STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/14/24 through 1/15/24. The area surveyed was abuse related to an allegation of resident verbal abuse by a staff member. Good Samaritan Society Scotland was found not in compliance with the following requirements: F600 and F609.	F 000	1. Upon receipt of the allegation employee C was immediatley suspended from andy provisons of care for resient pending investigation outcomes. 2. All residents have the potential to be affected. 3. The administrator, DNS, Medical Director and any others identified as necessary will provide immediate education, to all staff licensed and unlicensed referecning the facility's abuse and neglect policy for the identity of any allegations of resident mistreatment, neglect or abuse. Employees who were unable to receive immediate education have been notified of mandated education required prior to working their next scheduled shift. To avoid further abuse from occuring the facility will conduct quarterly abuse neglect drills that will enhance the education and understanding of abuse identity and reporting. 4. To ensure ongoing compliance the administrator or assigned designee will perform audits to ensure staff have the knowledge and understand the identity of any abuse neglect for 3x week for 4 weeks, 2x week for 4 weeks then 1x month for 3 months. Completed audits and findings will be submitted to QAPI committee. The QAPI committee will determine the final reproting of scheduled audits if further auditing or interventions are required to ensure ongoing compliance.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, electronic medical record (EMR) review, observation, interview, and policy review, the provider failed to protect the resident's right to be free from verbal abuse for one of one sampled resident (1) with cognitive impairment by one of one certified nursing assistants (CNA) (C). Findings include:	F 600		02/07/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julie Ramey	Administrator	02/14/25

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 600	Continued From page 1 1. Review of the provider's 10/21/24 SD DOH FRI revealed: *On 10/18/24 cook D reported to registered nurse (RN) E "a verbal exchange between CNA [certified nursing assistant C] and resident [1]." *RN E instructed cook D "to write the information on a suggestion/concern form and place it under [the] administrator's door." *The suggestion/concern form was not found until 10/21/24 at approximately 1:30 p.m. *Cook D reported CNA C "was raising his voice demanding that [resident 1] shut her mouth and drink her coffee and you can't drink your coffee when you are arguing with me." *"Verbal abuse [was] substantiated." *CNA C stated, "I could have handled it better, and "I am guilty." *CNA C was suspended pending investigation. *Corrective action was given "in the form of written reminder." *Education was provided to "every staff member" on the abuse/neglect policy. *The family and provider were notified. 2. Review of resident 1's EMR revealed: *She was admitted on 12/16/22. *Her diagnosis included unspecified dementia, generalized anxiety disorder, rheumatoid arthritis, and cognitive communication deficit. *Her Brief Interview for Mental Status (BIMS) assessment score was 5 which indicated she had severe cognitive impairment. *Trauma assessments completed on 12/20/22 and 8/16/24 indicated a history of anxiety with difficulty breathing after childhood tonsil surgery and after her husband passed away. -There was no documentation that indicated a trauma assessment had been completed after	F 600		

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F 600	Continued From page 2 the 10/21/24 incident. *A 10/24/24 progress note indicated a discussion with the medical director regarding the DOH-reported investigation and a plan to correct the incident. -No other progress notes were identified regarding the allegations of abuse on 10/18/24. Review of resident 1's care plan revealed: *She had impaired cognitive function due to dementia, anxiety, and short-term memory impairment. -Interventions for that included: --"Monitor/document/report to health care provider any changes in cognitive function specifically changes in ...difficulty expressing self." --"Cue, reorientate and supervise as needed." *She had a hearing deficit and needed repeated information at times. -Interventions for that included, "Speak clearly and slowly." *She had a psychosocial well-being deficit related to dementia, anxiety, voiced past trauma of not being able to breathe, and changes in her routine. -Interventions for that included: --"Remove resident to a calm safe environment and allow to vent/share feelings when conflict arises." --"Provide assistance/encouragement/support to identify problems that cannot be controlled." --"Encourage calming breathing techniques ..." *"Resident has a mood problem R/T [related to] dementia, anxiety ...likes consistent routine." -Interventions for that included "Provide encouragement/assistance support to maintain as much independence and control as possible." 3. Observations and interview on 1/14/25	F 600		

