STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING _____ B. WING _____	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY TYNDALL	2304 LAUREL STREET TYNDALL, SD 57066

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/21/25 through 1/24/25. Good Samaritan Society Tyndall was found not in compliance with the following requirements: F657, F689, F760, and F880.	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 assessments.	F 657	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is r equired by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Schenkel	Administrator	2-20-25

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

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F 657	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the provider failed to revise and update a care plan for one of fifteen sampled residents (22) to reflect her care needs for supervision while using the bathroom. Findings include: 1. Observation and interview on 1/22/25 at 9:06 a.m. of resident 22 while seated in her wheelchair in her room revealed: *Her right eye and cheek were bruised from the eyelid to an inch below her eye. *Her forehead was bruised from her eyebrow into her hairline. *She had what appeared to be a lump or area of swelling just below her hairline. -The lump was approximately one inch by one inch. *She said she had fallen on her head. *She thought she had fallen from her bed when reaching for something on the floor. *She said she was embarrassed by the bruising to her face. *Her makeup was not covering the bruising as much as she would have liked. 2. Refer to the fourth and sixth paragraphs in F689 finding 2 for information related to her history of unhooking the lift sling straps and her fall on 1/17/25. 3. Review of resident 22's current care plan revealed: *Her care plan did not include if staff were required to stay with her while she used the bathroom. *There was no documentation regarding need for supervision while toileting.	F 657	1. The care plan for resident #22 has been updated on 1/23/25 to state, "do not leave resident unattended on toilet when using the lift as resident has history of removing straps." 2. Residents using mechanical lift in the bathroom were reviewed for safety with lift straps. One other resident with similar actions of attempting to get up while supported by the mechanical lift in the bathroom was identified and has also been care planned to be monitored while using the toilet. 3. Assessing the resident's safety awareness by using the Falls Tool UDA (assessment) to identify risk factors. These assessments will be completed on admission, readmission, quarterly and with significant change in condition. Findings on the assessments will guide care plan interventions. All staff were educated on care plans and where to find updates at all staff inservice on 2-6-25 lead by the Administrator. 4. The DON/Designee will audit 4 toileting opportunities/week for 4 weeks, 2x/week for 3 months to assure appropriate resident monitoring is occurring. All audits will be taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	2-20-25

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F 657	Continued From page 2 *It was noted that she had impaired cognitive function or impaired thought process relating to her diagnoses of multiple sclerosis, Alzheimer's disease, dementia, and other cognitive deficits. *Intervention for toilet use and transfers revealed: -She required two staff for toilet use. -She required the total body lift to transfer between surfaces, with the assist of two staff. *Her care plan was last revised on 1/20/24 and included that she was at risk for falls related to: Heart failure, Multiple sclerosis, Alzheimer's disease, Dementia, history of falls, poor safety awareness, and a history of removing the lift sling straps from the lift. 4. Interview on 1/24/25 at 10:02 a.m. with clinical care leader C revealed that: *As a result of resident 22's fall on 1/17/25, she expected staff to supervise the resident while she was using the bathroom. *She confirmed that resident 22's care plan had not been updated to reflect that change. *When asked how nursing staff were supposed to know which residents required supervision in the bathroom, she said that "there are a certain few that they [the staff] know they [the resident] will stay upright, they [the staff] know the ones [the residents] who they [the staff] can leave alone, and those [residents] who cannot." *CNAs learned of updated residents care information by: -Verbal communication between staff. -The "wing binder," which included the daily nursing huddle report sheet and other relevant care notes for CNA use. -The bulletin board in the employee break room. -The resident's care plan/Kardex (a brief overview of the resident that was generated directly from care plan). However, she stated that the CNAs	F 657		

