STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/21/21 through 6/23/21. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirements: F658, F686, F690, F755, and F880.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to follow physician's orders regarding: *One of one resident (18) with a low blood glucose reading. *One of one resident (45) who was to be weighed daily. Findings include: 1. Observation and interview on 6/21/21 with registered nurse (RN) E regarding resident 18 revealed: *At 5:32 p.m. RN E stated: -Resident 18's blood sugar (BS) was 49 milligrams per deciliter (mg/dl) and she had assisted him to eat a pudding cup. -He was alert and coherent so she did not think he needed Glucagon, a hormone to increase BS.	F 658	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. (1) On 6/22/21 resident 45 had been weighed. On 7/13/21 weights were reported to provider. On 7/12/21 resident 18's provider was notified of incidents of low blood sugar.	

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

Dennis Tadeff — Administrator — 7/14/21

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.

Amended on 7/19/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 658	Continued From page 1 -She was going to hold his insulin. -His supper tray was on the way to his room. *At 5:43 p.m. RN E stated his BS was 69 mg/dl and he was eating his supper. *This surveyor had not seen her leave the area outside the resident's room or use a phone to notify a physician of his low BS. Observation and interview on 6/22/21 at 8:38 a.m. of resident 18 in his room revealed he: *Was sitting on the edge of his bed eating breakfast. *Had no complaints during the interview except he wanted coffee. *Did not remember having a low blood sugar the prior evening and did not know what his BS was this morning. Interview on 6/22/21 at 8:50 a.m. with licensed practical nurse C revealed resident 18's BS was 168 mg/dl that morning and he did get his insulin prior to breakfast. Review of resident 18's progress notes revealed: *On 6/21/21 at 5:33 p.m. RN E had not given resident 18 his 16 Units of Novolog FlexPen because his BS was 49. *On 6/21/21 at 6:38 p.m. "Day nurse gave a report that resident had low blood sugar 49mg/dl. She reported after feeding pudding it went up to 65. This nurse went to check again at 1838, it was 203. Resident mentioned he had casserole. Resident is stable." *There were no other notes regard the above event. *There was no documentation regarding notification to his physician or a physicians order to hold his insulin.	F 658	(2) 15 residents with orders for daily weighs and 18 residents at risk for hypoglycemia could have been affected. By 6/30/21 all nursing staff have been educated on this and the importance of ensuring our residents are correctly weighed according to their plan of care and physician's order. By July 13 all nursing staff will be reeducated on the Hypoglycemic Episodes – Skilled Policy and Procedure with emphasis to notify physician if there is an order to do so when blood sugar is out of range. (3) DNS or designee will round daily to ensure weights are completed. DNS or designee will review exception reports daily and verify any blood sugar out of range has been addressed according to policy and physician orders. (4) MDS Coordinator will monitor compliance by auditing 5 residents with daily weights. Audits will occur 3 times per week for two weeks, weekly for 4 weeks, and monthly for 2 months. MDS Coordinator or designee will report findings to QAPI Committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 658	Continued From page 2 Review of resident 18's physician orders revealed an order with a start date of 1/24/21 for finger stick BS three times a day before meals and to notify the physician if BSs were less than 60 or higher than 400. Interview on 6/23/21 at 11:45 a.m. with director of nursing (DON) B regarding resident 18's low BS revealed she: *Had stated "It is never a nursing judgement call with low blood sugars." *Expected nurses to call a physician when a resident had a low BS. *Had talked with RN E on the phone and provided further education prior to this interview. Review of the provider's 4/6/21 Blood Glucose Monitoring, Disinfecting, and Cleaning policy revealed: *"1. Verify that the physician's orders include blood glucose high and low parameters and when to notify the resident's physician." *It had not indicated what the blood glucose high and low parameters should be. Continued interview on 6/23/21 at 12:00 p.m. with DON B revealed she did not have a policy specific to low blood sugars. Surveyor: 42477 2. Interview on 6/23/21 at 10:30 a.m. with resident 45 revealed: *He had a procedure to have a cardiac stent placed prior to arriving in the facility. *He had heart issues. *They weighed him "maybe once per week." Review of resident 45's electronic medical record (EMR) revealed he: *Was admitted to the facility on 2/10/21.	