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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/29/24 through 5/30/24 and 6/3/24 through 6/4/24. Areas surveyed included medication errors, care to treat infection, care to prevent falls, care to prevent rehospitalization, and elopement. Good Samaritan Society Sioux Falls Village was found not in compliance with the following requirements: F658 and F684. On 5/30/24: *At 10:41 a.m. administrator H and director of nursing D were given verbal and written notification of the immediate jeopardy and a request for a removal plan identified related to resident elopement at F684. On 5/31/24: *At 8:35 a.m. the removal plan was received. *At 8:45 a.m. the removal plan was accepted. On 6/3/24 at 8:30 a.m. while on-site the survey team verified the immediacy was removed. The current census: 158 residents.	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: Based on South Dakota Department of Health	F 658	F658 1. At time of survey resident one no longer resided in facility. 2. By 6/21/24 Director of Nursing or Designee will review all blood sugar orders in the facility and ensure orders are appropriate when addressing high or low blood sugars. During this audit Director of	6/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Ballou — TITLE: Administrator — (X6) DATE: 6/28/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 (SD DOH) complaint review, record review, interview, and policy review, the provider failed to ensure one of one sampled resident's (1): *Midodrine (blood pressure medication) had been administered as ordered. *Zofran (anti-nausea medication) had been administered as ordered. *Physician had been notified of a blood glucose (blood sugar) level below 70 as ordered. *Condition had been assessed by a nurse following an intervention that had been provided for a low blood sugar. *Prescribed medications had been taken after they had been prepared. *Medications that had been destroyed were documented. Findings include: 1. Review of the 5/9/2024 SD DOH complaint revealed, "...there was a little cup with pills in it beside his [resident 1] bedside." 2. Review of resident 1's electronic medical record (EMR) revealed: *He had been admitted on 5/6/24 and had returned to the hospital on 5/9/24. *His diagnoses included myocardial infarction (heart attack), type 2 diabetes mellitus, and nausea. *A physician's order dated "05/06/2024" for "Midodrine HCl Oral Tablet 5 MG [milligrams] (Midodrine HCl) give 5 mg by mouth before meals related to HYPOTENSION DUE TO DRUGS (I95.2) until 05/11/2025 23:59 Take 1 tablet (5mg) by mouth 2 times a day before meals." -This medication had been scheduled to be given at 7:00 am, 11:00 a.m., and 4:00 p.m. --It had been administered three times on 5/7/24 and three times again on 5/8/24.	F 658	Nursing or Designee will also review the medication administration record of all residents on the 700/800 (rehab) unit to ensure orders are accurate per physician order. 3. To ensure the deficient practice does not recur, Director of Nursing or Designee will educate nurses on hypoglycemic policy, medication administration policy, medication error policy and medication disposal policy by 6/13/24 via in-service. If employee is not able to attend in-service then education will be completed via phone or competency prior to next shift. 4. To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit five residents, rotating to different residents for each audit, who experience high or low blood sugars to ensure repeat blood sugar occurs within 15 minutes. Audit will also cover physician notification was followed for high or low blood sugar. Audit will be completed weekly x4 and bi-weekly x2. Director of Nursing or Designee will also audit for proper medication administration of five residents, rotating to different residents for each audit. Audit will be completed weekly x4 and bi-weekly x2. The	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2 *There had been no documentation in the EMR regarding the medications found in resident 1's room on 5/8/24 that he had not taken, the physician had been notified, or the medications had been destroyed. *On 5/8/24 at 9:19 p.m. resident 1 had a blood glucose level of 69. -A physician order for "Bedside glucose QID [four times a day]. Call PCP [primary care provider] if blood sugar is >400 or <70 before meals and at bedtime." --On 5/8/24 at 11:24 p.m., resident 1's repeated blood glucose level was 52. *A health status note on 5/8/24 at 11:31 p.m. indicated "Patient's HS [hour of sleep] blood sugar was low. Did accept juice at that time. Didn't feel that he could eat anything stating that he felt full." -The Physician had been notified on 5/8/24 at 11:39 p.m. and a physician's order had been obtained for "Glucagon Emergency Kit 1 MG (Glucagon (rDNA)) Inject 1 milligram (mg) intramuscularly as needed for low blood sugar." --The Glucagon had been documented as administered on 5/8/24 at 11:50 p.m. ---On 5/9/24 at 12:32 a.m. a repeated blood glucose level was 111. ----The repeated blood glucose level had been completed 42 minutes after the intervention. *There was a physician's order for "Zofran Oral Tablet 4 MG (Ondansetron HCl) Give 1 tablet by mouth every 12 hours as needed for nausea." -It had been administered on 5/9/24 at 2:55 a.m. for "[complaint of] c/o nausea and [large] lg emesis [vomiting episode] x1" and again on 5/9/24 at 8:09 a.m. --There was no documentation communication with the physician had occurred for a dose to be provided earlier than ordered.	