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F 657	Continued From page 3 "don't really use the Kardex." *Care plans were updated by nurses, the MDS coordinator, and herself. 5. Interview on 1/24/25 at 10:28 a.m. with DON B revealed: *Staff would be educated that residents can be left connected to the total body lift while toileting with the tension removed to ensure they were not suspended. -Staff would need to know if the resident was cognitive to be left alone in the bathroom. *Information would be available on the Kardex, which came directly from the care plan. -Nursing staff, including CNAs, have access to the Kardex. 6. Review of the provider's 7/29/24 Fall Prevention and Management policy revealed: *"Purpose -To promote resident well-being by developing and implementing a fall prevention and management program. -To identify risk factors and implement interventions before a fall occurs. -To give prompt treatment after a fall occurs. -To provide guidance for documentation." *"Proactive Approach before a Fall Occurs (e.g., New Admit) Procedure -1. On admission or readmission, review the applicable documents (i.e., discharge summary from transferring agency, transfer record, history and physical, lab values, nursing admit/readmit data collection) and any additional admit information documentation for fall risk factors. -2. Complete the Falls Tool UDA [user-defined assessment] for fall screening and identifying fall risk factors. -3. Care Plan the appropriate interventions,	F 657		

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F 657	Continued From page 4 including personalizing all '(SPECIFY)' areas. -4. Communicate fall risks and interventions to prevent a fall before it occurs per the 24-Hour Report, care plan and Kardex, daily stand-up meeting, and/or Fall Committee meetings.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to identify and implement interventions to prevent falls for two of two sampled residents (22 and 55) who fell and sustained injuries. Findings include: 1. Observation and interview on 1/22/25 at 9:16 a.m. with resident 55 while in the 200-hallway revealed: *She had a large bruise around her left eye. -The bruise was above her eyebrow and extended to her cheekbone. -The bruise was brown with yellowing edges. *When asked about the bruise, she could not remember. Observation on 1/22/25 at 2:09 p.m. revealed that resident 55 was resting in bed with the bed in the lowest position to the floor. There was an air	F 689	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. In response to F689: 1. The care plan for resident #22 has been updated on 1/23/25 to state, "do not leave resident unattended on toilet when using the lift as resident has history of removing straps." The care plan for resident #55 includes closer room to nurses and nurses station, and resident participated in physical therapy. 2. Residents at risk or who have experienced falls will be reviewed by investigative team or clinical team and interventions put into place. There were 12 residents reviewed on 2-13-25 at Falls Committee meeting. All residents are evaluated with Falls Data Collection Tool upon admission, significant change, annually and after falls occur. This tool helps to identify interventions that are added to care plan.	2-20-25

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F 689	Continued From page 5 mattress overlay on the bed and a fall mat on the floor next to her bed. Review of resident 55's electronic medical record (EMR) revealed: *She admitted to the facility on 12/27/24 for rehabilitation after surgical repair from a previous fall with fractures at the assisted living facility where she previously resided. *She was hard of hearing and wore hearing aids in both ears. *Her 12/27/24 Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated she had moderate cognitive impairment. *Her 12/27/24 falls tool assessment indicated she was at medium risk for falls. No interventions were selected in the "Action Plan" section. *Her 12/27/24 nursing admit data collection tool indicated the following: -She was not able to ambulate independently. -Grab bars had been installed on her bed. -She had received education about the following: --"Resident orientated to room and call light use." --"Resident orientated to facility routines, activities, accommodations." --"Therapy evaluations." --"Meal times and routine." --"Immunizations." --"Safety and fall prevention." --Her impaired hearing was a barrier to education. --She had verbalized understanding. Review of her baseline care plan initiated on 12/27/24 in relation to falls, fall risks, and fall prevention revealed: *"Educate resident not to bend over to pick up dropped items. Encourage use of grabber or to ask for assistance." *"Ensure that Resident is wearing appropriate	F 689	Staff are educated on care plan updates through Kardex and shift report. 3. All staff were educated regarding falls prevention and safety on 2-6-25. Nurses had additional education on 2-7-25 on accident/hazard and implementing interventions immediately. Investigation team to review falls/incidents regularly through clinical meetings.at least 2 times per week. Falls committee will also review at monthly Falls Committee meeting. 4. Director of Nursing or designee will complete Falls Focus audit to ensure care plans reflect fall interventions and focus audit to ensure interventions are being followed 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	

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footwear when ambulating or mobilizing in wheelchair."
*The "Safe Resident Handling Program" (SRHP) intervention for ambulation safety was initiated on 12/30/24.
*"SRHP - TRANSFER - Transfer Between Surfaces: non-mechanical stand aide and 1 staff assist [assistance]."
*She required the assistance of one staff member for other activities like bed mobility, dressing, and personal hygiene.