F 658	DNS or designee will audit 6 residents to ensure appropriate interventions and provider notification occurred. Audits will occur 3 times per week for two weeks, weekly for 4 weeks, and monthly for 2 months. DNS or designee will report finding to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. (5) Substantial compliance achieved by 7/13/21.	7/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 658	Continued From page 3 *Had the following diagnoses: -Congestive heart failure. -Diabetes. -Stenosis of the carotid arteries. Review of resident 45's physician orders revealed: *He was to be weighed daily due to his diagnosis of congestive heart failure. *If his weight increased by two to three pounds (lb) in a day or five lb in a week his physician was to be notified. Review of resident 45's recorded EMR weights revealed: *In April 2021: -There were 13 missed opportunities for daily weights. -He had a 2.8 lb weight increase on 4/16/21. -His weight was not checked again until 4/19/21. -There was no documentation his physician was notified. *In May 2021: -There were 13 missed opportunities for daily weights. -He had a 2 lb weight gain on 5/8/21. -There was no documentation his physician was notified. *In June 2021: -There were 10 missed opportunities for daily weights. -He weighed 172.8 lb on 6/4/21. -His next recorded weight was on 6/9/21, and he weighed 178 lb. -He had the same weight of 178 lb on 6/10/21. -A nurse's note on 6/11/21 acknowledged his weight increase. --He was not weighed or re-weighed. -His next weight was not obtained until 6/15/21.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 658	Continued From page 4 -There was no documentation his physician was aware of his weight fluctuations. Review of resident 45's EMR administration notes revealed: *The following were documented reasons as to why he was not weighed: -On 6/7/21, "no time allotted." -On 6/12/21, "time did not allow." -On 6/13/21, "no time allotted." -On 6/21/21, "CNAs did not get." Interview on 6/23/21 at 3:15 p.m. with DON B revealed staff should have followed physician's orders regarding obtaining weights. Review of the provider's 11/3/20 Weight and Height policy revealed: *Changes in residents' weights were to be reported to the physician, family, and/or resident. *They were to monitor for weight loss or weight gain in a resident.	F 658		
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	F 686	(1) On 6/23/21 wound nurse confirmed resident 59 has interventions in place to prevent a pressure ulcer from developing. (2) All other residents could have been affected. On 6/25/21 all resident's Braden scores were reviewed by the ADNS and wound nurse. By 6/30/21 those residents with a Braden score of 18 or less were reviewed to ensure interventions are place to prevent a pressure ulcer from developing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 686	Continued From page 5 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one resident (59) had interventions in place to prevent a pressure ulcer (PU) from developing. Findings include: 1. Review of resident 59's medical record revealed: *He was admitted on 6/1/21. *Multiple diagnoses including cancer, malnutrition, and history of a pressure ulcer to his coccyx. *He was at-risk for developing a PU. *No skin issues were documented on the admission assessment. *On 6/6/21 a small open area was noted to his coccyx. *On 6/10/21 the open area had been noted as a stage II pressure ulcer: -His physician was notified. -A Roho cushion had been in his wheelchair (w/c). *On 6/11/21 a new order for Calmoseptine to be applied to the pressure ulcer had been received. *On 6/17/21 a Roho cushion had been added to his recliner as he sometimes slept there as well. Observation and interview on 6/22/21 at 9:16 a.m. with resident 59 revealed he: *Was sitting on a cushion in his w/c. *Stated he had a PU and it was healing well. *Denied pain or discomfort to the area. Review of resident 59's care plan revealed: *He had a potential for skin impairment related to	F 686	(3) A new skin/wound checklist has been created for use when a new skin concern or wound has been identified. All nursing staff have been educated to use this checklist by 6/30/21. A Braden Scale for Predicting Pressure sore risk assessment will be completed upon admission. Appropriate interventions will be put into place day of admission for residents whose score indicate risk for pressure injury. (4) The wound nurse or designee will audit use of the checklist and initiation of appropriate interventions for all new admissions. Audits will occur 3 times per week for two weeks, weekly for 4 weeks, and monthly for 2 months. Wound nurse or designee will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. (5) Substantial compliance was achieved on 6/30/21.	