F 658	results of these audits will be brought to QAPI committee meeting by Director of Nursing or designee and continued until facility demonstrates sustained compliance as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3 3. Review of a 5/8/24 facility grievance report revealed: *Resident 1's "wife found two pills in a cup sitting on the night stand." *The "Pills will be given to Rehab Nurse Manager." 4. Interview on 5/29/24 at 3:30 p.m. with registered nurse (RN)/ Minimum Data Set coordinator F revealed resident 1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. 5. Interview on 5/30/24 at 9:48 a.m. with social worker (SW) M revealed: *A grievance had been filed by resident 1's wife on 5/8/24 at approximately 6:00 p.m. regarding her concerns about resident 1's nausea and vomiting, blood glucose levels, and medications found at his bedside. *An investigation had been initiated into her concerns at that time. *SW M had been present in the room when a small cup containing two pills had been found on resident 1's nightstand. -These medications were given to the nurse on duty, who indicated those were not medications she provided, and they were then stored overnight in SW M's locked office. --The small cup containing two pills had been given to administrator H on the morning of 5/9/24 by SW M. 6. Interview on 5/30/24 at 10:08 a.m. with administrator H revealed: *On the morning of 5/9/24 SW M had given him a small cup containing two pills.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 He indicated the pills had been found in resident 1's room on the evening of 5/8/24. *He had given the small cup containing two pills to director of nursing (DON) D. *He had been aware a grievance had been filed on 5/8/24 regarding resident 1. -He would have expected DON D to complete an investigation regarding those concerns. 7. Interview on 6/3/24 at 8:38 a.m. and again at 12:42 p.m. with DON D revealed: *Resident 1's midodrine had been ordered by the physician for "twice a day". -She confirmed it had been administered three times on 5/7/24 and three times again on 5/8/24. -The physician's order had been entered into the medication administration record incorrectly. --She stated, "It was on us to enter it correctly." ---She had not been aware of this medication error. *On the morning of 5/9/24 administrator H had given her a small cup containing 2 pills. -She had identified the pills as "mirtazapine [an anti-depressant] and midodrine that would have been given at bedtime." --An investigation had been completed regarding the pills found in resident 1's room. -She stated she had destroyed the pills, however, "we don't actually document the destruction of the medications." *She confirmed that there had been no documentation in the EMR regarding finding the two pills, the investigation she completed, or the destruction of the medications. *She would have expected the above documentation and stated, "The physician should also have been notified" that the resident had not received those medications as ordered. *She confirmed that resident 1 received Zofran	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 5 on 5/9/24 at 2:55 a.m. and again on 5/9/24 at 8:09 a.m. -The physician had ordered a dose every 12 hours as needed. --She would have expected documentation in the EMR that the physician was contacted before administering an early dose. -This would have been considered a medication error. -She had not been aware that the medication had not been administered as ordered. 8. Interview on 6/4/24 at 11:06 a.m. with clinical care leader /RN G revealed she would have expected: *When resident 1 had a blood glucose level of 69 the physician to have been notified immediately after the necessary care had been provided. *A blood glucose level to have been rechecked after 15 minutes if the initial reading was below 70. *After Glucagon had been administered a nursing assessment including a repeated blood glucose level to have been completed after 15 minutes. 9. Review of the provider's 10/30/2023 Hypoglycemic Incidents policy revealed: *"For residents with diabetes, the practitioner should be called immediately when the blood glucose value is less than 70mg/deciliter (dL) and is unresponsive or has consecutive blood glucose readings less than 70mg/dL." *"The rule of 15 should be followed when symptoms of hypoglycemia occur: give 15 grams of glucose ... Repeat blood glucose test after 15 minutes. If still below the target, give another 15 grams of glucose or carbohydrate." *"Notify practitioner."	