Incident note 12/28/24: "At 0815 [8:15 a.m.], resident was found on the floor at the foot of her bed. Resident was alert. Yelling out, 'I want to go to bed.' Gripper socks were on. Call light was attached to grab bar on side of bed. w/c [wheelchair] was not within reach. No walker. When resident asked [what] happened or what she was trying to do she stated, 'I don't remember.' VS [vital signs] with neuro's taken. Laceration noted on forehead at the hairline. Moderate amount of bleeding. Total lift used to set resident in chair. Shower provided d/t [due to] bleeding on hands, hair and face. Laceration cleansed and dry telfa [Telfa, a brand of wound dressing] dressing applied. Ice offered, refused. 2cm [centimeters] superficial wound. Bruising noted across bridge of nose and on left hand. ROM [range of motion] was WNL [within normal limits]. Physician notified by fax and son contacted. Will care plan to put bed in lowest position at night with mat beside bed."
*She continued to have increased pain, potentially from her multiple healing fractures, head laceration, and bruising from the fall.

Interview on 1/24/25 at 10:42 a.m. with director of nursing (DON) B revealed:

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F 689	Continued From page 7 *After resident 55's fall, fall interventions were initiated that included having the bed in the lowest position while she was in bed and having a cushioned fall mat in place next to her bed. *The care team held a "fall huddle" to determine what could have contributed to the fall, and brainstormed new interventions to prevent further falls. *Surveyor requested documentation of fall prevention interventions that had been implemented for resident 55 prior to her fall. Interview on 1/24/25 at 11:11 a.m. with social worker D revealed: *If a resident had a fall, she and the care team would have filled out a "fall scene huddle worksheet" to determine the fall details and recreate the fall scene. *At the time of resident 55's fall on 12/28/24, she had a different bed than the one she had at the time of the survey. -Her initial bed had a grab bar attached to it. -Resident 55 had not been assessed for the safe use of a grab bar. -Someone was supposed to have switched out her bed at supper time on 12/27/24, but that had not happened. *She remembered that resident 55 may have been confused after she admitted because she was in a new facility, she was incontinent, and she most likely tried to get out of bed on her own or rolled out of bed which resulted in the fall. -At the time of resident 55's fall, the call light cord was wrapped around the grab bar. Review of the "Fall Scene Huddle Worksheet" completed on 12/28/24 after resident 55 fell revealed: *Resident 55 said, "I don't remember" when	F 689		

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F 689	Continued From page 8 asked what she was trying to do just before the fall. *The night staff was noted to have last interacted with her and assisted her to the toilet at 5:59 a.m. on 12/28/24. *Under item #4 for "Description of fall scene" -Resident 55 had not been wearing her glasses. -The bed was noted to be in a "high position." -She was wearing socks. -Her wheelchair was not near her bed. -In the "environmental" section it was noted that she was a new admit and the lighting was "inadequate." -She was incontinent of urine. *Under item #6 for "Prior to fall, resident seemed:" and "After fall, resident seemed:" the following items were checked for both: -She was alert and oriented to person and place only. -She was confused and forgetful. *The staff narrative under item #7 read, "Call light [was wrapped] around grab bar. She may not have been able to reach it. New [admit.] Confused. Remote under her bed, could've been trying to grab it." *Under item #10 for "Resident Injuries/ROM" (range of motion): -Her ROM was noted to have been within her normal limits. -She had a laceration to her head and bruising to her left hand and bridge of nose. *There was a handwritten note on the first page that read, "? Need to remove grab bar from bed. Not in [care plan] ..." Review of the handwritten list of fall prevention interventions that were implemented prior to the resident's fall on 12/28/24 provided by DON B on 1/24/25 at approximately 12:00 p.m. revealed:	F 689		