6/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 686	Continued From page 6 fragile skin. *A stage II PU had been noted to his coccyx on 6/6/21. *Interventions put in place on 6/1/21 included: -"Provide pressure relieving/reducing devices on (SPECIFY: bed and in w/c)." --It did not specify where those pressure relieving device should have been. *Interventions put in place on 6/10/21 included: "Provide pressure relieving/reducing devices. Roho cushion in w/c." *Intervention put in place on 6/17/21 was: "Roho cushion in w/c and recliner (sometimes sleeps there)." Interview on 6/23/21 at 11:49 a.m. with director of nursing (DON) B regarding the above observation, interview, and record review revealed: *When a nurse finds a wound, they filled out a new skin condition sheet and left it for the wound care nurse. *Registered nurse (RN) F did wound care rounds every Thursday. *She: -Did not know why interventions had not been put in place until 6/10/21. -Would have expected the doctor to be notified when the nurse noted the PU on 6/6/21. -Thought she should change the procedure to have the on-call nurse notified when a wound was noted on a weekend. Interview on 6/23/21 at 3:50 p.m. with RN F regarding resident 59's PU revealed: *He had told her he had previously had an open area on his coccyx in the hospital that had healed. *It was her expectation that the nurse who	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 686	Continued From page 7 discovered a wound measured it, put interventions in place, and notified the physician. *She did wound care rounds on Thursdays. *On 6/10/21 she had done wound care rounds and updated the his care plan. *On 6/17/21 she had found that he was sleeping in his recliner at times, so she had added a Roho cushion to the recliner. *She agreed interventions should have been put in place prior to development of a PU. *She stated all residents had a Roho cushion in their w/c upon admission. -Agreed there had not been any supporting documentation to indicate resident 59 had a Roho cushion in his w/c upon admission. Review of the provider's 2/10/21 Pressure Ulcer policy revealed: "Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the locations without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable." Review of the provider's 4/21/21 Skin Assessment Pressure Ulcer Prevention and Documentation Requirements policy revealed: *Braden Scale for Predicting Pressure Sore Risk was utilized to identify residents at risk for skin breakdown. *When a nurse identified a PU the physician was to be notified and the measurements and characteristics of the wound should be documented in the medical record.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690	(1) On 7/6/21 resident 45 was reassessed for continued catheter use	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 690	Continued From page 8 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review,	F 690	and referred to urology for follow-up on 7/8/21. Catheter remains in place with additional urology follow. (2) All other residents with catheters were reviewed on 7/13/2021 and found to have documentation supporting necessity for continued catheter use. (3) All residents admitted with catheters or if catheter is initiated during stay will be assessed by the provider to determine appropriateness of continued catheter use. All nursing staff were educated that residents being admitted or readmitted with catheter are reassessed to ensure catheter use is still appropriate for that resident by 7/13/21. (4) Medicare case manager or designee will audit resident orders and medical record to ensure residents admitted or readmitted with a catheter have been reassessed for the continued use of a catheter. Audits will occur weekly for 2 weeks and monthly for 3 months. Medicare case manager or designee will report findings to the QAPI Committee monthly. The QAPI committee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 690	Continued From page 9 and policy review, the provider failed to ensure one of one sampled resident (45) had been reassessed for the continued use of a catheter. Findings include: 1. Observation and interview on 6/22/21 at 8:28 a.m. with resident 45 revealed he: *Stated he was at the emergency room (ER) until 4:30 a.m. *Was tired. *Was headed to a doctor's appointment. *Stated he was in the ER because of problems with his catheter. Further observation and interview on 6/22/21 at 10:28 a.m. with resident 45 revealed: *He had returned from his doctor's appointment. *He stated staff tried to insert a new catheter last night and were unable to. -As a result he experienced a lot of bleeding. *He was not sure why he had the catheter. *He had it when he arrived from the hospital. *No one had discussed the catheter with him. *The catheter sometimes caused him a lot of pain, he just wanted to scream. -It depended on who was taking care of his catheter. *He was able to use the bathroom with staff assistance. *He had some urinary tract infections (UTI)s related to his catheter. Review of resident 45's electronic medical record (EMR) revealed: *He was admitted to the facility on 2/10/21. *He was recovering from vision loss from a subdural hematoma and stent placement. *He was receiving physical and occupational therapy.	