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 6 10. Review of the provider's 5/21/2024 Medication: Administration Including Scheduling ... policy revealed" *"Purpose: To administer medications correctly and in a timely manner." *"An incident report will be completed for all medication errors." *"Do not leave medications at the bedside or at the table unless there is a specific physician order to do so, and the resident has been evaluated for self-administration. If the resident has not been assessed for safety of self-administration and there is not a physician order to leave the medication with the resident, stay with the resident until the medication is taken and you observe the resident swallow." 11. Review of the provider's 3/29/2024 Medication Errors policy revealed: *"When a medication error occurs, it will be reported promptly to the attending physician, resident and or responsible party and documented ..." *"Medication Error- The observed or identified preparation or administration of medication or biologicals which is not in accordance with the prescriber's order ... or accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils." *"Medication Error Types ... Wrong Dose/Amount -When the resident receives an amount of medication that is greater than or less than the amount ordered by the physician." -"Wrong Time- The failure to Administer a	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 7 medication to a resident within a predefined interval from its scheduled administration time ..." -"Omission- The failure to administer an ordered dose to a resident by the time the next dose is due ..." -"Transcription Error- Inaccurate transcription of an order." 12. Review of the provider's 8/01/2023 Medication: Disposition (Disposal) policy revealed: *"To ensure accurate disposal of medications ... 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, medication name, prescription number (as applicable), quantity, date of disposition and the involved staff member ..." *"Wasted/Dropped or Refused Medications: For non-narcotic medications ... destroy using drug buster or pharmacy approved method of destruction. Document in medical record the reason for the destruction."	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684	F684 A 1. On Monday May 27th when elopement occurred resident three was assessed and vital signs taken. Resident three's physician was notified and did order lab work-up on him for increased behaviors. Functioning of resident three's wander guard was completed on 5/27/24 and order was updated to check functionality daily as of 6/6/24.	6/28/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 by: A. Based on review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview and policy review the provider failed to ensure of one of one sampled resident (3) had been accurately accounted for when a door alarm had been activated. Findings include: Notice: Notice of immediate jeopardy was given verbally and in writing on 5/30/24 at 10:41 a.m. to administrator H and director of nursing (DON) D of the immediate jeopardy related to resident elopement and quality of care at F684. On 5/30/24: * At 10:41 a.m. administrator H and DON D were notified of a request for a removal plan. On 5/31/24: *At 8:35 a.m. the removal was received. *At 8:45 a.m. the removal was accepted. On 6/3/24: *At 8:30 a.m. while on-site the survey team verified the immediacy was removed. Plan: 1."On Monday 30, 2024 at 2:52 p.m. on shift message was sent to all employees that summarized the education summary of elopement. This serves as the immediate education for all employees. If staff are not able to complete education on 5/30. They will be required to complete the make-up prior to their next shift. RN S was educated on 5/28 on the process for call DON/Administrator immediately when resident safety is at risk-including	F 684	2. By 6/21/24 Director of Nursing or Designee will check functionality of all wander guards and orders will be updated to check functionality daily. 3. To ensure deficient practice does not recur, all staff were educated on 5/30/24 on elopement policy/procedure via in person hallway and department in-services. Those who were not in attendance were called via phone. Nurse S was educated on 5/28/24 on the process for calling DON/Administrator immediately when resident safety is at risk – including elopements. Nurse S was also educated on the next step of the policy to initiate a head count of all residents when a door alarm is sounded with no explanation. C.N.A. T received a final corrective on 5/28/24 for lack of rounding during shift when elopement took place. C.N.A. T also received elopement education on 5/30/24. 4. To monitor performance Elopement Drills will be completed weekly x4 and then bi-weekly x4. These will be completed on different shifts, different days of the week and in different locations within the building. The results of the drills will be brought to QAPI committee meeting by Director of Nursing or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9 elopements. The nurse was also educated on the next step of the policy to initiate a head count of all residents when a door alarm is sounded with not explanation." 