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F 689	Continued From page 9 *Staff provided call light education. *They monitored the resident every hour "for safety whereabouts." *Education was provided "not to bend over." *They provided "proper footwear education." -There was no documentation in her EMR that indicated the hourly safety checks had occurred. -There was documentation that indicated the provider had educated her about the call light, not to bend over, and proper footwear, however there was documentation that she was confused and moderately cognitively impaired at the time of admission. 2. Observation and interview on 1/22/25 at 9:06 a.m. of resident 22 while seated in her wheelchair in her room revealed: *Her right eye and cheek were bruised from the eyelid to an inch below her eye. *Her forehead was bruised from her eyebrow into her hairline. *She had what appeared to be a lump or area of swelling just below her hairline. -The lump was approximately one inch by one inch. *She said she had fallen on her head. *She thought she had fallen from her bed when reaching for something on the floor. Interview on 1/24/25 at 10:02 a.m. with clinical care leader C revealed: *Certified nursing assistants (CNAs) were trained that residents could have been left with the lift sling straps connected to lift equipment while using the toilet. -Some residents may have the lift sling straps loosened, and the lift equipment could have been left in front of them to supplement their upper body strength while they sat on the toilet.	F 689		

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F 689	Continued From page 10 *Resident 22 had poor torso strength due to her diagnosis of multiple sclerosis. -She could be left with the straps loosened but remaining attached to the lift. -It was not documented in the resident's care plan to leave her on the toilet with the lift equipment still attached and in the bathroom with her. -Her care plan did not include that she required staff supervision was required while she used the bathroom. *She expected CNAs to know which residents could have been left alone and which were not safe to have been left alone. -The default was that residents could have been left alone in the bathroom while still attached to the lift equipment until they saw reasons that they resident should not have been left alone. *Resident 22 was not required to have been supervised while on the toilet at the time of her fall on 1/17/25. *CNAs learned of updated residents care information by: -Verbal communication between staff. -The "wing binder," which included the daily nursing huddle report sheet and other relevant care notes for CNA use. -The bulletin board in the employee break room. -The resident's care plan/Kardex (a brief overview of the resident that was generated directly from care plan). However, she stated that the CNAs "don't really use the Kardex." *Care plans were updated by nurses, the MDS coordinator, and herself. Interview on 1/24/25 at 10:28 a.m. with DON B revealed: *Staff were educated that residents could be left connected to the total body lift while using the bathroom. The lift sling straps were loosened to	F 689		

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F 689	Continued From page 11	F 689		

ensure the resident was not suspended.
-Staff would need to know if the resident was cognitive to be left alone in the bathroom.
*Information would be available on the Kardex.
-Nursing staff including CNAs have access to the Kardex.

Review of resident 22's EMR progress notes revealed she had a history of unhooking the lift sling straps or threatening to unhook lift straps:
*A 4/4/24 social services note "Res [resident] unhooked lift strap on one occasion" when she was talking with her.
*A 4/5/24 nursing services note "removes sling from lift before staff can start to lift her."
*A 5/18/24 nursing services note "she was grabbing the loop and trying to take if off the hook" when staff were assisting her from the toilet with the total body lift.
*A 6/23/24 nursing services note "would attempt to unhook self and pull on [the] sling, making sling placement difficult. This could be a safety issue if behaviors continue."
*A 6/24/24 social services note "trying to remove straps from lift."
*A 7/15/24 nursing services note "needed redirection and distraction to keep her from attempting to unhook sling."
*A 7/22/24 social services note "res [resident] was removing straps to lift."
*A 7/23/24 nursing services note "Other observations: Agitation, Delusions. Impaired decision making. Safety concerns."
*An 8/25/24 note indicated the resident was put on the toilet, "when they returned she had unhooked the sling from the lift and had it off."
*A 9/4/24 care plan review note "Resident continues to think that she can walk so she tried to stand up and fell on the floor, Cna [CNA] found

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F 689	Continued From page 12	F 689		

her on the floor by her bed."
*A 9/25/24 nursing services note "Nurse notice CNA going in the room with stand aid [a lifting device for those who have difficulty rising from a seated to standing position], Nurse [went] running down the hall and stated that resident was a Hoyer lift [total body lift]. Resident tried to tell CNA to ignore her [the nurse] and do what she was going to do, nurse stated No, the CNA needs to know so she doesn't lose her license and or drop you because you do not stand."
*A 10/22/24 nursing services note regarding behaviors, "staff unable to safely transfer resident to toilet without the use of the lift."
*A 11/3/24 nursing note "she was trying to take the Hoyer sling off the Hoyer lift."

Review of resident 22's 1/9/25 BIMS assessment revealed a score of 8, which indicated she had moderate cognitive impairment.