F 690	determine on-going interventions and monitoring. (5) Substantial compliance achieved by 7/13/21.	7/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 690	Continued From page 10 *His diagnosis included: -Traumatic subdural hemorrhage. -Type II Diabetes. -Right eye vision loss. Review of resident 45's 6/22/21 care plan revealed: *He had an indwelling catheter. *Catheter care was to be performed by certified nursing assistants every shift. *Staff were to monitor/record/report for signs and symptoms of UTIs. Review of resident 45's 2/13/21 Bladder Incontinence Assessment Collection Tool revealed: *He had an indwelling catheter. *He was in the facility from the hospital. *He was regaining his sight after bleeding behind his eye. *His related diagnosis was left blank. Review of resident 45's 5/24/21 Bladder Incontinence Assessment Collection Tool revealed: *He had an external catheter. *Diagnosis listed stated: -"Foley catheter due to vision loss." *Diabetes and vision loss were the conditions marked that may affect continence. Review of resident 45's EMR progress notes revealed: *On 2/25/21: -He was to have a voiding trial completed on 2/17/21. -Physician was ok to keep his catheter until his vision and/or mobility improved. *On 3/2/21:	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 690	Continued From page 11 -He was feeling "off" and complaining of aching, and urgency to urinate. *On 3/3/21: -He was complaining of pain and pressure in his bladder. -Catheter was flushed and pain improved. *On 3/12/21 he complained of catheter burning, catheter was flushed and pain improved. *On 3/15/21: -He complained of lower abdominal pain and urgency. -Had trouble with draining and irrigation. -Unable to find the same size catheter so a different size catheter was placed. -Resident experienced 8 out of 10 pain rating. --10 being most severe. -Experienced bleeding. -On call physician stated to send him to the hospital. *On 3/15/21 emergency room urine analysis (UA) revealed he had a UTI. -He was started on antibiotics. *On 3/25/21: -Lab noted his white blood cells were trending up, new UA obtained. *On 3/30/21: -He was started on antibiotics. *On 4/19/21 he was experiencing pain from his catheter. *On 6/22/21: -Failed attempts to insert a catheter. -He was sent to the ER due to bleeding, pain, inability to urinate, and inability to insert a catheter. Interview on 6/23/21 at 3:15 p.m. with director of nursing B regarding resident 45 revealed: *It could have been his request to have the catheter.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 690	Continued From page 12 *She was not exactly sure why he had it, must be because of his vision. *If a resident did not want the catheter then they would look into removing it. *She was unable to find results of a voiding trial or if it had been completed. Interview on 6/23/21 at 4:29 p.m. with resident 45's physician's nurse I revealed: *He had the catheter in place when he was admitted from the hospital. *They were going to do a voiding trial from 2/11/21 through 2/17/21. *She was unable to find any documentation regarding the voiding trial or the results. Review of the provider's 5/27/21 Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen policy revealed: *"A resident is not to be catheterized unless the clinical condition demonstrates that catheterization is medically necessary and is not used solely for nurse/physician convenience." *"Educate resident and/or family risks and benefits of using the indwelling catheter. Document appropriately."	F 690		
F 755 SS=D	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.	F 755	(1) On 6/23/21 the topical medications found in Memory Lane spa room were removed and stored properly. By 7/13/21, all medication carts were audited to ensure the narcotic count was correct. RN F was educated on the procedure for destruction and documentation of a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 755	Continued From page 13 §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 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to: *Ensure narcotics were counted at shift change. *Document the destruction of dropped medications by one of one certified medication aide (CMA) G. *Ensure accountability of topical medications stored in the Memory Lane spa room. Findings include: 1. Observation and interview on 6/23/21 at 2:30 p.m. with director of nursing (DON) B during review of controlled substance count logs revealed she:	F 755	dropped medication on 6/30/21. (2) On 6/23/21, all other shower/bathing rooms were checked to ensure all topical medications are properly stored. By 6/30/21, all nursing staff and medication aides were reeducated on proper storage of medications/topical creams. By 6/30/21 all nursing staff and medication aides were reeducated on daily, consistent counts of the narcotics and how to document appropriately on the GSS Controlled Drugs/Count Record. By 7/13/21 all nursing staff and medication aides were reeducated on the disposal procedure of a dropped medication and how to correctly document that destruction in accordance with our policy and procedure. (3) Sign on spa room doors to remind staff to properly store all topical medications. Updated narcotic count sheets are put in place. Policy and procedure for destruction and documentation of a dropped medication revised.