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
	435045	A. BUILDING _____ B. WING _____	06/16/2021

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 Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/13/21 through 6/16/21. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: F657, F676, F686, and F755.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined 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	F 657	1.Resident 68 expired on 6/23/2021; 2.Facility IDT reviewed all residents experiencing falls after 5/1/2021. Care plans were reviewed to ensure that fall care plans were up to date with fall interventions by 7/7/2021. 3.DNS or designee will audit that interventions discussed in daily incident report meeting were put on the care plan and implemented. Audit will be completed by DNS or designee weekly x4, monthly x3. DNS or designee will provide update to QAPI at monthly QAPI meeting. 4.Nurse Managers will attend the daily incident report meeting to ensure that interventions are discussed and put in care plan immediately. All staff have been educated by Administrator and DNS on the above changes on 7/1/2021. All those unable to attend will be given information to review and sign off on. DNS will track all staff unable to make the in-service and make sure that they receive the education and submit quiz.	7/13/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason Hanssen
TITLE: Administrator
(X6) DATE: 7/2/2021

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

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F 657	Continued From page 1 assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure one of four sampled resident (68) care plan had been updated and revised for fall interventions. Findings include: 1. Review of resident 68's 6/15/21 physician's orders revealed: *Diagnoses of: -History of falls. -Wedge compression fracture of unspecified thoracic vertebra with routine healing. -Unspecified fracture of sacrum with routine healing. -Mild cognitive impairment. Observation and interview on 6/14/21 at 4:33 p.m. with resident 68 revealed: *She was "achy." *She was sitting on a mechanical lift sling in a recliner in her room. *She had a call light available for her to use and did not know what it was for. *Resident 18 had been in the room and stated resident 68 "falls all the time and I have to help her." Review of resident 68's current care plan with most recent updates of 6/3/21 revealed she had: *A fall with no injury related to (r/t) self transferring, impulsiveness. *Been at risk for falls r/t impaired mobility, weakness, and history of falls. *Goals to resume usual activities, and be free from falls without further incident through review	F 657		

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F 657	Continued From page 2 date. *Interventions updated on 6/3/21 to include: -Soft touch call light was in reach, position her in the middle of the bed, and ensure bolsters on air mattress were in correct position. -Monitor for cognition, safety awareness, and decision-making capacity. -Education to resident/family about safety reminders and what to do if a fall occurs. -Remind her not to bend over to pick up dropped items and encourage her to use a grabber or ask for assistance. -Ensure there were no environmental hazards (e.g., tubing, electrical supply cords, etc.). Review of the provider's Risk Management documents from 6/1/21 through 6/8/21 revealed resident 68 had fallen four times. Interventions identified had not been carried over to the care plan. The documents revealed: *On 6/1/21 at 10:00 p.m.: -She had been found on the floor and had been ambulating just prior. -She had stated she had been "trying to go lock the door" without asking for help when she fell. -Results of the investigation had not been identified. -There had been no corrective actions taken to prevent recurrence of this incident. *On 6/2/21 at 7:05 a.m.: -She had been found on the floor outside of her bathroom. -An unidentified certified nursing assistant (CNA) had left her in the bathroom, at the sink, in a wheelchair, and brushing her teeth. -She had stood up and caught her foot on the foot pedals of her wheelchair. -A new intervention of "stay with resident in bathroom" had been identified.	F 657		

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F 657	Continued From page 3 --Her care plan had not included the new intervention. *On 6/4/21 at 6:30 p.m.: -She had been found on the floor next to her bed. -She had been self-transferring and ambulating and she stated, "I just sat down." -Predisposing situation factors had been identified as improper footwear. -A new intervention of "ensure gripper socks or shoes" had been identified. --Her care plan had not included the new intervention. *On 6/8/21 at 7:48 p.m.: -She had been found on the floor next to her bed and she had stated she had to use the bathroom. -Results of the investigation had been identified as "hospice still reviewing information - attempts to transfer." -There had been no corrective actions taken to prevent recurrence of this incident. -Her care plan had not included new interventions. Interview on 6/15/21 at 3:49 p.m. with director of nursing (DON) D regarding resident 68 revealed: *Incidents were reviewed daily and an email sent to management requesting input on what may have caused the incident. *Beginning on 6/3/21 hospice had been considered. *Staff had not been aware of the intervention for gripper socks and she would inform them that day. *Agreed the interventions identified had not been added to the care plan. -Stated they should have had a different intervention on the care plan and "we need to try everything" to prevent falls.	F 657		

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F 657	Continued From page 4 Interview on 6/15/21 at 4:02 p.m. with CNA F regarding resident 68 revealed: *The nurse or her supervisor notified her when the care plan or Kardex was updated. *She thought the interventions to prevent falls included: -Ensuring she had her call light. -Keeping her door open and checking on her as they go by. -Using her wheelchair to take her to and from the bathroom. Interview on 6/15/21 at 4:30 p.m. with DON D and registered nurse (RN) I revealed: *Their normal process for incidents had not been followed. *When an incident occurred an email was sent to management. *There had been no email sent regarding falls for resident 68. -Her care plan had not been updated. *RN I agreed they had missed a step in the process. Review of the provider's 12/16/20 Falls Resource packet revealed: *"Fall reduction begins with proactively recognizing potential fall risk factors and proceeds with communicating actions to reduce the possibility of falls. Early identification of each resident's risk for a fall and promptly communicating interventions to avoid falls is vital for resident safety." *"Fall reduction efforts include:.....Communicating residents' fall risk and reduction efforts to employees: using opportunities such as: shift report, employee meetings and in-services, care conferences, PCC 24-hour report and clinical dashboard tools, care	F 657		

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F 657	Continued From page 5 plan (and Kardex)." *"After a fall.....Check the care plan to determine if the cause of the fall is addressed (to avoid additional falls from the same cause). Consider setting a short term goal to assist with monitoring the fall interventions closely to determine effectiveness; if not effective, revise the care plan and set new short term goal." Review of the provider's 10/16/20 Care Plan policy revealed: *"Purpose to develop a comprehensive care plan using an interdisciplinary approach." *"Policy this plan of care will be modified to reflect the care currently required/provided for the resident."	F 657		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following	F 676		

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F 676	Continued From page 6 activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 A. Based on interview, record review, and policy review, the provider failed to ensure fourteen of seventeen sampled residents (3, 5, 8, 17, 39, 41, 68, 69, 77, 83, 89, 92, 98, and 126) received restorative services. Findings include: 1. Interview on 6/15/21 at 10:00 a.m. with members of the resident council revealed: *Residents 8, 39, 69, 89, and 98 were in attendance. *They were not receiving their restorative services. *They felt they had experienced a decline in their mobility due to not receiving services. *They would like to see restorative services being completed. 2. Interview on 6/14/21 at 8:54 a.m. with resident 92 revealed she:	F 676	Restorative 1.Residents 3, 5, 8, 17, 39, 41, 68, 69, 77, 83, 89, 92, 98 and 126 restorative care plans and programs were reviewed and revised on 6/18/2021 by nurse managers. They were updated to ensure compliance. 2.All other residents: restorative care plans and programs were reviewed and revised by nurse managers on 6/18/2021. They were updated to ensure compliance. 3.Facility will audit that current restorative care plan are being followed by restorative therapy aides. Audit will be completed by DNS or designee weekly x4, monthly x3. DNS or designee will provide update to QAPI at monthly QAPI meeting. 4.Meeting held by the Administrator and DNS on 7/1/2021 with restorative therapy aides to discuss new parameters and programs. All staff educated on 7/1/2021 by the Administrator and DNS that restorative therapy aides are not to be pulled from restorative unless otherwise specified by DNS or Administrator. All staff have been educated on the above changes on 7/1/2021. All those unable to attend will be given information to review and sign off on. DNS will track all staff unable to make the in-service and make sure that they receive the education and submit quiz.	7/13/21