Review of resident 22's EMR regarding her fall on 1/17/25 revealed:
*She was found on the floor of her bathroom by a CNA.
*The bar from the left side of the total body lift was removed.
*The rest of the straps were not hooked to the other bar of the lift.
*She had a large bump on the right side of her forehead, and she voiced discomfort.
*Neurological checks were initiated.
*Her physician was notified by fax on 1/17/25 at 3:29 p.m.
-A response from her physician was not found.
*The 1/17/25 falls tool assessment noted the following:
-She was receiving more than two "risk factor medications."

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F 689	Continued From page 13 -She "appeared moderately affected by one or more" of the following factors: anxiety, depression, decreased cooperation, decreased insight, or decreased judgment especially related to mobility. -Her cognition was mildly impaired. -The risk factor checklist and intervention plan noted cognitive status, poor memory, and difficulty following instructions. -She was observed using the equipment in an unsafe manner. Review of the provider's internal Fall Scene Huddle Worksheet regarding resident 22 revealed: *The incident date was 1/17/25 at 2:18 p.m. *She had an unwitnessed fall. -Under Equipment/Safety, the box under Assistive Device was checked "none." -Her time last toileted was reported as 2:10 p.m. and 2:15 p.m. *She had taken the following medications in the last eight hours: antidepressant, antipsychotic, and a blood thinner. *She unhooked the straps and bar of the total body lift. *She was experiencing pain with movement. *It was also marked that she had a head injury, and abrasion, skin discoloration with bruising, and swelling. -There was a handwritten note that stated, "right side hematoma." Review of resident 22's current care plan revealed: *It was noted that she had impaired cognitive function or impaired thought process relating to her diagnoses of multiple sclerosis, Alzheimer's disease, dementia, and other cognitive deficits.	F 689		

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F 689	Continued From page 14 *Intervention for toilet use and transfers revealed: -She required two staff for toilet use. -She required the total body lift to transfer between surfaces, with the assist of two staff. *Her care plan was last revised on 1/20/24 and included that she was at risk for falls related to: Heart failure, Multiple sclerosis, Alzheimer's disease, Dementia, history of falls, poor safety awareness, and a history of removing the lift sling straps from the lift. *Her care plan did not include if staff were required to stay with her while she used the bathroom. -There was no documentation regarding need for supervision while toileting. 3. Review of the provider's 7/29/24 Fall Prevention and Management policy revealed: *"Purpose -To promote resident well-being by developing and implementing a fall prevention and management program. -To identify risk factors and implement interventions before a fall occurs. -To give prompt treatment after a fall occurs. -To provide guidance for documentation." *"Proactive Approach before a Fall Occurs (e.g., New Admit) Procedure -1. On admission or readmission, review the applicable documents (i.e., discharge summary from transferring agency, transfer record, history and physical, lab values, nursing admit/readmit data collection) and any additional admit information documentation for fall risk factors. -2. Complete the Falls Tool UDA [user-defined assessment] for fall screening and identifying fall risk factors. -3. Care Plan the appropriate interventions, including personalizing all '(SPECIFY)' areas.	F 689		

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F 689	Continued From page 15 -4. Communicate fall risks and interventions to prevent a fall before it occurs per the 24-Hour Report, care plan and Kardex, daily stand-up meeting, and/or Fall Committee meetings.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure one of one sampled diabetic resident (33) was free from a potential insulin medication error. Findings include: 1. Observation on 1/23/25 from 9:31 a.m. to 9:47 a.m. with registered nurse (RN) G during medication administration revealed: *RN G was preparing resident 33's insulin pen. *Resident 33 was scheduled to receive 10 units of Admelog insulin and 40 units of Tresiba insulin. *RN G primed both pens and dialed each pen to the correct ordered dose. -He then walked over to licensed practical nurse (LPN) J to verify the correct dosage. LPN J verified that each insulin pen was dialed at the correct dose. *While the surveyor walked with RN G back to resident 33's room, the surveyor heard a noise that sounded like the insulin pen was clicking as if the dose was changed. *RN G brought the insulin pens to resident 33's room and set the pens down on resident 33's bedside table. *The Tresiba insulin pen was then observed to be	F 760	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. In response to F760: 1. Resident #33 did not receive the incorrect dose of insulin. The nurse was able to correct the insulin pen and administer the correct dose. 2. There are currently 4 other residents using insulin pens. All resident with insulin pens will receive a triple check with administering nurse preparing the insulin, a second nurse/CMA double checking the dose and then the administering nurse will check the dose again just before administration.	2-20-25