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 755	Continued From page 14 *Agreed there had been missing signatures on the controlled substance count logs. *Expected nurses and CMAs to count all narcotics at change of shift. *Did not audit the controlled substance count logs to ensure compliance. Review of the provider's June 2021 Controlled Substance Count logs revealed the controlled substances locked in the: *Magnolia Lane medication cart had not been counted for all shifts on fifteen out of twenty-two days. *Magnolia Lane medication room had not been counted for all shifts on three out of twenty-two days. *Memory Lane medication cart had not been counted for all shifts on eleven out of twenty-two days. Review of the provider's 12/11/20 Medications: Controlled policy revealed: **"3. Each time the keys that secure controlled medications change from one nurse/medication aide to another, the oncoming and off-going nurse/medication aide will work together to reconcile all controlled medications, including discontinued controlled medications and document the same." 2. Observation and interview on 6/23/21 at 8:07 a.m. of CMA G preparing and administering medications to resident 34 revealed she: *Had crushed resident 34's Lasix, Tylenol, aspirin, iron, and Lexapro and then had accidentally dropped them on the floor. *Had dispensed the medication again, crushed them, and then administered them to resident 34. *Filled out a form and sent the form to pharmacy	F 755	(4) Administrator or designee will monitor compliance by auditing storage of topical medications, completion of narcotic counts, and proper destruction of dropped medications. Audits will occur weekly for 4 weeks, then monthly for 2 months. Administrator will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. (5) Substantial compliance achieved by 7/13/21.	7/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 755	Continued From page 15 to send out a new dose of the medications that had been dropped. *Would let the nurse know she had dropped the medications. *Had not documented in the medical record the medications had been dropped. Interview on 6/23/21 at 11:19 a.m. with registered nurse (RN) F about the above observation and interview revealed she: *Did know CMA G had dropped resident 34's medications. *Did not document the dropped medications anywhere. *Did not know if CMA G documented the dropped medications. Interview on 6/23/21 at 11:24 a.m. with DON B about the dropped medications revealed she would have expected the nurse to document the dropped medications in the resident's medical record. Review of the provider's 10/6/20 Medication, Disposition (Disposal) Of policy revealed: *"5. Disposal of any medication will be carried out under local, state [,] and federal guidelines or in consultation of the pharmacist in the appropriate disposal procedure. Documentation will include the resident's name, medications name, prescription number (as applicable), quantity, date of disposition [,] and the involved staff member, consultant [,] or other applicable individuals. Surveyor: 42477 3. Observation on 6/22/21 at 1:57 p.m. of the tub room on the Memory Lane hallway revealed: *The door to the tub room was unlocked. *There was a bottle of prescription topical powder	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 755	Continued From page 16 in an unlocked cabinet. -Half of the powder had been used. --It had a resident's name on it. *There was a prescription bottle of dandruff shampoo in the unlocked cabinet. -It had a resident's name on it. Interview on 6/23/21 at 10:11 a.m. with RN F revealed: *The topical prescription powder should have been kept in the locked medication cart. *She was unsure of why it was in the unlocked tub room. *The prescription dandruff shampoo should have been kept in the locked medication cart and not in the unlocked tub room. Interview on 6/23/21 at 3:15 p.m. with DON B revealed the prescription topical powder and prescription dandruff shampoo should not have been kept in the unlocked tub room. Review of the provider's 12/28/20 Medications: Acquisition Receiving Dispensing and Storage policy revealed medications would be stored in a locked medication cart, drawer, or cupboard.