2."Certified nursing assistant (CNA) T, on the top half of 200 on 5/26 from 10 p.m. - 6 a.m. was noted to have missed a toileting round of resident 3 at 4:00 a.m. This would have decreased the time of the residents' elopement. The CNA T received a final corrective action on 5/28/ for lack of rounding during this shift. This standard will be upheld for any employees that are found to have failed to complete their rounding as ordered/recommended." 3."All staff were educated on 5/30 on the importance of rounding on all resident's multiple time a shift. Residents with high fall and elopement to chart in the hallways so residents can be in eye site." 4. "All staff were educated on utilizing our call system as all exit doors are on the call system to notify all staff if an exit door is alarm on the scrolling screen and the radios." 5. "Monday May 27th-when elopement occurred, assessment of resident was completed, and vital signs taken." 6. "Tuesday May 28th an elopement drill was completed with day shift around lunch time. Education was provided to staff involved with elopement." 7. "Wednesday May 29th around 5 p.m., an potential elopement alert was initiated due to a phone call from someone in the community	F 684	Designee and continued until the facility demonstrates sustained compliance as determined by the committee. F684 B 1. By 6/03/24 resident two's care plan was reviewed and updated to ensure cares and services are reflected on care plan. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure deficient practice does not recur, Director of Nursing or Designee will educate nurse leadership on reviewing and maintaining accurate care plans by 6/20/24 via in-service. Certified nurse assistants were education on 6/27/24 on answering call lights in timely manner. If employee is not able to attend in-service then education will be completed via phone or competency prior to next shift. 4. To monitor performance and ensure ongoing compliance the Director of Nursing or designee will audit five residents who are dependent on staff for cares. Care plan will be reviewed to ensure comprehensive care plan outlines services provided and arranged by	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 stating in a resident was outdoors near Marion Road. Staff responded to code and facility did head count and everyone was accounted for." 8. "Thursday May 30th, hallway and department education is being completed with all staff regarding elopement processes and policy review. Elopement policy/procedure was reviewed, explained what an elopement is, who is considered an elopement risk, steps to take when a potential elopement occurs, who to notify if a resident does elope and how to respond to door alarms and completing head counts if no residents were found when alarm was responded to." 9."Resident 3's physician was out to facility and updated again on recent elopement events. Resident 3's physician ordered lab work-up on him as this an increase in his normal behaviors. He also would like and update on Monday on how he is doing." 10. "Elopement Drills will be completed weekly x4. These will be completed on shifts, different days of the week and different locations within the building. Then every other week x 4 weeks." On 5/31/24 8:35 a.m. the removal plan was received. On 5/31/24 at 8:45 a.m. the removal plan was accepted. On 6/3/24 at 8:30 a.m. while on-site the survey team verified immediacy was removed. Once the immediacy had been removed the scope and severity was a "G".	F 684	the facility. Audit will be completed weekly x4 and bi-weekly x2 and results brought to QAPI. Administrator or Designee will audit call time for 13 residents to review outliers weekly x4 then bi-weekly x2. The results of these audits will be brought to QAPI committee meeting and continued until facility demonstrates sustained compliance as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 1. Review of the SD DOH FRI revealed: *On 5/27/24 at 5:50 a.m. the report had been submitted that indicated resident 3 had eloped (left without staff knowledge) from the facility. *The resident had been located by staff and brought back to the facility. -His vitals were as follows: Temperature 98.0 Fahrenheit, Pulse rate 109 beats per minute, respiratory rate 10 breaths per minute, blood pressure 131/71, and oxygen saturation (oxygen level in the blood stream) of 97%. 2. Review of resident 3 electronic medical record (EMR) revealed he: *Had been admitted on 2/7/24. *Had diagnosis of: dementia with agitation. -BIMS (brief interview mental assessment) completed on 5/13/24 with a score of 4 which indicated severe cognitive impairment. *Had been assessed and determined to have a risk for elopement on : -On 2/7/24. -On 2/8/24. -On 5/27/24. *Had an order for the placement of a wander guard (door activating bracelet) on 2/7/24 and to ensure the wander guard was in place twice a day. *Resident 3's care plan was revised on 5/14/24 for staff to have checked the functioning of the wander guard monthly. 