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F 760	Continued From page 16 dialed at 32 units instead of 40 units. *RN G lifted the resident's shirt and prepared an area on her abdomen to inject the Tresiba. -Just as RN G was about to administer the incorrect insulin dose, the surveyor stopped RN G and requested that he verify the units again. -RN G was surprised that the Tresiba insulin was at 32 units rather than 40 units. -He did not know how the insulin pen was dialed back to 32 as he had verified with LPN J that the pen was dialed to correct dosage. *Had the surveyor not intervened, resident 33 would have received the wrong dose of insulin. *RN G then dialed the Tresiba insulin pen up to 40 units and administered the insulin to resident 33. *After leaving resident 33's room, RN G again indicated that he did not know how the insulin pen was dialed back to 32 units rather than 40 units. 2. Interview on 1/23/25 at 12:53 p.m. with LPN J revealed: *The facility's policy was to have two licensed nurses verify a resident's insulin dosage prior to administering the insulin. *She confirmed that she verified resident 33's Tresiba insulin pen was dialed to 40 units when RN G showed it to her. *She did not know how the insulin pen was dialed back to 32 units in the time RN G walked to resident 33's room. *She would have considered that situation a medication error if RN G would not have noticed the insulin pen was at the incorrect dosage. -Had resident 33 received 32 units of insulin rather that 40 units, her blood sugar level may have been higher than normal due to the reduced amount of insulin administered.	F 760	3. Nurses were educated on insulin administration and the triple check method on 2-7-25. 4. Director of Nursing or designee will complete audits on insulin administration/medication administration 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	

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F 760	Continued From page 17 3. Interview on 1/23/25 at 1:13 p.m. with director of nursing (DON) B revealed: *She would have considered the above observation a medication error. *She said, "The resident would have been at risk." 4. Review of resident 33's electronic medical record revealed she had a physician's order for "Tresiba FlexTouch Subcutaneous Solution Pen injector 200 UNIT/ML [milliliter] (Insulin Degludec) Inject 40 [units] subcutaneously one time a day ..." 5. Review of the manufacturer's instructions for the Tresiba FlexTouch insulin pen revealed: *" ...3. Prime your pen: Turn the dose selector to 2 units, press and hold the dose button until the dose counter shows '0,' and ensure a drop of insulin appears." *"4. Select your dose: Turn the dose selector to the number of units you need to inject." 6. Review of the provider's 9/5/24 Medication: Insulin Administration, Insulin Pens, Insulin Pumps policy revealed: *"Insulin Pen ...Procedure - ...2. Verify provider order ... - ...11. Dial in the ordered dose on units."	F 760		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		

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F 880	Continued From page 18 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. In response to F880: 1. All non-mechanical lifts have been thoroughly cleaned as of 2-14-25. 2. Mechanical lifts are being cleaned routinely on each shift. 3. Administrator provided all staff education on the cleaning of non-mechanical lifts and all multi-use equipment on 2-6-25. Infection control practices including handwashing procedures and when to wash hands was also reviewed. Lift cleaning schedule will be established by 2-18-25 to ensure routine cleaning.	2-20-25

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F 880	Continued From page 19 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to follow infection prevention practices by not having ensured: *Shared resident lift equipment (at least six different stand aids) was maintained in a clean and sanitary manner per the manufacturer's recommendations. *One of one registered nurse (RN) (G) used a clean utensil to open a packet of powdered nutrition supplement and performed appropriate hand hygiene during an observed medication administration. Findings include: 1. Observation on 1/22/25 at 4:52 p.m. in the 100-hallway revealed: *There was a buildup of an unidentified brown	F 880	4. Director of Nursing or designee will complete audits on lift cleanliness and Hand hygiene 2 x week for 4 weeks, 1 x for 4 weeks, and 1 x monthly for 3 months with all audits taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	