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F 676	Continued From page 7 *Liked to walk to the library for exercises. *Had been receiving therapy in the facility. *Was unsure why she was not receiving exercises since stopping therapy. *Stated one person was responsible to help the residents with their daily exercises. -That aide was often pulled to work on the floor due to staffing shortages. *Had experienced a decline lately due to not receiving restorative services. Review of resident 92's 6/15/21 care plan revealed: *Her interventions included: -Upper extremity active range of motion exercises, 15 minutes a day, up to 7 days a week. -Walking with one staff member one time per day, up to 7 days per week Review of resident 92's restorative nursing logs revealed from 6/3/21 through 6/14/21 she had received 15 minutes of walking five times. Review of resident 92's therapy notes revealed: *As of 5/19/21 she had met her therapy goals. *Therapy found that she was appropriate for discharge from occupational therapy with maximum potential achieved and would transition to the restorative nursing program. 3. Interview on 6/14/21 at 9:08 a.m. with resident 3 revealed: *He had experienced some falls. *He stated he had not received exercises. *His most recent fall was a couple of days ago. *He felt he had experienced a decline in his mobility lately.	F 676	Bathing 1.Residents 39, 41 and 83 bathing schedules were reviewed by nurse managers on 6/17/2021. Bathing schedules printed and posted in the nursing stations for CNA.s to initial off after completion of bath/shower along with PCC documentation. 2.For all other residents, bathing schedules were reviewed by nurse managers on 6/17/2021. Bathing schedules printed and posted in the nursing stations for CNA.s to initial off after completion of bath/shower along with PCC documentation. 3.Nurse Managers are auditing bath schedules daily for compliance by comparing printed bath schedule with charting. Nurse Manager to ensure that at least one bath given per week to each resident. Audit will be completed by DNS or designee weekly x4, monthly x3. DNS or designee will provide update to QAPI at monthly QAPI meeting. 4.All staff have been educated by the Administrator and DNS on the above changes on 7/1/2021. All those unable to attend will be given information to review and sign off on. DNS will track all staff unable to make the in-service and make sure that they receive the education and submit quiz.	

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F 676	Continued From page 8 Review of resident 3's 6/15/21 care plan revealed: *He had the following interventions: -Upper extremity active range of motion exercises, 15 minutes a day, up to 7 days a week. -Walking with one staff member one time per day, up to 7 days per week. Review of resident 3's 3/26/21 therapy discharge summary revealed, recommendations discussed with patient [resident] and/or caregivers included one assist with transfers and ambulation with transition to restorative nursing program. Review of resident 3's restorative nursing therapy logs revealed: *From 4/13/21 through 6/13/21 he had not received any walking therapy. *From 4/13/21 through 6/13/21 he had not received any active range of motion exercises. Review of resident 3's 6/11/21 fall investigation revealed: *He had a fall while he was self-transferring. *The narrative comments were: -"Encourage call light use - encourage restorative..." 4. Interview on 6/14/21 at 9:13 a.m. with resident 39 revealed he used to be able to walk 900 feet but was now unable to walk that distance. Review of resident 39's restorative records from 4/16/21 through 6/14/21 revealed he had received restorative one time. 5. Review of resident 17's therapy notes revealed she was referred to therapy for an evaluation due	F 676		

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F 676	Continued From page 9 to cognitive deficits, increased weakness, and functional decline with activities of daily living (ADL)s. Review of resident 17's 6/15/21 care plan revealed she was to receive a variety of bilateral upper extremity exercises once per week, up to 7 days a week. Review of resident 17's restorative logs revealed from 4/12/21 through 6/12/21 she had received restorative services two times. 6. Interview on 6/14/21 at 1:30 p.m. with resident 77 revealed she: *Had lived at the facility for a couple of years. *Stated she felt she had experienced a decline in her mobility. Review of resident 77's 6/15/21 care plan revealed she: *Could perform active range of motion exercises for upper and lower extremities 15 minutes per day, up to 7 days per week. *Could perform walking for 15 minutes per day, up to 7 days per week. Review of resident 77's 4/12/21 through 6/12/21 restorative logs revealed she had: *Received active range of motion exercises twice. *Received walking therapy eight times. 7. Review of resident 41's 6/15/21 care plan revealed she was to receive passive range of motion to all joints one time per day, up to seven days per week. Review of resident 41's 4/12/21 through 6/12/21 restorative log revealed she had received 15	F 676		

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F 676	Continued From page 10 minutes of passive range of motion a total of 5 times. Resident 41 was unable to be interviewed due to cognitive barriers. 8. Review of resident 5's 6/15/21 care plan revealed she was to receive active range of motion exercises one time per day, up to seven days per week. Review of resident 5's 5/15/21 through 6/15/21 restorative logs revealed: *There had been a total of 30 opportunities to receive active range of motion exercises. *She had received active range of motion exercises 6 times. Surveyor 43844 9. Interview on 6/14/21 at 2:16 p.m. with resident 83 revealed he: *Had knee contractures and leg pain. *Had not been receiving any restorative therapy. -He would have participated in restorative therapy if it had been offered. Review of resident 83's 6/15/21 care plan revealed he was to receive: *Active range of motion exercises one time per day, up to seven days per week. *Passive range of motion to reduce the risk of contractures one time per day, up to seven days per week. Review of resident 83's 5/18/21 through 6/15/21 restorative nursing therapy logs revealed he had not received any restorative therapy. Review of resident 83's 1/26/21 physical therapy	F 676		

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F 676	Continued From page 11 discharge summary revealed he was to "remain at nursing home with RNP [restorative nursing program] in place." 10. Review of resident 68's 6/15/21 care plan revealed she was to receive active range of motion exercises once per day, up to seven days per week. Review of resident 68's 5/19/21 through 6/15/21 restorative nursing therapy logs revealed she had not received any restorative therapy. 11. Review of resident 126's 6/15/21 care plan revealed she was to receive active range of motion exercises once per day, up to seven days per week. Review of resident 126's 5/19/21 through 6/16/21 restorative nursing therapy logs revealed she had not received any restorative therapy. 12. Interview on 6/15/21 at 8:15 a.m. with restorative nursing aide N revealed: *He had been working as a restorative aide in the facility for nine years. *All of the residents were mostly on the same restorative program. *Their goal was to complete restorative nursing seven days a week. -They set their goal at seven days because they would attempt to achieve five days per week. *He was pulled frequently from restorative nursing to work as a CNA on the floor. *He said he was pulled usually at least two times per week. *He agreed restorative nursing was not being completed for residents.	F 676		