3. Interview on 5/29/24 at 10:10 a.m. with resident 3's wife revealed: *She had not been notified of resident 3's elopement when it had occurred, but had not been updated on the provider's investigation. *He had eloped from another facility before.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 *Resident 3 had a wander guard on his wheelchair since he was admitted on 2/7/24. 4. Interview on 5/29/24 at 2:25 p.m. with registered nurse (RN) E regarding resident 3's wander guard placement and function revealed: *She had only checked the placement of the wander guard. *RN E had known that checking the functionality of the wander was to have been performed monthly. -There had not been any documentation of the functionality of the wander guard. 5. Interview on 5/30/24 at 8:50 a.m. with DON D regarding a progress note and investigation timeline of resident 3's elopement revealed: *DON D stated certified nursing assistant (CNA) T had reported that resident 3 had not been assisted with toileting during the 5/27/24 4:00 a.m. rounds. -It was then when the resident 3 had been identified as missing. *Resident 3 had been found and escorted back into the building on 5/27/24 at 5:39 a.m. *RN S had checked the doors when the alarm sounded at 5/27/24 at 3:25 a.m. and had not identified resident 3 as missing. *She agreed that a progress note had not been created to account for resident 3's elopement on 5/27/24 at 3:15 a.m. and his return into the building at 5:39 a.m. *DON D indicated the nursing assessment upon the resident's return into the building had been documented in the facility's internal incident report. 6. Interview on 5/30/24 at 8:20 a.m. with clinical care leader RN/ C revealed she agreed that there	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 had not been any documentation of the functionality of resident 3's wander guard. 7. Interview on 5/30/24 at 9:11 a.m. with DON D regarding a progress note in resident 3's EMR regarding a second elopement revealed: *She was unsure of why a progress note had been made on 5/27/24 at 9:41 p.m. that indicted resident 3 had been outside of the building waving at cars. *She had not been aware of that elopement or another elopement by resident 3. 8. Review of the SD DOH FRI submitted on 5/31/24 at 4:00 p.m. regarding resident 3's second elopement revealed: *"State surveyor was in the building and called out a progress note of an elopement. After further investigation the resident was confirmed eloping. *"Investigation conclusion revealed:" -"Cameras was reviewed and confirmed that resident did exit the building after pushing on the outside door for 15 seconds. Staff responded to the alarm and escorted the resident back inside. Resident left the building at 8:06 p.m. and was escorted back into the building at 8:20 p.m." 9. Review of the provider's July 2023 Elopement policy revealed an elopement was defined as "When a resident who needs supervision leave the premises or a safe area without authorization." B. Based on review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure cares and services were provided to meet the needs for one of one sampled resident (2)	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14 with cognitive impairment, who was dependent on staff for all cares, used a call light at times to alert staff of needs, and had a history of falls. Findings include: 1. Review of the SD DOH FRI submitted on 5/20/24 revealed: -*On 5/18/24 at 12:30 p.m. resident 2 was found in her room by a nurse. -She was lying on her back, on the floor next to her bed. -she was naked and covered in feces. -The resident was assessed and no apparent injury was found. -Resident was able to perform range of motion (ROM) per her baseline without per baseline right side was flaccid (a type of paralysis) from a history of a stroke. -She was assisted off the floor with a hoyer lift, cleaned and put back in her bed. 2. Observation and interview on 5/29/34 at 10:23 a.m. with resident 2 and CNA N revealed: *Resident 2 was well-groomed and seated next to the nurse's station. *CNA N stated resident 2 could verbalize yes or no when asked questions and would display facial expressions. 3. Observation on 5/29/24 at 10:27 a.m. of resident 2 during an occupation therapy session with Occupational therapist (OT) U revealed: *OT U placed electrode pads that were connected to a device that stimulated muscle contractions on her right bicep and the palm of her right hand. *Resident 2 performed arm lifts with her right arm, then then performed right-hand clenching motions.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15 *Resident grimaced and denied pain and continued doing her exercises. * No other therapy activities observed were completed with resident 2 at that time. 4. Observation and interview on 5/29/24 at 11:38 a.m. with resident 2 while in her room revealed: *She communicated by whispering and nodding or shaking her head. *She indicated she had fallen at home but had not fallen at the facility. 