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F 880	Continued From page 20 substance in the footwell of the non-motorized stand aid. The black anti-slip covering in the foot plate was loose and rolling upwards from the edges, that exposed more of an unidentified brown substance. *There were food crumbs and unidentified white flakes in the footwell of the motorized stand aid. The black anti-slip strips were torn and peeling away. Additional random observations throughout the survey from 1/21/25 through 1/24/25 revealed: *The stand aids in the 100-hallway remained in the same unclean condition. *Three non-motorized stand aids in the 200-hallway had an unidentified brownish-orange and black buildup in the border of the footwells. -The black anti-slip covering in one of those stand aids appeared to have been loose and stretched out, and exposed more buildup underneath. *One of the non-motorized stand aids in the 300-hallway had an unidentified brownish-orange and black buildup in the border of the footwells. Interview on 1/24/25 at 10:26 a.m. with activities director F revealed: *She was cleaning one of the non-motorized stand aids in the 300-hallway at the time of the interview. *To her knowledge, all shared resident lift equipment was cleaned with sanitizing wipes after each resident use. *She did not know if the resident lift equipment was deep cleaned. Interview on 1/24/25 at 10:30 a.m. with licensed practical nurse (LPN) I revealed that she did not know if the resident lift equipment was deep cleaned or how often deep cleaning was	F 880		

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F 880	Continued From page 21 supposed to have occurred. Interview on 1/24/25 at 10:40 a.m. with director of nursing (DON) B revealed: *The shared resident lift equipment was to be cleaned after each use with sanitizing wipes. *She was not aware of the buildup of the unidentified substances in the footwells. *She did not know if the lift equipment was on a deep-cleaning schedule. Review of the 2/25/21 manufacturer's EZ Way Equipment Cleaning Guide revealed: *"To keep your EZ Way equipment clean and in good condition, we recommend that you use a standard germicidal spray, Sani-Wipe, or similar product and that you follow these guidelines: -DO NOT SPRAY PRODUCT DIRECTLY ON THE MACHINE. -Spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. -The germicidal spray, Sani-Wipe, or similar product can be used on the control panel and front panel graphics. If not using a wipe, make sure to spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. -Be careful not to wipe off the model and serial number sticker (located on the side of the mast, on floor lifts and sit-to-stands)." 2. Observation on 1/23/25 from 9:31 a.m. to 10:12 a.m. of RN G during medication administration revealed: *RN G did not perform hand hygiene prior to putting on a clean pair of gloves. He then checked resident 33's blood sugar level which involved pricking the resident's finger for a blood sample. *RN G then gathered those used supplies and	F 880		

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F 880	Continued From page 22	F 880		

went back to the medication cart.
-With those gloved hands, he cleaned the glucometer, then removed those gloves and performed hand hygiene.
*RN G prepared resident 33's insulin and brought the insulin pens into her room.
-He set the insulin pens down onto a barrier on her overbed table.
-He did not perform hand hygiene and put on a clean pair of gloves.
-After he administered the resident's insulin, he removed those gloves, did not perform hand hygiene, and went back to the medication cart to prepare the rest of resident 33's medications.
*While RN G was preparing resident 33's powdered nutrition supplement:
-He pulled a pair of scissors out of his shirt pocket. Without cleaning or sanitizing the scissors, he cut open the pouch of powdered nutrition supplement and poured the contents into a plastic cup.
*He prepared the rest of resident 33's medications and brought them to her room.
-He did not perform hand hygiene and put on a pair of clean gloves.
-He assisted the resident with taking her medications, including administering her eye drops.
-After the resident finished taking her medications, RN G removed his gloves and discarded them into the trash. He did not perform hand hygiene. He went back to the medication cart to prepare the next resident's medications.