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F 600	Continued From page 3 between 9:26 a.m. and 12:00 p.m. with resident 1 revealed: *She ate independently in the dining room and used a four-wheeled walker for mobility. *She was pleasant with conversation but when asked about her care she would pause for long periods and then redirect the conversation. -Her answers to questions were inconsistent. -She was unable to recall an incident where staff had shouted at her. *She was observed in church and therapy that day. 4. Interview on 1/14/25 at 11:26 a.m. with activities supervisor (AS) G regarding resident 1 revealed: *Resident 1 frequently engaged in activities, liked to stay busy, attended group activities, and enjoyed playing the piano. *She confirmed that resident 1 occasionally became anxious but had not noticed any changes in her behavior recently. *AS G stated she had never witnessed resident abuse towards any resident and received education on resident abuse every year. -She stated she would go "straight to the charge nurse with any concern," after she made sure the resident was safe. She would follow up to make sure a report was filed. 5. Observation and interview on 1/14/25 at 11:46 a.m. with licensed practical nurse (LPN) H and resident 1 revealed: *Resident 1 approached licensed LPN H in the hallway and asked "What should I do?" Her voice was very anxious. *LPN H told resident 1 it was almost time for lunch and asked if she needed to use the restroom.	F 600		

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F 600	Continued From page 4 -Resident 1 started repeating, "Please God, Please God," louder and louder as she independently approached her bathroom. As she entered her room, she repeatedly stated "Go to the bathroom and then to lunch." Interview on 1/14/25 at 11:49 a.m. with LPN H regarding resident 1 revealed: *Resident 1 was frequently anxious, often thought something was wrong, and could be hard to redirect. *At times resident 1 would "scream at the top of her lungs." *LPN H had never witnessed any staff speak unkindly to resident 1. *She had received training on how to deal with residents with difficult behaviors, and resident abuse at a recent all-staff meeting. *She stated if she had witnessed resident abuse, she would first ensure that the resident was safe and then she would find the registered nurse or go directly to the director of nursing. *She knew a report would need to be sent to the DOH. 6. Interview on 1/14/25 at 1:38 p.m. with cook D regarding the above incident revealed: *CNA C was getting "very verbal" in the dining room with resident 1. *Resident 1 had been trying to get a Styrofoam cup to take her coffee to her room. CNA C did not want her to leave with the coffee. He told her "Tough ****, drink the coffee and you can't leave with it." When she approached CNA C, he left the area. *She stated that she was paraphrasing because she could not recall the exact words that had been used. *She stated she "didn't do anything right away"	F 600		

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F 600	Continued From page 5 but had gone home and called the nutrition and food services supervisor (NFSS) F who told her, it was a little bit too late and to talk to the charge nurse in the morning. *She reported her concerns to RN E "first thing that morning [10/19/24]." -RN E told her to write a report and slide it under administrator (Admin) A's door. *On 10/21/24 she spoke to NFSS F again about her concerns and they went down to get the report out of Admin A's office and gave it to the social worker to ensure it had been reported. *Cook D received education on reporting abuse when she was hired on 9/3/24 and again after the incident occurred. Interview on 1/14/25 at 1:56 p.m. with NFSS F about the incident that occurred between CNA C and resident 1 revealed she: *Recalled that "an incident had occurred" with a CNA and a resident "in the dining room". *Thought cook D had texted her about the incident the evening it occurred but was not sure. -Was unable to recall any specific information about the incident. *Instructed cook D to report her concerns to the charge nurse. *Thought cook D had been at work and would have reported it to the charge nurse at that time. *Confirmed abuse concerns needed to be reported to the charge nurse and a form needed to be filled out. *Could not recall if she had been questioned about the incident or had spoken to the management team about it. *Had attended an all-staff meeting that included abuse after that incident. Interview on 1/14/25 at 2:30 p.m. with CNA C	F 600		

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F 600	Continued From page 6	F 600		

revealed:
*He had been a CNA at that facility for eight years and had received online training every year about resident abuse.
*Regarding the incident above, resident 1 was in the dining room trying to take a glass coffee cup out of the dining room.
-No other residents were present at that time.
*CNA C was frustrated, and "It escalated."
*He had tried to get her to stop and told her to "Shut up." He said, "It was a bad decision."
*He walked away and told the charge nurse he had been frustrated with resident 1.
*He completed his shift on 10/18/24 and was not scheduled to work again until 10/21/24. He was sent home when he went to work that day (10/21/24).
-He was allowed to return to work "two or three days" later and received written information about verbal and mental abuse.

Review of the Suggestion or Concern form completed by cook D on 10/18/24 revealed:
*"As I was preparing to leave for the night [CNA C] was raising his voice demanding that [resident 1] "Shut her mouth and drink her coffee." [Resident 1] said something I did not hear in return [CNA C] then said, "You can't drink coffee when you are arguing with me." [Resident 1] continued to try to argue. [CNA C] raised his voice again and told her to "Shut your mouth and drink your coffee." She went to say something again, and he said, "Shut up, I don't care."
*Two additional staff were present when the incident occurred.