5. Interview with CNA N on 5/29/24 at 1:43 p.m. regarding resident 2 revealed. *She had fallen more than once since she had been admitted, but had no significant injuries from those falls. *Resident 2's memory is was not consistent. *She would have crawled out of bed if not watched, *CNA N was not aware of resident 2 having had any fall alarms, or anything being discussed with her family about that. 6. Interview with the licensed practical nurse (LPN) R on 5/29/24 at 1:47 p.m. revealed: *Resident 2 had fallen multiple times since she had been admitted. *The day shift was staffed with two nurses and two CNAs. *She has not worked short-staffed on her shifts. *She had placed resident 2 in her recliner per her request. *A couple of minutes later she stood and fell. *She had no injuries from that fall. 7. Interview on 5/29/24 at 2:00 p.m. with LPN O revealed: *Resident 2 room was located across from the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 nurse's station. -Resident 2 would have wanted to sleep all day and would have refused to get up at times. -She had a high fall risk. -She had fallen two days ago without an injury. *She would stand up on her own at times. *LPN O had been working there five days when resident 2 fell on 5/18/24. -She had been shown the call light system during her orientation but was not familiar with it and was not sure about fall alarms. *She had not heard the call light system and stated it had not been making a sound. *She was aware resident 2's call light had been on from 11:41 a.m. until 1:05 p.m. the night she fell. *When she went into resident 2's room she found her on the floor. *Resident 2 had been moved to room closer to the nurse's station for increased monitoring. 8. Observation and interview on 5/30/24 at 7:59 a.m. with the director of nursing (DON) D while reviewing the recorded camera video from 5/18/24 revealed: *There was a long call light for resident 2's room from 11:40 to 1:05 p.m. *The video showed the hall from the nurse's station to the end of the hall where resident 2's was located on the right side of the hall. *There were multiple people who had moved up and down the hall whom she identified as visitors. *CNA K was seated near the nurses station, was on her cell phone, and had not answered the call light. *She would have expected CNA K to have made rounds during that time and to have answered call lights. *She said the nurses appeared to have been	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 busy with other duties as they moved about the hall. *The video showed on at least two occasions, staff members had been together in that hall and had not responded to the call light. *She explained when a resident activated a call light the room number would be displayed on a digital board in the hall and at the nurses's station and it would alert to the staff walkie-talkies. *It would have alerted a nurse manager if the call light was not responded to within 15 minutes, then administration if still not responded to after 20 minutes. *It had a digital voice that would announce over the intercom and would repeat, "Bedroom nurse call [room number]" or "Bathroom nurse call [room number]." *The walkie-talkies could be turned off and the volume could be turned down. *The nurse manager was attending to another resident at that time. *She was not sure why resident 2's call light was not answered timely. *She agreed the needs for resident 2 should have been anticipated due to her admitting diagnoses of an aneurysm affecting her right side, impaired cognition and communication, and Clostridium difficile (C-diff, a condition that can cause frequent diarrhea, colon inflammation, and colon damage). *She agreed that resident 2 was incontinent of her bowels during two of her falls. *She agreed that the resident 2's needs related to C-diff had not been anticipated on more than one occasion. *She stated LPN O had been oriented to the call light system. *She stated the nurse on shift LPN O, would have been responsible for CNA K's care she provided	F 684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 to the residents. 9. Observation and interview on 6/3/24 at 8:34 a.m. with resident 2 and LPN O and LPN R revealed: *LPN O had assisted resident 2 from her room and seated her near the nurse's station. *Resident 2 had a laceration to the right side of her head that was actively bleeding and had a raised area on the back of the left side of her head. *Resident 2 indicated she fell after trying to get herself up. *LPN O stated, she was standing at the med cart outside of resident 2's room and heard her fall but did not see her fall. *LPN O then took resident 2 into her room to clean her wound. *LPN R stated she was completing paperwork for resident 2 to transfer to the emergency room for further treatment. 