 12:52 p.m. with certified nurse aide (CNA) E revealed: *The peanut butter cups and at least two of the containers of ice cream belonged to resident 2. -Resident 2's friend brought her snacks and did not always label the items he placed into the freezer. Interview on 8/20/24 at 9:14 a.m. and again at 2:07 p.m. with administrator A revealed: *She expected that if a resident requested ice cream that ice cream or an alternative would have been provided. *The incident on 5/22/24 occurred during the hiring transition of the administrator and director of nursing. *She had contacted the previous interim DON regarding the incident and confirmed that the investigation and education provided were done verbally. -There was no documentation of the investigation or education provided. *She confirmed that the care plan had not been updated to reflect the resident's preferences. 4. Review of the provider's January 2022	F 561		

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F 561	Continued From page 6 Resident's Rights for Skilled Nursing Facilities policy revealed: *"The resident has a right to and the facility must promote and facilitate 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."	F 561		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657	1. Corrective action to residents affected: Care plan updated for Resident 2 to reflect food/snack preference. 1. Identify other potential Residents affected: All other residents' care plan has been updated to reflect food/snack preference. 2. Measures put into place or systemic changes made to ensure that will not recur: All staff will be educated on updating resident care plans to reflect residents' food/snack preferences. 3. Monitor process for the system change including frequency and person responsible: Director of Nursing or designee will complete audits to ensure the residents care plan reflects residents choice for snack/food preferences for 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee. 4. Dates when corrective action will take place: 9-13-2024	9/13/24

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F 657	Continued From page 7	F 657		

This REQUIREMENT is not met as evidenced by:
Based on review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure the care plan was revised to reflect the current snack preferences for one of one sampled resident (2).
Findings include:

1. Review of the provider's 6/24/2024 (SD DOH) (FRI) regarding resident 2 revealed:
*On 5/22/24 an incident occurred when resident 2 was offered ice cream. She had stated she wanted ice cream, was told she had already had ice cream and was not allowed more.
-Resident 2 became upset and was taken to her room to "calm down".
*It was later discovered that resident 2 had a "right eye that was swollen as well as a bump/bruise from her lateral aspect [tail] of the right eyebrow."
*The "care plan was updated ..."
*"Staff was educated to continue giving ice cream to the resident even if she did already have her normal amounts for the day."
*"Staff was educated on resident rights and choices."
*"Resident does not have any weight issues or diabetic concerns to support limiting ice cream at this time."

2. Review of resident 2's electronic medical record (EMR) revealed:
*An admission date of 8/13/21.
*Diagnoses that included: Huntington's Disease, Major Depressive Disorder, anxiety, and a history of other mental and behavioral disorders.
*A Brief Interview for Mental Status (BIMS) score

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F 657	Continued From page 8 of 15 which indicated she was cognitively intact. *A 5/21/24 nutritional status progress note (PN) indicated "Wt [weight] down significantly since was 191 on 12/1 [12/1/23]... Recommend: 1. Provide diet as ordered assisting with all intake. Provide smaller portions per Res [resident] request. 2. General snacks/hydration per diet order to be offered b/t [between] meals. 3. Monitor intake/wt [weight]." *A 5/22/24 nurse PN indicated: "Reported to this nurse, that after [the] resident had her HS [evening] snack, she asked staff for ice cream, which was given to her. Activities staff then asked her later if she wanted ice cream and she stated yes, but was informed that she already had ice cream. Resident began yelling and swearing at staff as well as kicking staff. At this time, resident in room screaming, as she wants ice cream. Informed resident that she already had her ice cream. Resident yelling and stating, "oh what ever," and "pack my shit I'm leaving." *A 6/8/24 nurse PN indicated: "Reported to this nurse, that resident in living room screaming as she requested candy, but had just finished with HS [evening] snack and also ice cream. Stated she would need to wait, and began screaming." *A 6/15/24 nurse PN indicated: "This morning at ~ [approximately] 0600 [6:00 a.m.] resident in [her] room screaming because she wanted candy and ice cream. CNA [certified nursing assistant] had informed [the] resident that it was almost breakfast. Resident then yelling "oh, whatever. Get the hell out of here." *A 7/1/24 nurse PN indicated: "Reported to this nurse, that this past evening, resident requesting ice cream for the second time, plus an HS snack and staff told her she would have to wait, as other residents wanted and needed snacks as well. Resident then began screaming and leaning	F 657		

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F 657	Continued From page 9	F 657		

forward in her broda chair [a specialized wheelchair], then throwing herself back into [the] chair."
*The care plan had not been updated to reflect the resident's preference for ice cream, or candy.
*The care plan did not indicate that "Staff was educated to continue giving ice cream to the resident even if she did already have her normal amounts for the day."

3. Interview on 8/19/24 at 3:40 p.m. with resident 2 and her male friend revealed:
*Her friend brought ice cream to the facility regularly.
-It was stored in the shared resident freezer.
*She stated she wanted ice cream for a snack but could not get the ice cream when she wanted it.
*She stated, "I don't have any independence."
*She preferred ice cream because it was easy to swallow.
*This was a long-standing preference as her friend had provided ice cream for her in her previous living environment.

Interview on 8/20/24 at 9:14 a.m. and again at 2:07 p.m. with administrator A revealed:
*She expected that if a resident requested ice cream that ice cream or an alternative would have been provided.
*The incident on 5/22/24 occurred during the hiring transition of the administrator and director of nursing.
*She confirmed that the care plan had not been updated to reflect the resident's preferences.