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F 676	Continued From page 12 Interview on 6/15/21 at 3:25 p.m. with director of nursing (DON) D revealed: *Restorative nursing assistants had been pulled from the restorative program to work as CNAs two out of five days each week. -Refusal of care would have been documented. *CNAs required additional training to work as restorative nursing assistants. *Her minimum expectation would be that restorative therapy would be completed five days per week. Surveyor 42477 13. Review of the provider's 4/21/21 Restorative: Nursing Care Implementation and Screening-Rehab/Skilled Therapy & Rehab policy revealed: *"Residents are provided appropriate treatment and services to attain/maintain functional abilities in activities of daily living..." *"The goal of restorative nursing care is to attain and maintain the maximum possible independence and/or prevent rapid declines through their interventions for each resident." Review of the provider's 5/19/21 Restorative Nursing Documentation-Rehab/Skilled policy revealed: *"Physician's order is no longer required to implement or discharge from restorative nursing program..." *Restorative nursing programs were designed to maintain residents' independence and to avoid becoming dependent on caregivers. Review of the provider's Admission Handbook-Resident Handbook revealed restorative therapy was to be provided to all residents in order to help maintain their current	F 676		

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F 676	Continued From page 13 function level. B. Based on interview, record review, and policy review, the provider failed to ensure three of eighteen sampled residents (39, 41, and 83) received weekly bathing. Findings include: 1. Interview on 6/14/21 at 9:13 a.m. with resident 39 revealed he: -Was supposed to receive a bath two times per week. -That had not happened very often. *Sometimes had been "lucky" to get one bath per week. Review of resident 39's 6/15/21 care plan revealed he required an extensive assist of one person for bathing. Review of resident 39's bathing records revealed in thirty days he received three showers out of eight opportunities. 2. Review of resident 41's 5/12/21 through 6/12/21 bathing records revealed, she had received one bed bath in 30 days. Review of resident 41's 6/15/21 care plan revealed she required staff assistance of two people for bathing. Resident 41 was unable to be interviewed due to cognitive barriers. Surveyor 43844 3. Interview on 6/14/21 at 2:16 p.m. with resident 83 revealed he: *Had a shower once every two weeks. -Would have preferred a bath at least two times	F 676		

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F 676	Continued From page 14 per week. Review of resident 83's 5/15/21 through and 6/10/21 bathing records revealed he: *Had a shower scheduled for Friday of each week. *Had received one shower in four weeks. Surveyor 42477 Interview on 6/14/21 at 1:38 p.m. with CNA O revealed: *She worked as a bath aide/CNA. *Due to staffing, they were not always able to complete the resident's baths. Surveyor 43844 Interview on 6/15/21 at 4:38 p.m. with registered nurse (RN) I revealed: *The process when a resident had not received a scheduled bath would have been: -To re-assign the bath to the next shift to complete. -Any remaining baths not given would have been completed on the weekend. -She would have been notified if a bath had not been given by the end of the day. -She thought documentation had not been completed. Interview on 6/15/21 at 3:25 p.m. with DON D revealed her expectation would be that: *The nurse manager would have made arrangements for bathing to be 'caught up' on weekends. *Residents would have received at least one bath per week. *CNAs would have notified the nurse when a resident refused care.	F 676		

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F 676	Continued From page 15 Surveyor 42477 Review of the provider's 9/10/20 Bathing policy revealed: *The purpose was: -"To promote cleanliness and general hygiene." -"To stimulate circulation of the skin." -"To promote comfort, relaxation and well-being." -"To observe resident's condition." -"To assist resident with personal care." -"To promote safety for the resident in the bath." Surveyor: 43844	F 676		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure ongoing monitoring, assessments, resident education, and interventions were implemented for one of two sampled residents (83) who acquired an in-house pressure ulcer. Findings include:	F 686		

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F 686	Continued From page 16 1. Observation on 6/14/21 at 8:52 a.m. of resident 83 revealed he had: *Been sitting in his wheelchair in his room. *A pressure relieving boot on his right foot and a tennis shoe on his left foot with both feet placed on the wheelchair pedals. *A pressure relieving air mattress on his bed with another boot laying on that bed. *A mechanical lift sling laying on the second bed in the room. Observation and Interview on 6/14/21 at 1:49 p.m. with resident 83 revealed he: *Had been in bed. -Was laying on his back. -Had a pressure relieving boot on his right foot and a tennis shoe on his left foot. -Had a pillow underneath his knees. --Both knees were bent, and he was unable to straighten them. *Stated he: -Had a "boil, what I call my sores" from his wheelchair. -Had one on his heel and one on his buttock. -Wore a "padded boot" and thought his foot had a "wrapping" under the boot. -Had a sore "bottom" that hurt from sitting in his wheelchair ten to twelve hours each day. -Had pain in his right foot and it was "aggravating." -Had a towel between his knees at night due to knee problems. -Had not received any restorative exercises and he would have participated if he had been offered. -Thought the provider was "terribly understaffed, many people just don't come to work." -Thought his boil/sores were improving.	F 686	1.Resident 83 was screened by therapy department on 6-30-2021 for proper wheel chair positioning. 2.All residents that are wheelchair bound have been screened by the therapy department for proper wheelchair positioning to include foot pedal placement. Admission Nursing Checklist was updated to includethe following: -Therapy evaluation for wheelchair positioning to include foot pedal placement. -Ensure all pressure relieving interventions arein place related to the Braden Score. -Floor nurse to turn in checklist to nurse manager when completed. 3.DNS or Designee will audit that admission checklist is being completed, turned in to nurse manager and that appropriate interventions were put into place for all new admissions. Audit will be completed by DNS or designee weekly x4, monthly x3. DNS or designee will provide update to QAPI at monthly QAPI meeting.	7/13/21

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F 686	Continued From page 17 Review of resident 83's medical record revealed: *He had been admitted on 1/25/21. *His diagnoses had included: -Parkinson's disease. -Peripheral vascular disease, unspecified. -Bilateral primary osteoarthritis of knee. -Raynaud's syndrome without gangrene (a disorder that can cause decreased blood flow to areas of the body including the toes and knees). -Iron deficiency anemia, unspecified. -Unspecified protein-calorie malnutrition. -Other multiple and varied diagnosis. Review of resident 83's 1/29/21 Minimum Data Set (MDS) assessment revealed: *His Brief Interview for Mental Status (BIMS) assessment score was fifteen indicating his cognition was intact. *He: -Did not have a pressure ulcer or injury. -Had been at risk for developing pressure ulcers or injury. -Had used a pressure reducing device for chair and bed. -Had not been on a turning/repositioning program. -Required two staff members and extensive assistance to: --Turn in bed from one side to the other. --Position body while in bed. --Transfer to and from bed to chair or wheelchair. -Required one staff member and extensive assistance for personal hygiene. -Had impairment in his range of motion to both sides of his lower extremities. Review of resident 83's 1/25/21 nursing admission assessment revealed he:	F 686	4.Facility IDT meets every two weeks and reviews residents at high risk for pressure and those triggering for pressure. Information pulled from CareWatch. Review to ensure appropriate interventions are in place for those triggering. All staff have been educated by the Administrator and DNS on the above changes on 7/1/2021. All those unable to attend will be given information to review and sign off on. DNS will track all staff unable to make the in-service and make sure that they receive the education and submit quiz.	