10. Interview on 6/4/24 at 7:20 a.m. with agency RN P revealed: *Resident 2 had fallen on 6/2/24 while she had been working. *No injuries were noted. *She stated she had placed her on 15-minute checks, but these are not documented anywhere as being done. *The 15-minute checks were not being done before resident 2's fall on 6/2/24. *She stated resident 2 should have one-to-one care. *Nurses were to initiate interventions after a resident had a fall. 11. Interview and observation on 6/4/24 at 7:50 a.m. with LPN O and resident 2 revealed:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 *Resident 2 opened her closed room door independently while in her wheelchair. *She could not open her door while in the room until LPN O showed her the automatic door open button on the wall and then resident 2 opened the door by pushing the button. 12. Interview on 6/4/24 at 7:56 a.m. with clinical care leader registered nurse RN G revealed: *Resident 2's care plan for falls consisted of toileting every 2 hours. *Resident interventions could be seen in a resident chart in the risk management area. *CNAs were to review the interventions in the residents' care plans. *She stated resident 2 could have a mat on the floor but she would be afraid she would trip over it when she tried to get up independently. *She agreed she was moved to room closer to the nurse's station for increased monitoring but it was not on her care plan. *She stated activities were care planned to keep her busy to help with not transferring herself, she did not find this in her care plan while using her computer during the interview. *She was to be seated at the nurse's station for one-to-one monitoring, and this was not on her care plan. *She was aware of the long call light response wait time that occurred on 5/18/24. *She does not do call light audits unless a situation requires audits. *If the nurse manager on the weekend was too busy to assist with a long call light she could have called for assistance. *No fall alarms of any kind are allowed there. *Agency staff do not have access to their policies. 13. Interview on 6/4/24 at 8:56 a.m. with DON D	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 revealed: *Professional standards are their facility policies. *A Brief Interview for Mental Status (BIMS) was the only cognition tool used at the facility unless there was a drastic change in a resident's score. 14. Record review of resident 2's Minimum Data Set (MDS) dated 5/22/24 revealed: *Her Brief Interview for Mental Status (BIMS) score was 3. *A BIMS score of 00-07 indicated severe cognitive impairment. 15. Record review of Resident 2's incident reports revealed: *On 5/18/24 she was found in her room on the floor naked next to her bed with feces all over her, without injury. This was an unwitnessed fall. *On 5/21/24 she was found kneeling by her bed with her upper torso and arms lying in bed, without injury. This was an unwitnessed fall. *On 5/27/24 she fell by a nurse at the nurses station across from her room, without injury. This was a witnessed fall. *On 6/2/24 She was found on the floor, without injury. This was an unwitnessed fall. 16. Record review of Resident 2's current care plan revealed interventions that included staff were to:: *Ensure/provide a safe environment: pressure call bell available at all times. Initiated and revision date 5/17/24. *Monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance, and lower extremity joint function. *Provided occupational (OT)/speech therapy (ST) cue cards into the resident's room due to impaired speech related to a history of stroke.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21 This was dated 5/20/24, there was no revision date. *There were no other fall interventions indicated in her care plan. 17. Record review of resident 2's electronic medical records (EMR) revealed diagnoses including cerebral infarction (stoke) affecting right dominant side, cerebral aneurysm (ballooning of a blood vessel in the brain), Parkinson's disease without dyskinesia without mention of fluctuations, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and transient cerebral ischemic attack (blocked blood flow that may cause stroke-like symptoms). 18. Record review of resident 2's nurse progress notes revealed: *On 5/17/24 the nursing interventions provided/required by nursing to address the resident's medical condition included, medication administration, encouraged and assisted with ADLs, safe transfers, contact precautions applied for cares, antibiotic administration for Clostridium difficile treatment (C-diff). How effective are the interventions/what progress is the resident making, noted as effective. *On 5/18/24 the LPN O went into the resident's room and found the resident on the floor naked covered in feces lying on her back. The resident was on the floor next to her bed. Resident was assessed for injuries, and no apparent injury was found. Resident able to perform Range of motion without per baseline as her right side remains noted flaccid from history of stroke. Resident assisted off the floor via hoyer lift and cleaned and put back in her bed. Facility protocol being followed.