4. Review of the provider's November 1, 2023, Care Plan policy revealed:
*"Each resident will have an individualized, person-centered, comprehensive plan of care ..."

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F 657	Continued From page 10 *"Person-centered care- A focus on the resident as the locus of control and supporting the resident in making his or her own choices and having control over their daily life."	F 657		
F 689 SS=D	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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, Roam Alert (door alarm) log review, and video review, the provider failed to ensure the safety of one of one sampled resident (1) identified at risk for elopement, who had eloped (left the facility without staff knowledge) after staff turned a door alarm off. Failure of staff to ensure the door alarm was rearmed resulted in the resident's elopement and put him at risk for physical injury or serious harm. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of provider's 7/28/24 SD DOH FRI revealed: *On 7/28/24 resident 1 had wandered throughout the building that night. *Staff had redirected him away from the doors	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 11 throughout the night. *At 5:00 a.m. staff noticed he was not in his room and initiated a search inside and outside of the building. *The sheriff was notified of the missing resident at 6:20 a.m. *Administrator A and director of nursing (DON) B were notified at 5:40 a.m. *An unidentified staff member found resident 1 wandering at 6:30 a.m. on a nearby road and accompanied resident 1 back to the facility at 6:40 a.m. *The nurse notified emergency medical services who assessed resident 1 at 7:15 a.m. at the facility, found no injuries, and recommended to increase his hydration for the day. -His wander guard (door alarm bracelet) was found to be in working order. *His daughter was notified of the incident. *DON B reviewed the camera footage and discovered resident 1 exited the 100 hallway door at 4:41 a.m. *Approximately one minute before that, certified nursing assistant (CNA) C had responded to resident 1's attempt to exit that door. CNA C entered the bypass door alarm PIN code, which turned the alarm off, redirected resident 1, and then responded to another resident's call light. *Door alarm audits were conducted every Wednesday. *Staff audited door alarms for the rest of day 7/28/24. *DON B revised the provider's Alarms-Bed, Chair and Door Policy on 7/28/24 to include: -"If resident is exit seeking, staff will redirect away from door." -"Staff will reset alarm." -"Stay with the exit door until lock is reset and alert lights are red."	F 689		

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	435087	A. BUILDING ______ B. WING ______	C 08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY CANISTOTA	**700 WEST MAIN ST CANISTOTA, SD 57012**

(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 689	Continued From page 12 -"Resident is to be assisted to a common area a good distance away from the exit." -"Resetting the alarms needs to be done by using the codes on keypads first, and then using badge to reset if keypad does not reset." -"Staff will then start a head count and have eyes on all residents. Once all are accounted for radio an "all clear, everyone is here" message." -"Alarm activated and no resident is in sight. One staff member will check to see which door it is and radio staff to check that door." *Education of the policy and process revision was provided to the staff by DON B. Review of resident 1 electronic medical record (EMR) revealed: *His Brief Interview for Mental Status (BIMS) score was three which indicated he had severe cognitive impairment. *He had diagnoses of: -Dementia with behavioral disturbances. -Anxiety disorder due to psychological condition -Major depressive disorder, recurrent. *His elopement risk assessments dated 10/11/23, 1/12/24, 4/12/24,7/20/24 and 7/28/24 all identified him at risk for elopement. *On 4/13/21 a care plan focus area identified his elopement risk. -An intervention for: "Wander guard used to alert staff to resident movements" was initiated on 4/13/21. -On 7/28/24 he eloped. -On 7/28/24 an intervention to "ensure exit door alarms are in working order" was added to his care plan. Review of the provider's Roam Alert (wander guard) log and video camera footage of the incident revealed:	F 689		

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F 689	Continued From page 13 *Resident 1 at 4:40 a.m. caused alarm to sound at 100 hallway door. *At 4:41 a.m. CNA C entered a door alarm bypass PIN code. -Resident 1 was redirected by CNA C back up the hallway in a direction away from the door. *At 4:41 a.m. a call light was activated in another resident's room. CNA C walked past resident 1 in the hallway and responded to another resident's call light. *Resident 1 turned around and exited the door at the end of the hallway at 4:41 a.m., unseen by staff. *The Roam alert log indicated "Bypass On" was detected in the 100 hallway at 4:41 a.m. and "Bypass off" was detected at 4:42 a.m. Interview on 8/20/24 at 3:00 p.m. with DON B revealed: *15-minute visual checks were started on 7/28/24 upon resident 1's return to the building until 8/1/24 and were then changed to one-hour checks for 24 hours. *His behavior charting was completed every shift. *His behaviors improved after the addition of scheduled Tylenol and Tramadol medications for pain. *An elopement drill was conducted with staff on 7/28/24. *After the door alarm bypass PIN code was entered, it would not alarm and would reactivate after 90 seconds. *Alarms policy was updated and revised on 7/28/24. *Staff education was provided regarding alarm policy changes starting 7/28/24 and was completed 7/30/24 for all staff. The provider's implemented actions to ensure the	F 689		

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

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F 689	Continued From page 14 deficient practice does not reoccur was confirmed on 8/20/24 after: record review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding door alarms, response and their alarm deactivation and re-activation process, policy update, and observation and staff interviews revealed the staff understood the education provided and the revised process. Based on the above information, non-compliance at F689 occurred on 7/28/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 8/20/24, the non-compliance is considered past non-compliance.	F 689		