Interview on 1/14/25 at 4:02 p.m. and again on 1/15/25 at 10:24 a.m. with Admin A revealed:
*Admin A was on vacation when the above

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F 600	Continued From page 7 incident occurred and returned to work on 10/22/24. *CNA C had "acknowledged that he should have approached it better ." *The incident occurred and was observed by cook D on 10/18/24 who reported it to RN E on 10/19/24 around 6:00 a.m. *RN E had instructed cook D to complete a concern form and put it under Admin A's door. *That form was found on 10/21/24, the SD DOH was notified and CNA C was suspended pending an investigation. *CNA C had completed his shift on 10/18/24 and had not worked on 10/19/24, 10/20/24, or 10/21/24. *She confirmed that the incident reporting had not been completed "timely." *Individual staff training had been initiated on 10/22/24 with a memo that each staff member was to read and sign. -Admin A expected all staff "to follow the guidance in the memo." *An all-staff meeting was held on 10/25/24, that covered the topic of resident abuse and emphasized that there was a two-hour timeline for reporting to the DOH. *She confirmed cook D had reported her concerns to NFSS F. -She expected cook D to have reported those concerns to the charge nurse immediately. "No matter what. There is always a charge nurse here." *She thought NFSS F should have known those concerns needed to be reported immediately. *She expected RN E to notify the DOH within two hours, by completing a report, and to notify the director of nursing services, social worker, or administrator of the allegation immediately. *The incident had been addressed at the last	F 600		

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F 600	Continued From page 8 Quality Assurance Performance Improvement (QAPI) meeting held on 10/28/24. Review of the provider's 7/22/24 Abuse and Neglect policy revealed: *"To ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location." *"To ensure the location has an effective system in place that, regardless of the source, prevents mistreatment, neglect exploitation and abuse of residents ..." *"To ensure that residents are not subjected to abuse by anyone, including, but not limited to, vocation employees ..." *"To ensure that all identified incidents of alleged or suspected abuse neglect ... are promptly reported and investigated." *"The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation." *"Residents must not be subject to abuse by anyone, including, but not limited to, location employees ..." *"Alleged or suspected violations including any mistreatment, neglect exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services." *"The charged nurse or licensed nurse will be notified immediately, assess the situation to determine whether any emergency treatment or action is required and complete an initial investigation .... The charged nurse also will	F 600		

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F 600	Continued From page 9 ensure that any potential for further abuse is eliminated by taking one of the following actions: a. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident." *"In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.)" *"If there is an allegation of abuse, neglect exploitation or mistreatment ... then it will be reported immediately, but not later than two hours after the allegation is made."	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 609		

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

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F 609	Continued From page 10 procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint online report, document review, interview, and policy review, the provider failed to report an incident of alleged abuse in the required timeframe to the SD DOH for one of one sampled resident (1). Findings include: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, interview, and policy review, the provider failed to report an incident of alleged abuse in the required timeframe to the SD DOH for one of one sampled resident (1). Findings include: 1. Review of the provider's 10/21/24 SD DOH FRI revealed: *On 10/18/24 cook D reported to registered nurse (RN) E "a verbal exchange between CNA [certified nursing assistant C] and resident [1]." *RN E instructed cook D "to write the information on a suggestion/concern form and place it under [the] administrator's door." *The suggestion/concern form was not found until 10/21/24 at approximately 1:30 p.m. Interview on 1/14/25 at 1:38 p.m. with cook D regarding the above incident revealed:	F 609	1. Upon receipt of the allegation employee C was immediatley suspended from any provisons of care for resident 1 pending investigation outcomes. 2. All residents have the potential to be affected. 3. The adminstrator, DNS, Medical Director and any others identifed as necessary will provide immediate education to all staff licensed and unlicensed, referencing the facility's abuse neglect policy on the timely reporting required of any allegations of mistreatment, neglect and abuse. Employees who were unable to receive immediate education have been notified of the mandated education required prior to working their next scheduled shift. And to avoid further defecient reporitng from occuring the facility will conduct quarterly drills that will enhance the understanding of abuse identity and the timely reporting of. To ensure ongoing compliance the administrator or assigned designee will perform audits to ensure all reportable incidents have been reported timely 3x week for 4 weeks, 2x week for 4 weeks and 1 x month for 3 months. Completed audits and findings will be submitted to the QAPI committee. The QAPI committee will determine the final reporting of scheduled audits if further auditing and interventions are required to ensure ongoing compliance.	02/07/25