Interview at that time with RN G about the above observations revealed:
*He stated he was nervous about the survey process.
*He agreed he missed several opportunities for

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F 880	Continued From page 23 hand hygiene throughout the medication administration observation. *He was not aware that the scissors should have been cleaned and sanitized prior to using them to open the pouch of powdered nutrition supplement. Interview on 1/23/25 at 1:13 p.m. with DON B revealed: *She expected staff to perform hand hygiene before putting gloves on, and after taking gloves off. *Staff should not use scissors to open packages of powdered nutrition supplement, medicated patches, or other packages used for medication administration. Review of the provider's 3/29/22 Hand Hygiene policy revealed: *"Policy: - ...All employees are responsible for maintaining adequate hand hygiene by adhering to specific infection control practices. -All employees in patient care areas ...will adhere to the 4 Moments of Hand Hygiene and 2 Zones of Hand Hygiene. --1. Entering Room. --2. Before Clean Task. --3. After Bodily Fluid/Glove Removal. --4. Exiting Room. --5. Zones: Patient zone and Health-care zone. - ...Gloves are a protective barrier for the HCW [healthcare worker] according to standard precautions. --1. Gloves are never to be reused or sanitized. --2. Hand hygiene should be performed after glove removal." *"Procedure: HCW will use waterless alcohol-based hand sanitizer or soap and water to	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 clean their hands: -When entering patient room. -Before preparing or administering medications. -Before donning sterile gloves. -If gloves are used to perform a clean/aseptic procedure, hand hygiene must be completed before donning gloves. -After removing gloves regardless of task completed. - ...When moving from contaminated body site to a clean body site during patient care. -When entering healthcare zone (supply drawers, linen drawers or cupboards). -When exiting patient room."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY TYNDALL	**2304 LAUREL STREET** **TYNDALL, SD 57066**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 1/22/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Good Samaritan Society Tyndall was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K131 and K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 131 SS=D	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served.	K 131	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the t ruth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it i s required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Schenkel	Administrator	2-15-25

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY TYNDALL	**2304 LAUREL STREET** **TYNDALL, SD 57066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 131	Continued From page 1 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the fire-resistive rating for one randomly observed ninety-minute rated fire door assembly (Activity corridor). Findings include: 1. Observation and testing on 1/22/25 at 12:15 p.m. revealed the west leaf of the ninety-minute, cross-corridor doors in the corridor, to the west of resident room 218 in the therapy wing was not latching. Testing of that door leaf revealed it would strike the east leaf at the top preventing it from latching into the door frame. That door leaf must latch to maintain the ninety-minute fire-rating of the cross-corridor doors. The deficiency could affect 100% of the occupants of the smoke compartments on either side of the cross-corridor doors. Interview with the maintenance director at the time of the above observations confirmed those findings. He stated he was unaware those conditions existed.	K 131	In response to K131 1. The door to the west of Room 218 was fixed on 1-23-25 and the door leaf is properly latching into the door frame. 2. All other fire doors have been checked to ensure proper latching on 1-23-25. 3. The Administrator provided education at all staff in service on 2-6-25 about doors properly latching. Fire doors will be inspected each month during monthly fire drill to ensure proper latching. This will be recorded in TELS preventive maintenance. 4. The Administrator or designee will audit TELS and doors randomly each month for 3 months and report to the Safety committee until the facility demonstrates proper compliance.	2-20-25
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by	K 211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435098	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/22/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY TYNDALL	**2304 LAUREL STREET** **TYNDALL, SD 57066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door location (family room north exit door). Findings include: 1. Observation beginning at 12:57 p.m. on 1/22/25 revealed the family room north exit door was unable to be easily opened. Testing of the door revealed it would not open without applying greater than fifty pounds of force in the direction of the path of egress. Interview at the time of the observation with the maintenance director confirmed those conditions. He stated he believed the ground shifting was causing that condition. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 211	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. In response to K211 1. The family room door was modified on 2-14-25 to allow door to be opened easily. 2. All other exit doors have been checked on 2-14-15 to ensure proper opening. 3. The Administrator provided education at all staff in service on 2-6-25 about egress doors. Exit doors will be inspected weekly. This will be recorded in TELS preventive maintenance. 4. The Administrator or designee will audit TELS and doors to ensure they open properly. These audits will be completed monthly for 3 months and reported to the Safety committee until the facility demonstrates proper compliance.	2-20-25

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
	10695	A. BUILDING: _____ B. WING _____	01/24/2025

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GOOD SAMARITAN SOCIETY TYNDALL	2304 LAUREL ST TYNDALL, SD 57066

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/21/25 through 1/24/25. Good Samaritan Society Tyndall was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/21/25 through 1/24/25. Good Samaritan Society Tyndall was found in compliance.	S 000		

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

Julie Schenkel | Administrator | 2-15-25