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F 686	Continued From page 18 *Had no contractures to his lower extremities. -This was not correct per documentation by physical therapy. *Had no pressure ulcers. -Had a focus of the potential for pressure ulcer development related to his decreased mobility. -Had a goal of having intact skin, free from redness, blisters, or discoloration. -Did not have specific interventions to prevent pressure ulcers on this assessment. *Was not able to move up in his bed from a lying position on his own. *Required an assistive device or employee assistance to turn from side to side while in bed. *Was not able to move from a lying or reclining position to sitting on the edge of the bed on his own. *Required guided maneuvering of limbs by an assistive device or employee assistance. *Required a repositioning sling or device. *Was unable to bear weight on at least one leg. Review of resident 83's 1/26/21 physical therapy evaluation revealed he had: *Been unable to ambulate and transfer independently. *Significant lower extremity instability. *Bilateral knee contractures. Review of resident 83's 1/25/21 Braden Scale for Predicting Pressure Sore Risk assessment revealed he had a score of 17 which indicated a mild risk for developing pressure ulcers. Review of resident 83's 1/25/21 initial care plan revealed he had: *A focus of "The resident has potential for pressure ulcer development R/T [related to] decreased mobility."	F 686		

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F 686	Continued From page 19 *A goal of "Resident will have intact skin, free of redness, blisters or discoloration by/through review date." *Interventions of -"Monitor/remind/assist to turn/reposition at least every two hours." -"Pressure reducing mattress, cushion in w/c [wheelchair]." -"Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care." *A revision to this care plan was made on 5/18/21 to include an additional intervention of: -"Air mattress, Roho cushion in wheelchair." Review of resident 83's current care plan revealed: *Focus: -On 2/23/21 for a right heel pressure ulcer. -On 3/11/21 to include the right heel pressure ulcer and a right lower buttock pressure ulcer. *Goal: -Initiated on 2/23/21 of: "Resident's pressure ulcer will show signs of healing and remain free from infection by/through review date." -Initiated on 5/2/21 of: "Resident's pressure ulcer will show signs of healing and remain free from infection through review date." *Interventions included: -On 2/23/21: --"Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration, etc. noted during bath or daily care. --"Assess/record/monitor wound healing daily. Report improvements and declines to the health care provider. " --Heel boot to right foot when up in chair; bilateral boots on when in bed.	F 686		

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F 686	Continued From page 20 -On 3/11/21: --"Educate resident/family as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning." --Assist to turn/reposition at least every 2 hours. Prefers going from wheelchair to bed or recliner." --Inform resident/family of any new area of skin breakdown. *An intervention of "Transfer resident to (SPECIFY) bed/chair to rest (SPECIFY) after meals." had been removed. *On 4/21/21: -"Air mattress applied to bed, cushion to wheelchair or recliner." *Revised on 5/12/21 to: "Air mattress applied to bed, cushion to wheelchair and recliner. Currently trying a Roho cushion in his wheelchair." *Revised on 6/15/21 to: "Air mattress applied to bed, cushion to wheelchair and recliner. Roho cushion in his wheelchair." Review of resident 83's medical progress notes revealed: *On 2/4/21 a care plan review had been completed. -He had met goal of no pressure injury. -He had benefited from a repositioning schedule, pressure reducing mattress, and a cushion on his wheelchair. *On 2/6/21 he had complained of pain to his right foot. *On 2/20/21 at 3:30 a.m. a pressure ulcer measuring 6 centimeters (cm) by 3.5 cm was identified on his right heel. -It had looked black and had been blanchable, with pus oozing from it. *On 2/21/21 his daughter had been informed of	F 686		

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F 686	Continued From page 21 his right heel pressure ulcer. *On 2/23/21 a fax was sent to the physician requesting treatment for his right heel pressure ulcer, treatment orders were received. *On 3/11/21 his daughter had been informed of a wound to his bottom right buttock area. *On 4/8/21 a voice message was left "with his daughter to update that his bottom was not improving and that he needs to lay down in order to get his bottom healed. Resident was willing but was definitely not thrilled about the idea. Writer also updated that we will be changing the treatment as well and to call if she had any questions." *There had been no documented education regarding pressure injuries to resident 83 prior to 4/8/21. Review of Resident 83's medication administration record (MAR) from 1/26/21 through 2/26/21 revealed he: *Received 650 milligrams (mg) of Tylenol 8 hour tablet extended release 56 times. -Forty-nine times for unspecified pain. -On 2/11/21, 2/12/21 for right leg pain -On 2/12/21, 2/13/21, 2/24/21 for leg pain. -On 2/25/21 for right leg and heel pain. -On 2/26/21 for right heel pain. *On 2/15/21 he had a prescription order added for Tylenol extra strength 500 mg three times per day for pain and had received it 34 times from 2/15/21 through 2/26/21. Review of resident 83's 1/25/21 through 4/7/21 progress notes revealed there had been no documentation of him refusing to be repositioned. Review of resident 83's 2/19/21 skin assessment revealed he:	F 686		

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F 686	Continued From page 22 *Had a pressure sore on his right heel. -It measured 6 cm by 3.5 cm. -It was black, blanchable, sore to touch and had pus oozing from it. Review of resident 83's 2/21/21 wound assessment revealed he: *Had a pressure ulcer on his right heel: -It measured 5.5 cm x 3.5 cm. -It had red edges surrounded by black edges and had a slight foul odor. -There had been a presence of possible complications, including increasing area of ulceration, or soft tissue infection. *Had pain related to the wound and described it as tender. *Had a heel lift boot applied. Review of resident 83's 3/11/21 wound assessment revealed he: *Had a pressure ulcer to his right buttock. -It measured 3.5 cm x 3 cm. *Had pain related to the wound and described it as sore. *Had been repositioned to a recliner. Interview on 6/15/21 at 4:32 at p.m. with registered nurse I regarding resident 83 revealed: *His wounds had started on his right heel. *He had not been evaluated or assessed for positioning until after the pressure ulcer had been identified in February 2021. *She had been the person to assess him for positioning after the pressure ulcers developed. *His foot pedals on his wheelchair had not been positioned properly when he was up in his chair which pushed his legs upward, putting pressure on his heels, which caused the pressure ulcer. *Staff then noticed redness on his buttock several	F 686		

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F 686	Continued From page 23 days later. -It appeared to correlate to his right heel and how he had been repositioned to relieve pressure from his foot which caused more pressure to be put on his buttocks. *He would allow staff to reposition him but would not lay down. *He had been more compliant with lying down since they had educated him why it was important to offload for pressure relief. -Education provided to him had been documented on 4/8/21. Interview on 6/15/21 at 4:44 p.m. with certified nursing assistant (CNA) G regarding resident 83's wounds revealed: *She checked with the nurse for direction in caring for anyone with a pressure ulcer. *He wore a pressure relieving heel boot on his right foot due to a pressure ulcer. *He should have been repositioned once every two hours. Interview on 6/15/21 at 4:47 p.m. with CNA H regarding resident 83's wounds revealed: *She usually came to work after 4:00 p.m. *He was in bed when she came to work. -He laid down after lunch to relieve pressure from his bottom. *When he was in bed there was a pillow under his heels and pressure relieving boots on both feet. *He got up at 5:30 p.m. for supper and went to bed at 9:00 p.m. *His wound dressings were changed at 9:30 p.m. each night. Interview on 6/16/21 at 7:04 a.m. with director of nursing D regarding resident 83 revealed she was not sure if a wheelchair positioning assessment	F 686		

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F 686	Continued From page 24	F 686		

had been completed, "as he had contractures when admitted." She stated she would provide the assessments if she found them. There were no wheelchair positioning assessments provided.