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	Time cannot be turned back to a time prior to the identification of *lack of appropriate wound care procedural technique during resident dressing change. *lack of appropriate hand hygiene and glove use as well as maintenance of mechanical lift during resident personal care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 17 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 §483.70(e) 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 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880	Administrator, DON, and Infection control nurse were provided education/re-education by the Lead Infection Prevention Specialist on 7/12/21. The administrator and DON in consultation with the medical director and infection control nurse and whomever else identified will review, revise, create as necessary policies and procedures about: *Appropriate wound care procedural technique. *Appropriate hand hygiene and glove use as well as sanitary maintenance of mechanical lift during resident care. *Appropriate procedure technique during assigned tasks that include passing fresh water. *Necessary infection control and prevention plan that includes effective compliance. All staff who provided above care and services to residents will be educated/re-educated on 7/7/21 by the Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 18 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: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure proper infection prevention practices were followed for: *One of one sampled resident's (47) wound care by one of one licensed practical nurse (LPN) C. *Hand hygiene after perineal care for one of one certified nurses aide (CNA) D for one of one resident (2). *Hand hygiene of one of one CNA H during water pass for all facility residents. Findings include: 1. Observation on 6/22/21 at 12:02 p.m. of LPN C while performing wound care for resident 47 revealed she had: *Entered resident 47's room and set a foam dressing inside the package on top of the bedside table and then set her marker, wound measurement tool, and cup of MediHoney on top	F 880	**Identification of Others:** ALL residents have the potential to be affected if staff do not adhere to: *Appropriate wound care procedural technique during resident dressing change. *Appropriate hand hygiene and glove use as well as sanitary maintenance of mechanical lift during resident personal care. ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by the Administrator on 7/7/21. **System Changes:** Root cause analysis conducted answered the 5 Whys: Key Root cause analysis findings identified included regarding: *The wound care dressing change process, storing the plastic barriers with wound supplies will be an easy and efficient reminder to gather with the other wound supplies needed for the dressing change as you bring them to the resident room.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 19 of the dressing. *Opened the dressing package, removed the dressing and wrote a date on it with the marker, and set it on top of the package. -Moved the measuring tool, marker, and cup of MediHoney on the bedside table. -Cleaned the wound and then changed her gloves and performed hand hygiene. -Used the wound measurement tool to measure the wound and touched the wound with it. -Applied the Medihoney and then covered the wound with a foam dressing. Interview on 6/22/21 at 12:07 p.m. with LPN C regarding the above observation revealed she: *Had not cleaned or disinfected the bedside table prior to setting the wound care supplies on top of it. *Agreed the bedside table was a contaminated surface and it could have contaminated the dressing supplies. *Agreed touching the wound with the measuring tool after cleaning it could have contaminated the wound. *Agreed she should have used a barrier under her supplies to prevent them from possible contamination. Interview on 6/23/21 at 12:07 p.m. with director of nursing (DON) B regarding the above observation revealed she agreed LPN C: *Should have put a barrier under the supplies to prevent them from possible contamination. *Could have contaminated the wound by touching it with the wound measurement tool. Review of the provider's 5/19/21 Wound Dressing Change policy revealed: "8. Create field with equipment/dressing wrappers. Use sterile	F 880	Root cause analysis finding regarding: * The missed hand hygiene following perineal care, the bathroom design does make getting to the hand washing sink difficult and although we cannot change the design of the bathroom, CNA can have pocket hand sanitizer available to use until the CNA can access a hand washing station. Root cause analysis finding regarding: *The missed cleaning of the resident lift that the standard be the lift is cleaned and sanitized while the CNA is still in the resident room instead of in the hallway where the CNA can get interrupted or pulled away to the assistance of another resident and the cleaning of the lift task is forgotten. Root cause analysis finding regarding missed hand hygiene during water pass is the opportunity to work with the CNAs to change our water pass process to utilize our current GSS Water Pitcher procedure to make the water pass more efficient and help to eliminate those opportunities of missed hand hygiene. Administrator, DON, infection control nurse, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 20 technique if required." 