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F 609	Continued From page 11 *CNA C was getting "very verbal" in the dining room with resident 1. *Resident 1 had been trying to get a Styrofoam cup to take her coffee to her room. CNA C did not want her to leave with the coffee. He told her "Tough ****, drink the coffee and you can't leave with it." When she approached CNA C, he left the area. *She stated that she was paraphrasing because she could not recall the exact words that had been used. *She stated she "didn't do anything right away" but had gone home and called the nutrition and food services supervisor (NFSS) F who told her, it was a little bit too late and to talk to the charge nurse in the morning. *She reported her concerns to RN E "first thing that morning [10/19/24]." -RN E told her to write a report and slide it under administrator (Admin) A's door. *On 10/21/24 she spoke to NFSS F again about her concerns and they went down to get the report out of Admin A's office and gave it to the social worker to ensure it had been reported. *Cook D received education on reporting abuse when she was hired on 9/3/24 and again after the incident occurred. Interview on 1/14/25 at 1:56 p.m. with NFSS F about the incident that occurred between CNA C and resident 1 revealed she: *Recalled that "an incident had occurred" with a CNA and a resident "in the dining room". *Thought cook D had texted her about the incident the evening it occurred but was not sure. -Was unable to recall any specific information about the incident. *Instructed cook D to report her concerns to the charge nurse.	F 609		

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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 609	Continued From page 12 *Thought cook D had been at work and would have reported it to the charge nurse at that time. *Confirmed abuse concerns needed to be reported to the charge nurse and a form needed to be filled out. *Could not recall if she had been questioned about the incident or had spoken to the management team about it. *Had attended an all-staff meeting that included abuse after that incident. Interview on 1/14/25 at 4:02 p.m. and again on 1/15/25 at 10:24 a.m. with Admin A revealed: *Admin A was on vacation when the above incident occurred and returned to work on 10/22/24. *The incident occurred and was observed by cook D on 10/18/24 who reported it to RN E on 10/19/24 around 6:00 a.m. *RN E had instructed cook D to complete a concern form and put it under Admin A's door. *That form was found on 10/21/24, the SD DOH was notified and CNA C was suspended pending an investigation. *CNA C had completed his shift on 10/18/24 and had not worked on 10/19/24, 10/20/24, or 10/21/24. *She confirmed that the incident reporting had not been completed "timely." *Individual staff training had been initiated on 10/22/24 with a memo that each staff member was to read and sign. -Admin A expected all staff "to follow the guidance in the memo." *An all-staff meeting was held on 10/25/24, that covered the topic of resident abuse and emphasized that there was a two-hour timeline for reporting to the DOH. *She confirmed cook D had reported her	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435095	A. BUILDING _____ B. WING _____	C 01/15/2025

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GOOD SAMARITAN SOCIETY SCOTLAND	130 6TH STREET SCOTLAND, SD 57059

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F 609	Continued From page 13 concerns to NFSS F. -She expected cook D to have reported those concerns to the charge nurse immediately. -She stated. "No matter what. There is always a charge nurse here." *She thought NFSS F should have known those concerns needed to be reported immediately. *She expected RN E to notify the DOH within two hours, by completing a report, and to notify the director of nursing services, social worker, or administrator of the allegation immediately. Review of the provider's 7/22/24 Abuse and Neglect policy revealed: *"To ensure that employees are knowledgeable regarding the reporting and investigative process of abuse and neglect allegations in the location." *"To ensure the location has an effective system in place that, regardless of the source, prevents mistreatment, neglect exploitation and abuse of residents ..." *"To ensure that all identified incidents of alleged or suspected abuse neglect ... are promptly reported and investigated." *"The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation." *"Alleged or suspected violations including any mistreatment, neglect exploitation or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged violations: the director of nursing services or the supervisor of social services." *"The charged nurse or licensed nurse will be notified immediately, assess the situation to	F 609		

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
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F 609	Continued From page 14 determine whether any emergency treatment or action is required and complete an initial investigation .... The charged nurse also will ensure that any potential for further abuse is eliminated by taking one of the following actions: a. If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident." *"In case of absence of the administrator, follow the chain of command for notification (director of nursing services, social worker, etc.)" *"If there is an allegation of abuse, neglect exploitation or mistreatment ... then it will be reported immediately, but not later than two hours after the allegation is made."	F 609		