Interview on 6/16/21 at 8:52 a.m. with administrator E regarding resident 83's pressure ulcers revealed:
*They could have benefited from a wound nurse.
-Had two applicants for the wound nurse position.
*The resident was cognitive and staff would not have known he had pain in his heel unless he informed them of his pain with his positioning.

Review of provider's 2/10/21 Pressure Ulcers policy revealed:
*"Purpose: to provide appropriate assessment and prevention of pressure ulcers, as well as treatment when necessary."
*Policy:
-"Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable."
-"A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing."
-"Residents will receive appropriate assessments and services to promote and maintain skin integrity. If a resident's clinical condition makes compromise of skin integrity clinically unavoidable, this information will be documented in the medical record."

Review of provider's 4/21/21 Skin Assessment

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F 686	Continued From page 25 Pressure Ulcer Prevention and Documentation policy revealed: *Purpose: -"To systematically assess residents with regard to risk of skin breakdown." -"To accurately document observations and assessments of residents." -"To appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers." *Procedure: -"1. All residents will be identified for their risk of developing pressure ulcers on admission/readmission by a registered nurse using the Braden Scale for Predicting Pressure Sore Risk UDA [User-Defined Assessment]. Those residents determined to be at risk will have the Braden Scale completed weekly for the first four weeks following admission." "6. Residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk Data Collection Tool UDA, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, incontinence, diagnoses, mobility and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation UDA is a required tool that is used to determine an individualized repositioning schedule. The positioning schedule should be communicated to the nursing assistants using the Kardex in PCC-POC. Any resident at risk will be placed on a pressure redistribution surface as determined appropriate." *"11. The interdisciplinary teams should determine any modifications that are necessary to	F 686		

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

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F 686	Continued From page 26 the resident's plan of care. Interventions should focus on physical, mental and psychosocial aspects that may be impacted. Treatments and interventions should be consistent with the resident's goals. Education should be provided to the resident and or family."	F 686		7/13/21
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755	1.All medications requiring destruction in facility will be destroyed by the DNS/ designee by 7/8/2021. E Kits with expired medications will be replaced by Pharmacy by 7/13/2021 and monthly thereafter. Locks were changed to tag lock system by nurse (K)on 6/15/2021. On 6/17/2021: E-kits sign out/lock change sheets were replaced at each E-kits by DNS. The nurse on the floor will send in medications for destruction to to pharmacy rather than in facility. 2.Process put into place to send medications back to pharmacy for destruction weekly. 3.DNS or designee will audit that E-Kit and sign out sheets are being used appropriately, that medications are sent back to the pharmacy on a weekly basis and that pharmacy will change out E-Kits on a monthly basis. Audit will be completed by DNS or designee weekly x4, monthly x3. DNS or designee will provide update to QAPI at monthly QAPI meeting.	

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F 755	Continued From page 27 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Surveyor: 32332 Based on observation, interview, record review, and policy review, the provider failed to have a system to ensure: *Accountability and security for three of four emergency medication kits (E-kits) (200, 400, and rehabilitation [rehab] unit kits). *E-kits had been reviewed monthly for missing medications and outdated medications. *Medications awaiting destruction were secured and accounted for in two of four medication rooms (200 and rehab units). Findings include: 1. Observation and interview on 6/16/21 at 8:30 a.m. of the rehab medication room with registered nurse (RN) nursing supervisor K revealed: *The E-kit was secured with a numbered breakaway lock. -The lock number was 6215585. *There was no medication list outside the E-kit to indicate what medications were available for use. *A medication list was found inside the E-kit. That medication list: -Had been signed by a pharmacist on 5/6/21. -Indicated the lock number was 5674227. --There was no date or signature on the medication list to indicate when and who placed the lock on the box. Review of the contents of the above E-kit during a medication count with RN nursing supervisor K revealed the kit should have contained:	F 755	4.Targeting information specific for nurses on E-Kit policy and procedure as well as medication return and destruction procedure given to Nurses on 7/1/2021 by DNS/designee. All staff have been educated on 7/1/2021 by the Administrator and DNS. All those unable to attend will be given information to review and sign off on. DNS will track all staff unable to make the in-service and make sure that they receive the education and submit quiz.	

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F 755	Continued From page 28 *Six tablets of warfarin 1 milligram (mg). -Only five tablets were present. *Six tablets of warfarin 2.5 mg. -Only five tablets were present. *Two injections of glucagon 1 mg. -Only one injection was present. *Twelve capsules of Keflex. -Only eight capsules were present. Continued review of the refrigerator in the rehab medication room and continued interview with RN nursing supervisor K during the above rehab unit medication room revealed a locked E-kit box containing one pharmacy medication bottle. *She stated: -There was only lorazepam in the refrigerator E-kit. -The nurses counted the lorazepam every shift and signed off on it. *The breakaway lock number was 6215203. *Review of the contents in the refrigerator E-kit revealed: -The pharmacy medication bottle: -Indicated the bottle had been sent from the pharmacy on 10/29/19. -Indicated there should have two vials of lorazepam 2 mg per milliliter (ml). -The bottle contained only one vial of lorazepam. -That vial had expired on 1/21/21. Review of the refrigerator E-kit sign out/count sheet revealed: *The medication had been verified each shift with the on-coming and out-going nurse that the lorazepam had been present. *Each time the nurses counted the medication they documented: -Their names. -The date and time.	F 755		

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F 755	Continued From page 29 -The lock number. *Other areas on that record that had not been filled out included: -The name and dose of the medication they were counting. -The amount on hand. -The amount removed from the E-kit. -The name of the resident the medication was removed for. Further review of the refrigerator E-kit revealed: *On 5/24/21 at 6:00 p.m. the out-going nurse signed the form and indicated the lock number was 5674124. -The on-coming nurse had not signed the form at that time. *On 5/25/21 at 6:00 a.m. the outgoing nurse and the on-coming nurse signed the form indicating the lock number was 6215203. Continued interview with RN nursing supervisor K regarding the missing medications in the rehab E-kit and the rehab refrigerator E-kit, and the expired lorazepam revealed: *The E-kit content list should have been placed on the outside of the E-kit to allow nurses to identify what emergency medications were available. *When a medication was removed from the E-kits the nurse was supposed to have filled out an Emergency Kit Replacement Slip. The slip should have indicated the: -Resident's name. -Drug name, strength, directions, quantity removed, prescriber, and the signature of the nurse removing the medication. -Breakaway tag number removed. -New breakaway tag number placed. *She was unable to locate E-kit replacement slips	F 755		

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F 755	Continued From page 30 for the above missing medications. *The pharmacist was to have replaced the E-kits monthly and monitored for outdated medications but she had not been in the building during the pandemic. *RN nursing supervisor K did not know who was to have been monitoring the E-kits and medication rooms for problems while the pharmacist remained out of the facility. Further review of the 6/16/21 at 8:30 a.m. rehab medication room and interview with RN nursing supervisor K revealed: *An unlocked cupboard containing a large, overflowing container of multiple residents' non-narcotic medications awaiting destruction. -Those medications had nothing attached to the medication to identify the amount of doses of each medication placed in the cupboard. *Multiple bags of non-narcotic medications that had belonged to residents who brought them in with them at the time of their admission. -Those medications had no documentation attached to them to indicate the amount of doses of each medication placed in the cupboard. Continued interview with RN nursing supervisor K at the above time regarding the above medications with no system of accounting revealed: *The expectation for the nurses was to destroy the medications awaiting destruction in their down-time. -There was no system for getting the destruction done in a timely manner. *The medications brought in by residents were supposed to have been sent home with family members that the time of admission.	F 755		