2. Observation on 6/22/21 at 10:16 a.m. of CNA D assisting resident 2 to use the bathroom revealed she : *Used a stand lift to assist resident 2 to the toilet. *Performed pericare and without removing her soiled gloves or performing hand hygiene she had touched the break handles on the wheelchair, the stand lift sling, the stand lift handles, and the stand lift buttons. *Removed her soiled gloves, tied up garbage, positioned the bedside table in front of her, placed call light with in reach, flushed the toilet, and then performed hand hygiene. *Put lift back in the hallway alcove with out cleaning it. Interview on 6/22/21 at 10:28 a.m. with CNA D regarding the above observation revealed she: *Would have normally removed her gloves and washed her hands after assisting a resident with perineal care. *Said there was not enough room to move about in the bathroom and made it hard for her to do the task correctly. *Agreed she could have contaminated several surfaces by not removing her soiled gloves and performing hand hygiene. *Needed to assist another resident and then was going to come back and disinfect the stand lift. Interview on 6/23/21 at 12:07 p.m. with DON B revealed she: *Expected all staff to remove gloves and perform hand hygiene after assisting a resident with perineal care. *Agreed CNA D could have contaminated several surfaces in the room.	F 880	Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 7/9/21 and discussed root cause analysis findings. QIN provided additional resources, including the Wound Dressing Change Observation audit tool. QIN and Administrator also discussed the other deficiencies identified in the 2567. **Monitoring:** Administrator, DON, infection control nurse, and whomever else determined will conduct auditing and monitoring for areas identified. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified thru the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 21 *Expected staff to disinfect the stand lifts after each use. Review of the provider's 4/6/21 Hand Hygiene and Handwashing policy revealed to perform hand hygiene or handwashing in the following situations: *"If hands are visibly soiled." *"After using the restroom." *"After having direct contact with another person's skin." *"After touching equipment or furniture new the resident/patient." *"After removing gloves." 3. Observations on 6/22/21 from 9:26 a.m. through 9:33 a.m. of CNA H passing ice water down City View wing revealed: *She pushed a cart with six large pitchers of ice water. *She entered rooms 232, 231, 230 and brought water cups out to the cart from each room and filled them, put them back into the room, and had not performed hand hygiene. *She entered rooms 227, 225, 224, 223 brought water cups out to the cart from each room and filled them, put them back into the room, and had not performed hand hygiene. -She had coughed into her left hand twice while filling room 225's water pitcher. *Exited room 225 and performed hand hygiene. *Entered rooms 224, 222, 220 brought water cups out to the cart from each room and filled them, put them back into the room, and had not performed hand hygiene. Surveyor: 42477 4. Observation on 6/22/21 from 9:38 a.m. through 9:50 a.m. revealed:	F 880	Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	7/13/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 22 *CNA H had just left City View hallway with a cart of water pitchers. *She began filling Memory Lane residents' water cups. *She brought residents' drinking cups out to the hallway to fill them up. *She removed the lid, touching the resident's used straw. -Filled the cup with ice water, and placed the lid/straw back on the cup. *She then brought the refilled water cup back into the resident's room. *She had not completed hand hygiene. *She went into rooms 213, 211, 210, 209, 208, and 207: -Most of those rooms housed more than one resident. -She sanitized her hands two times. Interview on 6/22/21 at 9:50 a.m. with CNA H revealed she was supposed to sanitizer her hands "every three rooms or so." Interview on 6/22/21 at 3:15 p.m. with DON B revealed her expectation was for the CNA to sanitize her hands at least every room.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435046	A. BUILDING _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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
E 000	Initial Comments Surveyor: 16385 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 6/21/21 through 6/23/21. Good Samaritan Society Sioux Falls Center was found in compliance.	E 000		