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 22 *On 5/19/24 Nursing interventions noted, medication administration, encouraged and assisted with ADLs safe transfers, contact precautions applied for cares, antibiotic administration for C-diff treatment. Effectiveness noted, effective. *On 5/22/24 nursing interventions involved, assist with all cares, able to feed self after set up, assisted as needed, therapy as needed. Effective of interventions noted, monitor safety and anticipate needs. *On 5/20/24 nursing interventions included, medication administration, encouraged and assisted with ADLs, safe transfers, contact precautions applied for cares, antibiotic administration for -diff treatment. Effectiveness noted, effective. *On 5/21/24 note involved, resident was noted kneeling by bed and recliner, upper body and arms on bed, knees on floor. Resident had diarrhea noted on linen, resident was checked and was dry 1 hour prior and staff was doing 15 minute visual checks due to risk of falls. She was seen 5-10 minutes prior to fall and was sleeping. She was alert and assisted back to bed after assessment completed with no injuries noted, range of motion with in normal limits (WNL), vitals signs WNL, neurological exam (neuros) WNL. Resident resting in bed, calm at this time. *On 5/22/24 the nursing interventions involved, assist with all cares, assisted as needed, therapy as needed. Effectiveness noted, monitor safety and anticipate needs. *On 5/24/24 nursing interventions involved, will monitor medications, pain, skin integrity, vital signs and mobility. Effectiveness noted, has been progressed to sit to stand. *On 5/25/24 the nursing interventions involved, medications administration, encouraged and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23 assisted with ADLs, safer transfers, contact precautions applied for cares, antibiotic administration for C-diff treatment. Effectiveness noted, cares need to be anticipated. *On 5/25/24 nursing interventions involved, encouraged and assisted with ADLs, safe transfers, contact precautions applied for cares, antibiotic administration for C-diff treatment. Effectiveness noted, Cares need to be anticipated. *On 5/26/24 nursing interventions involved, medication administration, encouraged and assisted with ADLs, safe transfers, contact precautions applied for cares. Effectiveness noted, cares need to be anticipated. *On 5/27/24 nursing interventions involved, medication administration, encouraged and assisted with ADLs, safe transfers. Effectiveness noted, resident continues to be a high fall risk with frequent checks required. *On 5/28/24 nursing interventions involved, assist with all cares, able to feed self after set up, assisted as needed, therapy as needed. Effectiveness noted, continue to assist as needed, more responsive. *On 6/1/24 the nursing interventions involved, assist with all dressing, hygiene, transfers, bed mobility, locomotion, and toileting. More restless this evening after supper, attempting to verbalize more, Continues poor safety awareness, able to feed self after set up, appetite good, therapy as able. Effectiveness noted, continue to anticipate needs. *On 6/2/24 the nursing interventions involved, assist with dressing, hygiene, transfers, bed mobility, locomotion and toileting. More restless this eve after supper. Attempting to verbalize more. Continues poor safety awareness. Able to feed self after set up. Appetite good. Neuros	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435045	A. BUILDING _____ B. WING _____	C 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY SIOUX FALLS VILLAGE	3901 S MARION RD SIOUX FALLS, SD 57106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24 WNL after unwitnessed fall. Therapy as able. *On 6/3/24 The incident progress note read, After resident was done eating breakfast, resident was put in her room to watch television, while the resident was watching television she attempted to stand up and fell on the floor and hit her head which resulted in a knot to the back of her head and a laceration to the right side of her head that didn't stop bleeding even with pressure. *On 6/3/24 the nurse progress note read, resident returned from emergency room visit following fall this a.m. During her hospitalization the resident received 6 staples to the laceration noted on the right side of her head. 19. Review of the provider's 11/1/23 Rehab/Skilled and Long Term Care Therapy Rehab policy revealed: *Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. *The care plan will emphasize the care and development of the whole person ensuring that the resident will receive appropriate care and services. It will address the relationship of items or services required and the facility responsibility for providing these services. 20. Review of the provider's 8/1/23 call light policy revealed staff were to:: *Ensure the resident always had a method of calling for assistance. *Promptly answer the residents' call lights.	F 684		