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F 755	Continued From page 31 2. Observation and interview on 6/16/21 at 10:00 a.m. of the 200 medication room with RN J revealed: *The E-kit was secured with a numbered breakaway lock. -The lock number was 5661372. *The medication list had been located outside the E-kit and had identified: -The pharmacist had signed the E-kit form on 5/18/21. -The breakaway lock number was 5674096. -The breakaway lock had been changed to 5661372. -There was no date or signature on the medication list to indicate: --When and who placed the lock on the box. --When and who placed a new breakaway lock on the box. Review of the contents of the 200 E-kit and interview with RN J at the above time revealed the E-kit should have contained: *One dose of epinephrine 1 mg per ml. -No epinephrine was located. *Four doses of Narcan 0.4 mg. -No Narcan was located. Continued interview on 6/16/21 at 10:00 a.m. with RN J revealed: *The night nurse told her the new lock had been placed on the E-kit. *She thought the night nurse had used the E-kit to remove antibiotics but: -There was no indication antibiotics had been removed. -There was no documentation to indicate the nurse had used an Emergency Kit Replacement Slip.	F 755		

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F 755	Continued From page 32 Further review on 6/16/21 at 10:00 a.m. of the 200 medication room with RN J revealed: *A large container of non-narcotic medications awaiting destruction sitting on an open shelf beside the door. -Those medications had no documentation attached to identify the amount of doses of each medication placed on the shelf. *Multiple bags of non-narcotic medications that had belonged to residents who brought them to the facility at the time of their admission. -Those medications had: --Dates on the bags as early as February 2021. --No documentation attached to them to indicate the amount of doses of each medication when they were placed in an unlocked filing cabinet. Interview with RN J regarding the excess medications up for destruction and extra medications in the filing cabinet revealed: *The nurses did not have extra time to destroy the medications. *The medications in the filing cabinet should have been sent home with family or destroyed after getting permission from the resident or family. Surveyor 29354 3. Observation and interview on 6/16/21 at 10:22 a.m. in the 400 wing medication room with licensed practical nurse (LPN) Q regarding the E-kit revealed: *The E-kit was secured with a numbered breakaway lock. -The lock number was 5659150. *The medication list was folded up and stored in an outside pocket on the E-kit. -The list of medications included the brand, strength, route, quantity, and expiration date. -At the bottom of that list was the date 2/16/21	F 755		

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F 755	Continued From page 33 with tag number 6217169 and changed with tag number 5659150. --There was no date listed when it had been changed or who had changed it. *LPN Q: -Was unsure when the numbered breakaway lock had been changed. -Confirmed they had used a pad lock on the E-kits prior to the blue breakaway locks. -Removed the breakaway lock from the E-kit. Review of the medications inside the E-kit revealed: *There were several expired medications. *There was Naloxone carpujet listed as having a quantity of four. -There were none in the E-kit. *LPN Q confirmed the above. Surveyor 32332 4. Phone interview on 6/16/21 at 10:30 a.m. with pharmacist R regarding missing medications and accountability in the E-kits revealed: *The pharmacy had a new chief. *The pharmacists had not been coming into the facility since the pandemic began. *The E-kits were sent out by the provider to the pharmacist to refill in the pharmacy. *If there were missing non-narcotic medications in the E-kits the pharmacy did not address the missing medications. They would send a bill to the facility. *She was not sure who was responsible for reviewing the medication rooms and carts during the pandemic. *The date listed on the outside medication list on the E-kits was when they had been checked by the pharmacy and not when they had delivered the E-kits to the facility.	F 755		

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F 755	Continued From page 34 *When the nurse opened the E-kit they were to update the breakaway lock by documenting it. *The E-kits were delivered to the facility by a "driver." *She was not sure of what wing the E-kits went to when they were brought into the building. *She thought the provider was better at swapping out the E-kits periodically. 5. Interview on 6/16/21 at 11:00 a.m. with director of nursing (DON) D regarding the E-kits and medications up for destruction or return to family members confirmed: *There was a lack of accountability in the E-kits, extra medications up for destruction, and those medications that were to have been returned to family members to take home. *The rehab unit had been using the breakaway locks on their E-kit for several months. *The other unit E-kits had just started using the breakaway locks this week. *The pharmacists had not been coming into the building during the pandemic. *The provider had not made anyone responsible for monitoring the E-kits for security and accountability of medications during the pandemic. *She was not aware the pharmacist had not notified the facility for non-narcotic missing medications form the E-kits. *The pharmacists should have been monitoring the expiration dates on the E-kit medications. *They changed out the E-kits monthly. *The pharmacists began coming back into the building on 5/1/21. *They had not had the nurses monitoring the E-kits. *They had used pad locks on the E-kits until 6/15/21, then they started using the breakaway	F 755		

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F 755	Continued From page 35 locks. *They had changed to a new pharmacy in January 2021. On 6/16/21 at 12:00 p.m. DON D: *Notified the survey team that the lorazepam vial that had been missing from the rehab medication refrigerator E-kit had been located. -The lorazepam had been removed from the refrigerator for resident 381 by LPN S at the request of resident 381's hospice nurse to have it available for her. -The lorazepam had not been used and had been placed in the medication cart to have it available. *Confirmed the lorazepam: -Had not been signed out of the E-kit. -Should have been documented as removed from the E-kit and identified who it had been removed for. -Should not have been stored in the medication cart. Review of the provider's December 2020 Medications: Acquisition Receiving Dispensing and Storage policy revealed: *Medications were to have been stored in a locked medication cart, drawer, or cupboard. *All medications brought into the location the resident or family members are used only on written order by the physician. All other medications were to be removed from the location and returned to the family. *Emergency medication kits - "To be determined by facility, consultant pharmacist and medical director." *"The emergency kit must be tracked by the facility and communicated per emergency kit form to the pharmacy." *Services provided by the consultant pharmacist	F 755		

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F 755	Continued From page 36 had included: -Quarterly medication cart audits. -Quarterly medication room audits. Review of the provider's October 2020 Emergency Drug Boxes policy revealed: *The purpose was to ensure a system was in place for use of the emergency drug box. *When a drug was used from the box, the pharmacist would be notified according to state specific regulation. *A list of emergency medications including the amounts dosages/strengths would be posted on the outside of the box. *The pharmacist was responsible for monitoring expiration dates. *Record keeping would be in accordance with the pharmacy system. Review of the 10/10/19 pharmacy consulting agreement revealed the consultant pharmacist: *Was to provide consultation on all aspects of the provision of consultant services in the facility. *Would establish a system of records of receipt and disposition of all controlled drugs to enable an accurate reconciliation including drug destruction once monthly. *Determined that drug records are in order an that an account of all controlled drugs was maintained and reconciled quarterly. *Provide: -Quarterly medication cart audit. -Quarterly medication room audit. -Monthly medication pass/observation/quality assurance activities.	F 755		