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

Marissa Tindoff | Administrator | 7/14/21

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
	435046	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 WEST SECOND STREET SIOUX FALLS, SD 57104

(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 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/22/21. Good Samaritan Society Sioux Falls Center building 01 (1957 original building) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Maggie Tordoff | Administrator | 7/14/21

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.

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
	435046	A. BUILDING **02 - BUILDING 02 - 1965, 1972, AND 2000 ADDITION** B. WING _____	**06/22/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	**401 WEST SECOND STREET SIOUX FALLS, SD 57104**

(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 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/22/21. Good Samaritan Society Sioux Falls Center building 02 (1956, 1972, and 2000 additions) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Marissa Tirdeff | Administrator | 7/14/21

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.

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
	10679	A. BUILDING: _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 W 2ND ST SIOUX FALLS, SD 57104

(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: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/21/21 through 6/23/21. Good Samaritan Society Sioux Falls Center was found not in compliance with the following requirement: S127.	S 000		
S 127	44:73:02:06 Housekeeping Cleaning Methods and Equipment The facility shall establish written housekeeping procedures for the cleaning of all areas in the facility and copies made available to all housekeeping personnel. All parts of the facility shall be kept clean, neat, and free of visible soil, litter, and rubbish. Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 42477 Based on observation and interview, the provider failed to ensure two of two observed facility tub rooms with stored chemicals remained locked and not accessible to residents. Findings include: 1. Observation on 6/21/21 at 4:57 p.m. of the tub room on the Magnolia Heights wing revealed: *The door was unlocked. *The light was off. *There was a spray bottle of disinfectant sitting on top of the tub.	S 127	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. (1) On 6/23/21 the chemicals found in Memory Lane spa room were stored properly and locked.	

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

Marissa Tadeff — Administrator — 7/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10679	A. BUILDING: _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS CENTER	401 W 2ND ST SIOUX FALLS, SD 57104

(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 127	Continued From page 1 Observation on 6/22/21 at 1:57 p.m. of the tub room on the Memory Lane wing revealed: *The door was unlocked. *There was a cabinet labeled "chemical cabinet" which was unlocked. -It had bottles of chemicals located inside. Further observation on 6/23/21 at 10: 00 a.m. of the Memory Lane tub room revealed the chemicals were still located in the unlocked cabinets. Interview on 6/23/21 at 3:15 p.m. with director of nursing B revealed: *Chemicals were to be locked in the cabinet of the tub room. *They had some residents who tended to wander around the facility. Review of the provider's 4/20/21 Chemical Use and Storage policy revealed: *The policy pertained to storage of chemicals around food sources. *They did not have an additional chemical storage policy.	S 127	(2) On 6/23/21, all other shower/bathing rooms were checked to ensure all chemicals are properly stored and locked. By 6/30/21, all nursing staff were reeducated on proper storage of chemicals. (3) Sign on spa room doors to remind staff to properly store all chemicals. (4) Administrator or designee will monitor compliance by auditing storage of chemicals in the spa rooms. Audits will occur weekly for 4 weeks, then monthly for 2 months. Administrator will report findings to the QAPI Committee monthly. The QAPI committee will determine on-going interventions and monitoring. (5) Substantial compliance achieved by 7/13/21.	7/13/21