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

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E 000	Initial Comments Surveyor: 29354 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities, was conducted from 6/13/21 through 6/16/21. Good Samaritan Society Sioux Falls Village was found in compliance.	E 000		

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

Jason Hanssen | Administrator | 7-2-2021

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/14/21. Good Samaritan Society Sioux Falls Village was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 6/16/21. Please mark an F in the completion date column for K252 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 K223, K225, K325, K345, K351, K374 and K761 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect	K 223		

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

Jason Hanssen | Administrator | 7/2/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING **01 - SIOUX FALLS GOOD SAMARITAN VILLAGE** B. WING _____	**06/14/2021**

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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K 223	Continued From page 1 smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain the required self closing devices for three randomly observed hazardous areas (storage room labeled as women's locker room, wheelchair storage room, and soiled laundry room) as required. Findings include: 1. Observation on 6/14/21 at 8:30 a.m. revealed the room labeled as women's locker room, but used solely for storage was over 100 square feet and was used for combustible storage. The corridor door from that room was left open, and did not have an automatic closer. 2. Observation on 6/14/21 at 8:35 a.m. revealed the room labeled as wheelchair storage room, was over 100 square feet and was used for general storage. The corridor door from that room was left open, and did not have an automatic closer. 3. Observation on 6/14/21 at 10:15 a.m. revealed the soiled laundry storage room, was over 100 square feet. The corridor door from that room was left open, had an automatic closer but the door did not latch. Interview with the maintenance supervisor at the time of each observation confirmed these findings.	K 223	1.The womens locker room, wheelchair storage room, and the soiled laundry room will all have door closures placed and operable by 9-1-2021 2.All other applicable doors will be assessed for closure devices by 7/13/21 by the Environmental Services Director. 3.Environmental Services Director or designee will audit 4 random doors weekly x 4, Monthly x3 and report findings at monthly QAPI meetings. 4.All staff have been educated on the above information on 7/1/2021. All those unable to attend will be given information to review and sign off on.	9/1/21

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K 223	Continued From page 2 The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of that smoke compartment.	K 223		
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain conforming exit stairs (basement second exit) in one of two required stair exits. Items were stored in the stair enclosure. An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit. Findings include: 1. Observation on 6/14/21 at 9:15 a.m. revealed two banquet tables used as a makeshift ramp were stored on the stairway. Observation also revealed that the ramp had delivered a pallet load of 40 pound salt bags down to the basement level. In order to access the stair, climbing over the salt bags was required. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated that he was unaware any of the items were in the stairwell.	K 225	1.The exit stairs in the basement have been cleared of any blockage and signs have been posted to "not block exit". 2.All exit doors have been checked for blockage by the Environmental Services Director/designee. 3.Environmental Services Director or designee will audit all exit doors weekly x 4, Monthly x3 and report findings at monthly QAPI meetings. 4.All staff have been educated on the above information on 7/1/2021. All those unable to attend will be given information to review and sign off on.	7/13/21

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K 225	Continued From page 3 The deficiency affected one of two stair enclosures.	K 225		
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: Surveyor: 40506 Based on observation and record review, the provider failed to maintain two conforming exits from the basement. Findings include: 1. Observation at on 6/14/21 at 9:15 a.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 K000.	K 252		F
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101	K 325		

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K 325	Continued From page 4 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to properly limit quantity of alcohol based hand rub (ABHR) refills in one randomly observed room (600 wing storage room). Findings include: 1. Observation on 6/14/21 at 2:00 p.m. revealed the 600 wing storage room had 77 containers (mixture of quart and liter containers) of ABHR stored. Requirements for quantities are found in the Life Safety Code, as well as the Flammable	K 325	1.The alcohol-based hand rub has been moved to alternate locations around the facility to maintain compliance of less than 10 gallons in one space. 2.All other storage rooms have been audited to insure they do not exceed 10 gallons of alcohol-based hand rub. 3.Environmental Services Director or designee will audit all storage rooms weekly x 4, Monthly x3 and will report findings at monthly QAPI meetings. 4.All staff have been educated on the above information on 7/1/2021. All those unable to attend will be given information to review and sign off on.	7/13/21

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

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K 325	Continued From page 5 Liquids Code. Ten gallons is the maximum quantity allowed. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for ABHR use and could affect 100 percent of the occupants of the smoke zone.	K 325		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the facility failed to test and provide the correct data for the fire alarm system as required. Findings include: 1. On 6/14/21 at 8:35 a.m. device test results as examined (alarm initiating, supervisory alarm initiating, and notification) did not provide an itemized list with the following information, device type, address, location, and test result as required. The Maintenance Director was present when the	K 345	1.Fire detection vendor was on-site on 7/1/21. They installed parts to fix our current system. We received a list from our supplier on 7-6-2021 to provide sensitivity readings per device. 2.Fire detection system has been updated with the sensitivity reading capabilities and we will receive sensitivity reading per device. 3.Environmental Services Director or designee will report sensitivity readings to the monthly QAPI meetings when they are completed bi-annually. 4.All staff have been educated on the above information on 7/1/2021. All those unable to attend will be given information to review and sign off on.	7/13/21

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K 345	Continued From page 6 deficiency was identified. The fire alarm testing was discussed, and data requirements were acknowledged. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous tests affecting the building.	K 345		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the facility failed to continuously maintain automatic sprinklers in a reliable operating condition in five areas (food storage room, main dining area,	K 351	1. The ceiling tiles in question will be replaced by 7/13/2021 2.All areas of the facility have been checked for missing or damaged ceiling tiles. 3.Environmental Services Director or designee will audit 2 random areas of the facility weekly x 4, monthly x3 and report findings at monthly QAPI meetings. 4.All staff have been educated on the above information on 7/1/2021. All those unable to attend will be given information to review and sign off on.	7/13/21

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K 351	Continued From page 7 basement storage area across from maintenance director office, men's locker area, and women's locker area). Findings include: 1. Observation on 6/14/21 at 8:30 a.m. revealed the kitchen storage room had a tile that was damaged and incomplete. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained. 2. Observation on 6/14/21 at 8:50 a.m. revealed the main dining room had two tiles that were incomplete. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained. 3. Observation on 6/14/21 at 8:55 a.m. revealed the storage room across from the abandoned office previously occupied by the maintenance director had many missing ceiling tiles. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained. 4. Observation on 6/14/21 at 8:57 a.m. revealed the men's locker room had many missing ceiling tiles. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained.	K 351		

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K 351	Continued From page 8 5. Observation on 6/14/21 at 8:59 a.m. revealed the women's locker room had many missing ceiling tiles. The ceiling is a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such, the ceiling tiles are required to be maintained. The maintenance director was present when the deficiencies were observed, and acknowledged them. Failure to continuously maintain automatic sprinklers as required increases the risk of death or injury due to fire. These deficiencies have the possibility of affecting 100 percent of the occupants of the smoke compartment.	K 351		
K 374 SS=C	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 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: Surveyor: 40506 Based on observation and interview, the provider failed to maintain a corridor separation between	K 374	1.The smoke barrier doors on 300 wing to 500 wing and 500 wing to east of 500 wing will be fixed by 7-13-2021 2.All smoke barrier doors will be checked to insure proper closure and protection. 3.Environmental Services Director or designee will audit 5 random smoke barrier doors within the facility weekly x 4, monthly x3 and report findings at monthly QAPI meetings. 4.All staff have been educated on the above information on 7/1/2021. All those unable to attend will be given information to review and sign off on.	7/13/21

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K 374	Continued From page 9 smoke zones of two randomly observed corridor smoke separations (300 wing to 500 wing and 500 wing to wing east of 500 wing) in two of seven smoke compartments. Findings include: 1. Observation on 6/14/21 at 9:30 a.m. revealed the cross corridor smoke door separating the 300 wing from the 500 wing did not fully close and provide the required smoke barrier. 2. Observation on 6/14/21 at 9:38 a.m. revealed the cross corridor smoke door separating the 500 wing from the wing immediately east did not fully close and provide the required smoke barrier. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency affected two smoke compartment locations required to maintain corridor separation from use areas.	K 374		
K 761 SS=C	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC)	K 761		

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K 761	Continued From page 10 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation, interview, and record review the provider failed to properly maintain, inspect, and test randomly chosen doors (staff break room, 200 wing storage, 200 wing exit, 700 wing building separation door, gym cross-corridor) in the facility. Findings include: 1. Observation on 6/14/21 at 8:36 a.m. revealed the door to the staff break room adjacent to the kitchen could not close when released from it's magnetic hold open. 2. Observation on 6/14/21 at 9:25 a.m. revealed the door to the 200 wing storage room was obstructed from closing by the carpet transition strip. 3. Observation on 6/14/21 at 9:35 a.m. revealed the exterior exit door from the 200 wing was difficult to open because of the trasition rug leading outside. 4. Observation on 6/14/21 at 2:15 p.m. revealed the 90-minute cross-corridor fire doors at the 700 wing did not latch or prevent smoke transfer. 5. Observation on 6/14/21 at 2:17 p.m. revealed the 90-minute cross-corridor fire doors at the gym did not latch or prevent smoke transfer. Investigation on 6/14/21 at 3:10 p.m. with the maintenance director and using the facility computerized preventative maintenance system revealed that facility wide door preventative maintenance was last signed off on 6/4/21, and	K 761	1.The doors to the staff break room, 200 wing storage, 200 wing exit, 700 wing building separation door, and gym cross-corridor will be fixed by 9-1-2021. 2.All doors within the facility will be checked to insure that they close and latch properly. 3.Environmental Services Director or designee will audit 5 random doors in the facility weekly x 4, monthly x3 and report findings at monthly QAPI meetings. 4.All staff have been educated on the above information on 7/1/2021. All those unable to attend will be given information to review and sign off on.	9/1/21

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K 761	Continued From page 11 had been signed off nine of the previous twelve months. Interview with the maintenance director at the time of the observations confirmed those findings. The maintenance director commented that he was unsure why we found the issues. The deficiency affected the entire facility and as such had the possibility of affecting 100 percent of occupants.	K 761		

South Dakota Department of Health

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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 40506 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/13/21 through 6/16/21. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: S157 and S253.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in five randomly observed rooms (200 wing soiled utility, soiled laundry storage room, 600 wing soiled utility, 500 wing soiled utility, and 500 wing housekeeping/utility room). Findings include: 1. Observation on 6/14/21 at 9:40 a.m. revealed the exhaust ventilation for the 200 wing soiled utility was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Observation on 6/14/21 at 11:05 a.m. revealed the exhaust ventilation for the soiled laundry storage room was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Observation on 6/14/21 at 11:25 a.m. revealed	S 157	1.Vents on 200 wing soiled utility, soiled laundry storage room, 600 wing soiled utility, 500 wing soiled utility and 500 wing housekeeping/utility room have been assessed and will be corrected by 12/1/2021 by Copper Cottage. 2.All other vents in facility will be assessed by 7/13/2021 to insure they are working properly by Environmental Services Director or designee. 3.Environmental Services Director or designee will audit all vents weekly x 4, Monthly x3 and will provide update at monthly QAPI meeting. 4.All staff have been educated on the above changes on 7/1/2021. All those unable to attend will be given information to review and sign off on.	12/1/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason Hanssen — TITLE: Administrator — (X6) DATE: 7/2/2021

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 _____	06/16/2021

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 157	Continued From page 1 the exhaust ventilation for the 600 wing soiled utility was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Observation on 6/14/21 at 1:15 p.m. revealed the exhaust ventilation for the 500 wing soiled utility was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Observation on 6/14/21 at 1:20 p.m. revealed the exhaust ventilation for the 500 wing housekeeping/utility room was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Interview with the maintenance supervisor on 6/14/21 at the time of each observation confirmed the findings. He revealed he was unaware why the exhaust ventilation was not working at each location.	S 157		
S 253	44:73:04:14 Memory Care Units Each facility with memory care units shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming shall be provided and shall be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff;	S 253	1.Residents 9, 25, 26, and 379 now have orders to reside on SCU. 2.All other residents on SCU were audited and now have orders to reside on SCU. Admission checklist has been updated to indicate physician orders before admission on SCU. 3.Social Services Director or designee will audit all residents residing on the SCU weekly x 4, Monthly x3 to insure that they have orders in their chart. All audit findings will be reported at monthly QAPI meeting. 4.All staff have been educated on the above changes on 7/1/2021. All those unable to attend will be given information to review and sign off on.	7/13/21

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S 253	Continued From page 2 (4) Confinement and its necessity shall be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement shall be communicated to the resident's family; (5) Locked doors shall conform to Sections: 18.2.2.2 and 19.2.2.2 of NFPA 101 Life Safety Code, 2012 edition; and (6) Staff assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver shall be on duty on the memory care unit at all times. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on observation, record review, interview, and policy review, the provider failed to ensure four of four sampled residents (9, 25, 26, and 379) residing in the provider's Special Care Unit (SCU) had physicians' orders for placement in the secured unit. Findings include: 1. Random observation on 6/14/21 revealed residents 9, 25, 26, and 379 resided in the SCU. Review of resident 9, 25, 26, and 379's medical records revealed no physician's orders for placement in the SCU including medical justification for placement. Interview on 6/15/21 at 11:08 a.m. with supervisor of social services C regarding admissions to the SCU confirmed "We have to get an order for admission to our Special Care Unit." Interview on 6/16/21 at 8:39 a.m. with director of nursing D confirmed her expectation would be for residents to have a physician's order to be on a	S 253		

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S 253	Continued From page 3 secure unit, appropriate behaviors (i.e. safety concerns, wandering/exit seeking) warranting placement, and family consent. Review of the provider's 8/31/20 Admission Criteria-Special Care Unit policy revealed no statement regarding the need for a physician's order for placement that include medical symptoms that warrant placement on the SCU or the need for physician order to be reviewed periodically by the physician, physician assistant, or nurse practitioner.	S 253		
S 000	Compliance/Noncompliance Statement Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/13/21 through 6/16/21. Good Samaritan Society Sioux Falls Village was found in compliance.	S 000		

South Dakota Department of Health

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jason Hanssen

TITLE: Administrator

(X6) DATE: 7/2/2021

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
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S 253	44:73:04:14 Memory Care Units Each facility with memory care units shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming shall be provided and shall be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff;	S 253		

South Dakota Department of Health

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